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Consent to Medical Treatment and the Competent Adult

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The University of Glasgow

School of Law

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Table of Contents

	Page Number
Abstract	i
Acknowledgments	iii
Abbreviations	iv
Table of Statutes	v
Table of Cases	vi
Introduction	1
Part one: Ethics and Philosophy	8
Chapter One: Autonomy	8
Chapter Two: The Relevance of Beneficence, Justice and Virtue	51
Chapter Three: The Healthcare Professional-Patient Relationship: Setting the Context for Consent	83
Chapter Four: The Concept of Consent – what it is and what it isn't	131
Part Two: Consent and the Law	177
Chapter Five: The Legal Regulation of Consent	178
Chapter Six: Rationalising the Law and Ethics of Consent	237
Summary and Conclusion	276
Bibliography	

Abstract

Following the recent scandals, the provision and regulation of healthcare is currently in a state of flux, which makes it an ideal time to re-examine the law in this area. In this thesis I analyse the concept of consent to medical treatment. I explore its ethical basis in autonomy and examine how other principles and ethical approaches might interact with the rules derived from autonomy. I then situate the relevant ethical obligations within the context of the healthcare professional-patient relationship which subsequently allows me to develop a textured model of consent.

The model is predicated on the theory that consent is a secondary right, derivative on the underlying right which it controls. By giving or withholding consent, the autonomous person determines who may justifiably infringe the primary right. Importantly, however, the context of the professional-patient relationship highlights the relevance of consent, not just as permission, but also as agreement. This aspect of consent to medical treatment requires both the patient and the professional to engage in the dialogue of negotiation, with both parties being mutually open to persuasion.

I subsequently utilise the model of consent to analyse the current law, which is found to be deficient in a number of ways. Amongst other things I explore the conceptual difficulties of the split regulation between the torts of battery and negligence. I examine the current standard of disclosure and conclude that while it seems to be moving towards the more autonomy respecting prudent patient standard, the courts may still be affording expert witnesses too much say in determining which risks should be disclosed. Most importantly I expose the thin and unsatisfactory conception of autonomy that appears to ground the current legal approach.

Some of the common law's deficiencies lie in tort law's focus on the outcome rather than the process of the interaction between the healthcare professional and the patient. This is exacerbated by association of outcome responsibility with consent and the need for physical or psychiatric damage to occur before the legal wrong is acknowledged. There are three responses to these deficiencies. The common law could be allowed to continue its piecemeal development. The deficiencies of the common law could be patched up by developing professional regulation, or new legislation could be drafted to deal specifically with consent to medical treatment. If there is a genuine commitment to patient autonomy and patient centred care then I submit that legislation is justified.

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List of Abbreviations

AHA	Area Health Authority
BMA	British Medical Association
CC	County Council
CMO	Chief Medical Officer
DH	Department of Health
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
GDC	General Dental Council
GMC	General Medical Council
HA	Health Authority
HCP	Healthcare Professional
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council

Table of Statute and Conventions

Statute	Page number
1. European Convention on Human Rights	
a. Article 8	66, 224, 235
2. Human Rights Act 1998	66, 212, 224
a. Article 8	154, 245
3. Mental Capacity Act 2005	267
a. S.3	186, 240
b. S.9	184
4. Mental Health Act 1983	266
a. S.3(2)(c)	184
b. S.58	184
c. S.62	184
d. S.63	184
5. Public Health (Control of Disease) Act 1984	
a. Ss.35-38	184

Table of Cases

	Cases	Page
1.	<i>Abbas v Kenney</i> [1996] 7 Med LR 47.	207
2.	<i>Airedale NHS Trust v Bland</i> [1993] 1 All ER 821, HL.	178, 179, 183, 241
3.	<i>Al Hamwi v Johnston, The North West London Hospitals NHS Trust</i> [2005] EWHC 206; [2005] Lloyd's Rep Med 309.	220, 221, 222
4.	<i>Allied Maples Group Ltd v Simmons & Simmons</i> [1995] 4 All ER 907; [1995] 1 WLR 1602, CA.	244
5.	<i>Anns v Merton London Borough</i> [1978] AC 728, HL.	269
6.	<i>Appleton v Garrett</i> [1997] 8 Med LR 75.	194, 239
7.	<i>Attorney General's Reference (No. 6 of 1980)</i> [1981] 1 QB 715, CA.	183
8.	<i>Attwell v McPartlin</i> [2004] EWHC 829.	222
9.	<i>Bancroft v Harrogate Health Authority</i> [1997] 8 Med LR 398.	208
10.	<i>Blyth v Bloomsbury Health Authority</i> [1993] 4 Med LR 151, CA (decided 1987).	205, 206, 207
11.	<i>Bolam v Friern</i> [1957] 1 WLR 582.	226, 227
12.	<i>Bolitho v City and Hackney Health Authority</i> [1998] AC 232, HL.	209, 211-213, 247
13.	<i>Bolton Hospitals NHS Trust v O</i> [2002] EWHC 2871	264
14.	<i>Bowers v Harrow Health Authority</i> [1995] 6 Med LR 16.	206
15.	<i>Breen v Baker</i> (1956) The Times 27 th January.	191
16.	<i>Cambridgeshire County Council v R</i> [1995] 1 FLR 50.	185, 240
17.	<i>Canterbury v Spence</i> 464 F2d 772, 780 (1972), US CA District of Columbia.	151, 197, 217, 229-230, 249, 259, 263

18.	<i>Caparo Industries plc v Dickman</i> [1990] 2 AC 605, HL.	269
19.	<i>Chappel v Hart</i> [1998] HCA 55; [1999] <i>Lloyds Law Reports Medical</i> 223; (1998) 72 ALJR 1344, HCA.	232
20.	<i>Chatterton v Gerson</i> [1981] 1 All ER 257.	185, 192, 227
21.	<i>Chester v Afshar</i> [2002] EWCA Civ 724, CA.	232
22.	<i>Chester v Afshar</i> [2005] 1 AC 134; [2004] UKHL 41, HL.	233, 245, 252, 270
23.	<i>Cobbs v Grant</i> 502 P.2d 1, 12 (1972), SC California.	251
24.	<i>Collins v Wilcock</i> [1984] 1 WLR 1172.	179, 180
25.	<i>Cooper v Royal United Hospital Bath NHS Trust</i> [2005] EWHC 3381.	219-220
26.	<i>Cornelius v De Taranto</i> [2001] EMLR 12.	235
27.	<i>Cornelius v De Taranto</i> (2002) 68 BMLR 62, CA.	235
28.	<i>Corus (UK) plc v St Gobain Pipelines plc</i> [2006] UKHL 20, HL.	269
29.	<i>Crawford v Board of Governors of Charing Cross Hospital</i> (1953) <i>The Times</i> , 8 December, CA.	205
30.	<i>Crouchman v Burke</i> (1997) 40 BMLR 163.	219
31.	<i>Cull v Royal Surrey County Hospital</i> (1932) 1 BMJ 1195.	191
32.	<i>Davis v Barking, Havering and Brentwood Health Authority</i> [1993] 4 Medical Law Reports 85.	238, 239
33.	<i>De Freitas v O'Brien</i> [1995] 6 Med LR 108, CA.	208
34.	<i>Department of Health & Community Services (NT) v JWB and SMB</i> (1992) 66 ALJR 300, HCA.	183
35.	<i>Deriche v Ealing Hospital NHS Trust</i> [2003] EWHC 3104.	219
36.	<i>Devi v West Midlands Regional Health Authority</i> (1981) Transcript 491, CA.	191
37.	<i>Djemal v Bexley Health Authority</i> [1995] 6 Med LR 269.	206

38.	<i>Doughty v North Staffordshire Health Authority</i> [1992] 3 Med LR [1991] 81.	207
39.	<i>Early v Newham Health Authority</i> [1994] 5 Med LR 214.	207
40.	<i>Enright v Kwun</i> [2003] EWHC 1000.	222, 223
41.	<i>Eyre v Measeday</i> [1986] 1 All ER 488, CA.	207
42.	<i>Fairchild v Glenhaven</i> [2002] 1 AC 32, HL.	269
43.	<i>Fowler v Lanning</i> [1959] 1 QB 426.	180
44.	<i>Freeman v Home Office</i> [1983] 3 All ER 589; [1984] 2 WLR 130.	190
45.	<i>Freeman v Home Office</i> [1984] 1 All ER 1036, 1044, CA.	183, 190, 192
46.	<i>Freeman v Home Office (No.2)</i> [1984] 1 QB 524, HC.	183
47.	<i>Freeman v Home Office (No.2)</i> [1984] 1 QB 524, CA.	183
48.	<i>Gascoine v Sheridan</i> [1994] 5 Med LR 437.	207
49.	<i>Gillick v West Norfolk and Wisbech Area Health Authority</i> [1986] AC 112, HL	86
50.	<i>Glass v UK</i> [2004] 1 FLR 1019, ECtHR.	225
51.	<i>Gold v Haringey Health Authority</i> [1988] 1 QB 481, CA.	206,207
52.	<i>Goorkani v Tayside Health Board</i> 1991 SLT 94, OH.	233, 245
53.	<i>Gowton v Wolverhampton Health Authority</i> [1994] 5 Med LR 432.	229
54.	<i>Gregg v Scott</i> [2005] UKHL 2, HL.	245
55.	<i>Haystead v Chief Constable of Derbyshire</i> [2000] 3 All ER 890; [2000] 2 Cr. App. R. 339.	182
56.	<i>Heath v West Berkshire Health Authority</i> [1992] 3 Med LR 57.	208
57.	<i>Hicks v Ghaphery</i> 571 SE.2d 317, 335 (2002), SC West Virginia.	253, 255

58.	<i>Hills v Potter</i> [1984] 1 WLR 641.	192, 227
59.	<i>Hotson v East Berkshire HA</i> [1987] AC 750, HL.	244
60.	<i>Joyce v Merton, Sutton and Wandsworth Health Authority</i> [1996] 7 Med LR 1, CA.	206
61.	<i>Judge v Huntingdon Health Authority</i> [1995] 6 Med LR 223.	207
62.	<i>Junior Books v Veitchi</i> [1983] 1 AC 520, HL.	269
63.	<i>Kelly v Hazlett</i> (1977) 75 DLR (3d) 536, HCJ Ontario.	193
64.	<i>Latter v Braddell</i> (1881) 50 LJQB 166, Common Pleas Division.	187-188
65.	<i>Latter v Braddell</i> (1881) 50 LJQB 448, CA.	187, 189
66.	<i>LCB v UK</i> (1998) 27 EHRR 212, ECtHR.	241
67.	<i>Letang v Cooper</i> [1965] 1 QB 232, CA.	180
68.	<i>Loveday v Renton</i> [1990] 1 Med LR 117, CA.	207
69.	<i>Lybert v Warrington Health Authority</i> (1995) 25 BMLR 91, CA.	218, 219
70.	<i>Malette v Shulman</i> [1991] 2 Med L.R. 162; (1990) 67 DLR (4 th) 321, CA Ontario.	234
71.	<i>Marriott v West Midlands Health Authority</i> [1999] <i>Lloyd's</i> <i>Law Reports Medical</i> 23, CA.	213
72.	<i>Matthies v Mastromonaco</i> 733 A.2d 456 (1999), SC New Jersey.	254
73.	<i>McAllister v Lewisham and North Southwark Health</i> <i>Authority</i> [1994] 5 Med LR 343.	206-207, 226, 228- 229, 231
74.	<i>McKay v Essex Area Health Authority</i> [1982] 1 QB 1166, CA.	234
75.	<i>McFarlane v. Tayside Health Board</i> [2000] 2 AC 59, HL.	72, 234, 252, 270

76.	<i>Mink v University of Chicago</i> 460 F.Supp. 713 (1978), DC Illinois.	181
77.	<i>Mohr v Williams</i> 104 NW 2 (1905), SC Minnesota.	191
78.	<i>Morgan v MacPhail</i> 704 A.2d 617 (1997), SC Pennsylvania.	182, 243
79.	<i>Moyes v Lothian Health Board</i> [1990] 1 Med LR 463, 468, OH.	227
80.	<i>Nancy B v Hotel-Dieu de Quebec</i> (1992) 86 DLR (4 th) 385, Quebec Superior Court.	178
81.	<i>Newell and Newell v Goldenberg</i> [1995] 6 Med LR 371.	207, 233, 245
82.	<i>The NHS Trust v Ms T</i> [2004] EWHC 1279; [2005] 1 All ER 387.	265
83.	<i>Nishi v Hartwell</i> 473 P.2d 116 (1970), SC Hawaii.	259
84.	<i>Norfolk and Norwich Healthcare (NHS) Trust v W</i> [1996] 2 FLR 613.	264
85.	<i>North West Lancashire Health Authority v A, D & G</i> [1999] Lloyd's Rep Med 399, CA.	224
86.	<i>Osman v UK</i> (2000) 29 EHRR 245, ECtHR.	92
87.	<i>Palmer v Eadie</i> Lexis Transcript 18 May 1987, CA.	207
88.	<i>Parkinson v St James and Seacroft University Hospital</i> [2001] EWCA Civ 530, [2001] 3 All ER 97, CA.	270
89.	<i>Pearce v United Bristol Healthcare NHS Trust</i> (1998) 48 BMLR 118, CA.	213-218, 228, 248-260, 282
90.	<i>Pretty v UK</i> (2002) 35 EHRR 1, 17, ECtHR.	225, 235
91.	<i>Putensen v Clay Adams Inc.</i> 12 Cal.App.3d 1062 (1970), CA California.	251
92.	<i>R v Bolduc and Bird</i> [1976] 3 CCC 294, SCC.	196

93.	<i>R v Brown</i> [1993] 2 WLR 556, HL.	183
94.	<i>R v Collins, ex p Brady</i> (2000) 58 BMLR 173.	266
95.	<i>R v Day</i> (1841) 173 ER 1026, Circuit Court.	135
96.	<i>R (Burke) v GMC</i> [2005] EWCA 1003; [2006] QB 273; [2005] 3 WLR 1132, CA.	149, 152, 223, 224
97.	<i>R v Family Health Service Appeals Unit ex parte Singh</i> (1995) Unreported Transcript: John Larking 21 st January.	206
98.	<i>R v McCoy</i> [1953] 2 SA 4.	189-190
99.	<i>R v Olugboja</i> [1982] QB 320, CA.	187
100.	<i>R v Richardson</i> (1998) 43 BMLR 21, CA.	194-195
101.	<i>R v Tabassum</i> [2000] Lloyd's Law Reports Medical 404; (2000) <i>The Times</i> 26 May, CA.	195
102.	<i>Ratty v Haringey Health Authority</i> [1994] 5 Med LR 413, CA.	208
103.	<i>Re AK (Medical Treatment: Consent)</i> [2001] 1 FLR 129.	265
104.	<i>Re B (Consent to Treatment: Capacity)</i> [2002] EWHC 49; [2002] 2 All ER 449.	178, 179, 265-266
105.	<i>Re C (Adult: Refusal of treatment)</i> [1994] 1 WLR 290; [1994] 1 All ER 819.	185, 240, 266
106.	<i>Re E (A Minor) (Wardship: Medical Treatment)</i> [1993] 1 FLR 386.	265
107.	<i>Re F (Mental Patient: Sterilisation)</i> [1990] 2 AC 1; <i>F v</i> <i>West Berkshire Health Authority</i> [1989] 2 All ER 545, HL.	183, 184, 262
108.	<i>Re L An Adult: Non-consensual Treatment)</i> [1997] 1 FCR 609.	264
109.	<i>Re MB (An Adult: Medical Treatment)</i> [1997] 2 FCR 541, CA.	13, 178, 186, 231, 264

110.	<i>Re R (A minor) (Wardship: Consent to Treatment)</i> [1992] Fam 11; [1991] 4 All ER 177; [1991] 3 WLR 592, CA.	158
111.	<i>Re S</i> [1992] 4 All ER. 671.	264
112.	<i>Re T (Adult: Refusal of Treatment)</i> [1992] 3 WLR 782, CA.	125, 178, 184, 187, 190-191, 234, 246,
113.	<i>Re W (A Minor) (Consent to Medical Treatment)</i> [1993] 1 FLR 1, CA.	265 158
114.	<i>Rees v Darlington Memorial Hospital NHS Trust</i> [2002] EWCA Civ 88, [2003] QB 20, CA.	270
115.	<i>Rees v Darlington Memorial Hospital NHS Trust</i> [2003] UKHL 52, HL.	234, 245, 270
116.	<i>Reibl v Hughes</i> (1978) 21 OR (2d) 14, Ontario CA.	192
117.	<i>Reibl v Hughes</i> (1981) 114 DLR (3d) 1, SCC.	193-194, 229, 239
118.	<i>Rochdale Healthcare (NHS) Trust v C</i> [1997] 1 FCR 274.	96, 264
119.	<i>Rosenberg v Percival</i> [2001] 178 ALR 577, HCA.	269
120.	<i>S v McC; W v W</i> [1972] AC 24, 43, HL.	178
121.	<i>Schloendorff v Society of New York Hospital</i> 211 N.Y. 125; 105 N.E. 92 (1914), CA New York.	179, 184
122.	<i>Scott v Shepherd</i> (1773) 2 W. Blackstone 892.	180, 182
123.	<i>Sharpe v Southend Health Authority</i> [1997] 8 Med LR 299.	206
124.	<i>Shine v Vega</i> 709 NE.2d 58, 64 (1999), SC Massachusetts.	263
125.	<i>Sidaway v Board of Governors of the Bethlem Royal Hospital</i> [1985] AC 871, HL.	179, 192, 196-205, 226, 238, 247
126.	<i>Smith v Barking, Havering and Brentwood Health Authority</i> [1994] 5 Med LR 285.	227
127.	<i>Smith v Salford Health Authority</i> [1994] 5 Med LR 321;	219, 224

- (1994) 23 BMLR 137.
128. *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334. 207, 213, 218, 229
129. *Spring v Guardian Assurance* [1995] 2 AC 296, HL. 244
130. *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* [1998] 3 All ER 673, CA. 135, 178, 187, 264, 267
131. *Stobie v Central Birmingham Health Authority* (1994) 22 BMLR 135. 208
132. *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762. 264
133. *Thompson v Bradford* [2004] EWHC 2424. 222-223
134. *Thompson v Bradford* [2005] EWCA Civ 1439; [2006] Lloyd's LR Med 95, CA. 223
135. *Mrs U v The Centre for Reproductive Medicine* [2002] EWCA Civ 565, CA. 191
136. *Vandi v Permanente Medical Group* 9 Cal. Rptr.2d 463, 467 (1992), CA California. 254
137. *W v UK* (1988) 10 EHRR 29, ECtHR. 154, 225
138. *Waters v West Sussex Health Authority* [1995] 6 Med LR 362. 207
139. *Wyatt v Curtis* [2003] EWCA Civ 1779, CA. 217, 248

Introduction

The patient who is armed with information, who wants to ask questions, sometimes difficult and awkward questions, should be seen as an asset in the process of care and not an impediment to it.

- Sir Liam Donaldson, the Chief Medical Officer (CMO).¹

In recent years the healthcare professions have been rocked by a number of high profile scandals including the murderous activities of Harold Shipman and Beverly Allitt, the issue of organ retention, and the problems of paediatric cardiac surgery at the Bristol Royal Infirmary (BRI).² In addition to these, the cost of clinical negligence litigation, and adverse events in general, has further focused the Government's attention on healthcare practice.³ Part of the remit of the BRI Inquiry was to: 'make recommendations which could help to secure high quality care across the NHS'.⁴ One of the principles that formed the basis for the Inquiry's recommendations was that:

Patients must be at the centre of the NHS, and thus the patient's perspective must be included in the policy, planning and delivery of services at every level.⁵

A crucial part of developing a patient-centred service was the need to '[encompass] the notions of respect for and honesty towards patients'.⁶ Thus, not only was it important to focus on the mechanics of healthcare but also on the attitudes of the healthcare

¹ Speaking at the 2nd National Service Delivery and Organisation Conference (2003). Available at: http://www.dh.gov.uk/AboutUs/MinistersAndDepartmentLeaders/ChiefMedicalOfficer/WhatsNew/QuoteUnquote/QuoteUnquoteArticle/fs/en?CONTENT_ID=4102557&chk=mb0p0a, last accessed 31st July 2006.

² Kennedy, I. *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 –1995* (2001) Cm 5207.

³ See: CMO. *An Organisation with a Memory* (2000) London: Department of Health; in 2001, the National Audit Office (NAO) reported a seven-fold increase in costs since 1995-1996: NAO, *Handling Clinical Negligence Claims in England* (2001) HC 403 Session 2000-2001, 1.

⁴ *Op cit* n.2, Chapter 21 [1].

⁵ *Ibid.*, Chapter 21 [9].

⁶ *Ibid.*, Chapter 21 [14].

professionals (HCP). For the inquiry the way forward was to encourage a partnership between the professionals and the patients.⁷ The Inquiry noted that, while HCPs were in general dedicated to the good of the patient there was a persistent and entrenched culture of paternalism that:

[D]iscourage[s] patients from asking questions, and lead[s] to their being given only limited access to information, thereby preventing patients from participating fully in their care.⁸

A whole chapter of the final report was devoted to developing a culture of respect and honesty. It began with a summary of the problems encountered at the BRI, which included a closed culture of paternalism, with patient communication 'too often left by senior clinicians to nurses or junior doctors'.⁹ The Inquiry emphasised:

that the [professional-patient] relationship needs to be based on partnership rather than on outmoded paternalism, and we stress the importance of involving patients, wherever possible, in decisions about their treatment and care. We suggest that much greater attention must be given to patients' needs for information and for support for them and their families.¹⁰

This approach to respect, information and partnership was something that the Government had already committed to.¹¹ Furthermore, in submissions to the Inquiry, professional bodies, such as the Royal College of Surgeons and the Royal College of Nursing, also acknowledged the importance of partnership.¹² The Inquiry's concern for involving patients in treatment decisions gave rise to four key principles regarding information disclosure:

⁷ *Ibid.*, Chapter 21 [23].

⁸ *Ibid.*, Chapter 22 [17].

⁹ *Ibid.*, Chapter 23.

¹⁰ *Ibid.*, Chapter 23 [2].

¹¹ DH. *Patient and Public Involvement in the New NHS*, (1999) London: DH. (Health Service Circular: HSC (99) 210).

¹² *Op cit* n.2, Chapter 23 [14].

First, trust can only be sustained by openness. Secondly, openness means that information be given freely, honestly and regularly. Thirdly, it is of fundamental importance to be honest about the twin concerns of risk and uncertainty. Lastly, informing patients and in the case of young children their parents must be regarded as a process and not a one-off event.¹³

The Inquiry further found that information was often of poor quality, being out of date or designed to ensure compliance rather than enable rational decision-making.¹⁴ However, it was also recognised that time was an important constraint on effective communication and the Inquiry recommended that the National Health Service (NHS) ensure appropriate working arrangements.¹⁵ Finally, the Inquiry noted the predominance of a functional approach to consent. It argued that:

The real task is a process which involves explaining what is to take place; setting out what is known about the risks, uncertainties, and possible negative consequences, about the specific performance of the trust, of the specialty and of the consultant unit (as that information becomes available), about any alternatives and about the likely outcome; considering and explaining how the patient will be affected; and seeking and answering questions. Such a process is the only proper way to gain the patient's informed authority to proceed.¹⁶

The Inquiry suggested that rather than seeing consent as a discrete event, it should be integrated more fully into the process of providing healthcare. It concluded: 'What we are emphasising is the primacy of the patient's choice; the right of patients to be asked if they

¹³ *Ibid.*, Chapter 23 [18].

¹⁴ *Ibid.*, Chapter 23 [23].

¹⁵ *Ibid.*, Chapter 23 [29].

¹⁶ *Ibid.*, Chapter 23 [43].

wish to undergo the procedure, to be informed about the procedure and to be asked to agree'.¹⁷

The Department of Health (DH) responded by acknowledging a commitment to 'develop an NHS where there is a culture of openness and honesty ... and where patients and staff work in genuine partnership'.¹⁸ Emphasising the importance of patient-centred care, the DH stated:

We want to develop a culture of openness, honesty and trust; to ensure that patients have the information they need to make informed choices; and to enable patients to become equal partners with health care professionals in making decisions about treatment and care.¹⁹

The DH included in their reform programme 'a consent process which engages patients fully in decisions about their care'.²⁰

In fact, as the DH noted, it had already set up the *Good Practice in Consent Initiative*, as part of the implementation of the 2000 *NHS Plan*.²¹ This involved establishing an advisory group and publishing guidance documents and model consent form.²² In addition to its symbolic importance, the document provides helpful guidance on what is currently required by the law. For certain specific areas, such as consent to anaesthesia, the guidance is particularly helpful in clarifying who has responsibility. Unfortunately, however, the guidance does not venture far beyond that already required by the law. Nevertheless, it does serve to emphasise the importance of consent and it reinforces the commitment in the *NHS Plan*.

¹⁷ *Ibid.*, Chapter 23 [45].

¹⁸ DH. *Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry in to children's heart surgery at the Bristol Royal Infirmary 1984-1995* (2002) Cm 5363 London: The Stationery Office, Executive Summary [2]; see also para 1.4.

¹⁹ *Ibid.*, Executive Summary [12].

²⁰ *Ibid.*, Executive Summary [13];

²¹ See: <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/fs/en>, last accessed 31st July 2006.

²² DH. *Good practice in consent implementation guide: consent to examination or treatment* (2001) London: DH.

The commitment to patient-centred care is reinforced by the recent publication *Creating a Patient-led NHS*, which again indicates an intention to provide greater choice and information.²³ Other policies, such as the Expert Patient Programme,²⁴ the Patient Advice and Liaison Service,²⁵ the National Knowledge Service,²⁶ and the development of information technologies such as HealthSpace (which will allow each patient internet space to record their care preferences), cement the Government's intention to empower patients.²⁷ In June 2004, the Secretary of State for Health stated:

Patients' desire for high-quality personalised care will drive the new system. Giving people greater personal choice will give them control over these issues, allowing patients to call the shots about the time and place of their care, and empowering them to personalise their care to ensure the quality and convenience that they want.²⁸

However, without suitable legal protection, these political intentions may provide less than they promise.²⁹

²³ DH. *Creating a Patient-led NHS – Delivering the NHS Improvement Plan* (2005) London: DH, Chapter 1.

²⁴ Although this programme has a consequentialist motive, see: Melanie Johnson MP 'The Expert Patient Programme' (2004). Available at: http://www.dh.gov.uk/NewsHome/Speeches/SpeechesList/SpeechesArticle/fs/en?CONTENT_ID=4082345&chk=G3K07Q, last accessed 31st July 2006.

²⁵ *Op cit* n.18, para 2.12. See also, the DH PALS website: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PatientAndPublicInvolvement/PatientAdviceAndLiaisonServices/PatientAdviceAndLiaisonServicesArticle/fs/en?CONTENT_ID=4081305&chk=e%2BtVxu, last accessed 24th July 2006.

²⁶ *Op cit* n.18, para 2.11; See also the dedicated web site: www.nks.nhs.uk.

²⁷ DH. *NHS Improvement Plan 2004: Putting People at the Heart of Public Services* (2004) Cm 6268 London: DH, Executive Summary [12].

²⁸ The Rt Hon. John Reid MP. 'Building on the Best – An NHS for the Future' (2004). Available at: http://www.dh.gov.uk/NewsHome/Speeches/SpeechesList/SpeechesArticle/fs/en?CONTENT_ID=4087161&chk=T%2BByGgO, last accessed 24th July 2006.

²⁹ See: Coulter, A. 'Whatever happened to shared decision-making?' (2002) 5 *Health Expectations* 185; Sang, B. 'Choice, participation and accountability: assessing the potential impact of legislation promoting patient and public involvement in health in the UK' (2004) 7 *Health Expectations* 187, 190; Sillender, M. 'Can patients be sure they are fully informed when representatives of surgical equipment manufacturers attend their operations?' (2006) 32 *Journal of Medical Ethics* 395.

All healthcare interventions take place in the context of professional-patient contact making the professional-patient relationship - however fleeting - a core feature of healthcare provision. If patient-centred healthcare is to mean anything beyond shallow consumerism and political spin the focus must be on the interactions between the professionals and the patients they are caring for. If consent is necessary for the justification of healthcare interventions then, provided it is given a sufficiently textured interpretation, consent – and the communicative processes that envelop it – should be seen as integral to creation of a patient-centred system of healthcare. In the recent Report examining the professional regulation of doctors, it was noted that:

the public wants the assessment of doctors to go beyond technical skills to address the doctor's communication skills ... whether the doctor involves patients in treatment decisions and whether the doctor affords their patients dignity and respect.³⁰

It therefore seems an appropriate juncture to go back to square one and re-examine the law and ethics of consent to healthcare and the competent adult.

In the first part of the thesis I examine the moral basis of consent. I consider the meaning and importance of autonomy. Despite some recent challenges to the association between autonomy and consent,³¹ if autonomy is seen as the right of moral agents to make self-regarding decisions the connection is clear. The requirement for consent protects patients from paternalistic or other unjust actions that infringe their rights. While the rules implementing the requirement for consent may be criticised for failing to be sufficiently sensitive to a thick conception of autonomy,³² this does not undermine the essential relationship between autonomy and consent. However, the HCP's obligation to respect the patient's autonomy should not be examined in isolation of the professional's other

³⁰ CMO. *Good doctors, safer patients* (2006) London: DH, xi.

³¹ See, for example, Taylor, J.S. 'Autonomy and Informed Consent: A Much Misunderstood Relationship' (2004) 38 *The Journal of Value Inquiry* 383, 383.

³² O'Neill, O. *Autonomy and Trust in Bioethics* (2002) Cambridge: Cambridge University Press, 37-48.

duties. In chapter two I consider some of the other moral principles and approaches that may help to shape the extent of the HCP's duty to respect the patient's autonomy. Then, in chapter three, I situate the debate within the context of the professional-patient relationship. In the final chapter of Part One of the thesis I explore the concept of consent. In light of the earlier discussion, and bearing in mind the context of the professional-patient relationship, I develop a model of consent to healthcare interventions.

In Part Two, I examine the law's approach to consent. In chapter five, I consider the legal regulation of consent in battery and negligence. As far as possible, I explicate the rules that the courts have developed, particularly those in relation to risk disclosure and the communicative aspects of consent. This then allows me, in chapter six, to compare the legal model of consent against the model I developed in part one of the thesis. I end by briefly considering whether the common law could develop sufficiently to meet the criticisms of the current legal regulation, whether professional regulation could paper over the deficiencies or whether legislation is the most appropriate response.

PART ONE: ETHICS AND PHILOSOPHY

Chapter 1: Autonomy

In the introduction I suggested that consent is predicated on autonomy and if one considers the role consent plays, which I will discuss in more detail in chapter four, the connection with autonomy is apparent. Starting with the etymological derivation of autonomy, which comes from the Greek and means self rule, both senses of consent – as a waiver of a right and as a negotiated agreement – depend on the patient’s autonomy. Consent raises issues of liberty, power and control all of which are also relevant to the importance of autonomy.³³ Because of this connection, it is essential to explore autonomy in some detail. This will allow the attributes of consent to be given more substance, which is a necessary part of determining the moral and legal duties that consent imposes on the doctor. To explicate autonomy and its influence on consent I will explore four questions:

1. What is autonomy?
2. Why is autonomy valued?
3. What are the limits of autonomy?
4. What are the competing considerations and how do they impact on autonomy and consent?

The Nature of Autonomy

Various senses and conceptions of autonomy have been expounded.³⁴ If there are real differences between these views of autonomy then the conception adopted may affect the obligations arising from the patient’s right of consent. Dworkin provided a long list of the

³³ See e.g. Lehrer, K ‘Reason and Autonomy’ (2003) 20(3) *Social Philosophy and Policy* 177.

³⁴ Bergsma, J. Thomasma, T. *Autonomy and Clinical Medicine: Renewing the Health Professional Relation with the Patient* (2000) Dordrecht: Kluwer Academic Publishers at xiii-xiv; Beauchamp, T.L. Childress, J.F. *Principles of Biomedical Ethics* (5th ed., 2001) New York: Oxford University Press, 58; O’Neill. O. *Op cit* n.32, 21-22; Dworkin, G. *The Theory and Practice of Autonomy* (1988) Cambridge: Cambridge University Press, 5.

various ways in which autonomy has been used which include autonomy as liberty or freedom to act; as dignity; as 'freedom of the will'; as 'independence'; and as 'critical reflection'.³⁵ The list may be expanded to include: 'self-mastery, choosing freely, choosing one's own moral position and accepting responsibility for one's choice',³⁶ and 'self-control' and 'self-determination'.³⁷ Although Dworkin suggested that there is 'unlikely' to be a 'core meaning' of autonomy, since he then went on to explicate 'the nature of autonomy' and develop 'a concept of autonomy' it is presumably possible to describe a useful concept of autonomy. Furthermore, he later suggested that it is likely 'that there is no single conception of autonomy but that we have one concept and many conceptions'.³⁸

It is arguable that the list of uses of autonomy noted earlier, rather than simply listing alternative senses of autonomy, reflects an amalgam of various aspects and senses of autonomy. Approached in this way, it may be possible, in the context of health care, to determine a core concept with a choice of conceptions, especially as 'there is probably more agreement about ... [autonomy] in contemporary bioethics than elsewhere'.³⁹

Gillon defined autonomy as: 'the capacity to think, decide and act on the basis of such thought and decision freely and independently and without... let or hindrance'.⁴⁰ He argued that there are three senses of autonomy; of thought, of will (or intention); and of action.⁴¹ Mappes and Zembaty suggested that 'autonomy is typically defined as self-governance or self-determination'. They distinguished between autonomy as 'liberty of

³⁵ Dworkin, G. *The Theory and Practice of Autonomy* (1988) Cambridge: Cambridge University Press, 6.

³⁶ Faden, R. Beauchamp, T.L. *The History and Theory of Informed Consent* (1986) New York: Oxford University Press, 7.

³⁷ *Op cit* n.32, 22.

³⁸ *Op cit* n.35, 9.

³⁹ *Op cit* n.32, 23.

⁴⁰ Gillon, R. *Philosophical Medical Ethics* (1985) Chichester: John Wiley & Sons, 60.

⁴¹ *Ibid.*, 61.

action’; as ‘freedom of choice’ and as ‘effective deliberation’.⁴² In his essay on the autonomous man, John Benson suggested that such a man must exercise ‘independence in his thinking and his decisions about practical affairs’.⁴³ He also noted that an important form of autonomy is ‘the ability and willingness to undertake for oneself the ordinary tasks of daily life’.⁴⁴ He further argued that autonomy may be seen as an essential virtue. Thus: ‘To be autonomous is to trust one’s own powers and to have a disposition to use them, to be able to resist the fear of failure, ridicule or disapproval that threatens to drive one into reliance on the guidance of others’.⁴⁵ Young suggested two views of autonomy. The ‘minimalist view ... is ... being one’s own man or woman’ and, more globally, autonomy may be seen as ‘the unified ordering of the autonomous person’s life’.⁴⁶

What these views of autonomy mean is that, as far as the individual is concerned, it may be worthwhile distinguishing the *autonomous person*, the *autonomous life* and the *autonomous act*. For present purposes, the most important of these distinctions is between the *autonomous person* and the *autonomous act*.⁴⁷ This is because whether a life is autonomous is derivative on the other two concepts. *Autonomous persons* will not always act autonomously and, where they do not, the act may be contrary to their long-term autonomy or other interests. This raises the question of whether it is more harmful to interfere with a present non-autonomous act or to allow that person to harm his or her autonomous life or future autonomy. I will consider these issues in more detail later. Finally, the choice between protecting any decision of an autonomous person and only those decisions that are themselves autonomous has implications for the law since the latter position would justify a greater degree of interference.

⁴² Mappes, T.A. Zembaty, J.S. ‘Biomedical Ethics’, in: Mappes, T.A. Zembaty, J.S. (eds) *Biomedical Ethics* (3rd ed., 1991) New York: McGraw-Hill Inc. 1, 25-26.

⁴³ Benson, J. ‘Who is the autonomous man?’ (1983) 58 *Philosophy* 5, 6.

⁴⁴ *Ibid.*, 8-9.

⁴⁵ *Ibid.*, 9.

⁴⁶ Young, R. ‘Autonomy and the “Inner Self”’, in: Christman, J. (ed) *The Inner Citadel* (1989) New York: Oxford University Press 77, 78.

⁴⁷ *Op cit* n.36, 235.

If autonomy is equated with freedom of action then the relevance of any distinction between an autonomous person and an autonomous act disappears since every act of the autonomous person will, by definition, be autonomous. This particularly thin view of autonomy makes no demands for rationality nor does it require the actor to act morally, or even be capable of acting morally. At its most extreme, all that is necessary is the absence of external constraint and the capacity to make (and act on) a decision. Unless individuals are capable of making a rational decision they will be unable to determine the rightness or wrongness of their decisions and will not be responsible members of the moral community. As such, at least one of the reasons to value autonomy vanishes (see below) and, since respect for individuals includes both respecting their autonomy and caring about their welfare,⁴⁸ it is justifiable to interfere with the individual's self-determination to protect him or her from random and dangerous decisions. As J.S. Mill noted: 'Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury'.⁴⁹ Because autonomy as self-determination is of less value than conceptions of autonomy that require the capacity to engage with the rationality and consistency necessary for a moral life, and because it is readily overridden, it is perhaps better to rely on a thicker view of autonomy.

Beyond simple self-determination, it may be argued that autonomy requires at least some capacity for rationality, which has the consequence of creating a real distinction between an autonomous act and the acts of an autonomous person, not all of which will be rational. For Dworkin,

autonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and

⁴⁸ See e.g. Dworkin, G. *Op cit* n.35, 32.

⁴⁹ Mill J.S. 'On Liberty', in: Gray, J. (ed.) *On Liberty and Other Essays* (1991) Oxford: Oxford University Press 5-128, 14. I will consider paternalism and its possible justification in more detail later.

so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are.⁵⁰

Beauchamp and Childress criticised Dworkin's theory on two grounds. First they argued that: 'Acceptance or repudiation of a desire can be motivated by an overriding [higher-order] desire that is simply stronger, not more *rational* or *autonomous*'. Second: 'Few choosers, and also few choices, would be autonomous if held to the standards of higher-order reflection in this theory, which presents an aspirational ideal of autonomy'.⁵¹

Instead, Beauchamp and Childress focused on whether the act is autonomous. They stated: 'We analyze autonomous action in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action'.⁵²

Ignoring the implications of judging the act rather than the actor – which I will consider later – Beauchamp and Childress' approach may be criticised for at least two reasons. First, the requirement of understanding may be construed as a rational technical ability to make sense of the information. Understanding a splenectomy, for example, might be satisfied by the knowledge that this requires an abdominal operation with the attendant risks and sequelae such as post operative pain, a scar, the loss of the spleen and the need for injections to counter the increased risk of infection. However, although I might know the implications of the operation I may still fail to appreciate how they will affect my life

⁵⁰ *Op cit* n.35, 20. The idea of second order desires and, more appropriately, second order volitions, was first proposed as a way of distinguishing persons from non-persons by Frankfurt, H. 'Freedom of the Will and the Concept of a Person' reprinted in: Kane, R. (ed.) *Free Will* (2002) Blackwell Publishers: Malden (Mass) 127. See also: Richards, D.A.J. 'Rights and Autonomy' (1981) 92(1) *Ethics* 3, 13. Ronald Dworkin argues for something similar to this in his preferred 'integrity' view of autonomy: Dworkin, R. *Life's Dominion* (1993) London: Harper Collins, 224.

⁵¹ Beauchamp, T.L. Childress, J.F. *Principles of Biomedical Ethics* (5th ed. 2001) New York: Oxford University Press, 59.

⁵² *Ibid.*, 59.

– to associate *my* life with the consequences.⁵³ While it may not be possible to truly appreciate all the implications unless one has experiential knowledge, it seems reasonable to suggest that I ought to be able to exercise some degree of rational reflection on how the operation will affect my goals and the other things I value. As Beauchamp and Childress themselves explained:

many patients confronted with various forms of surgery understand that they will suffer postoperative pain. Nevertheless, their projected expectations of the pain are often inadequate. Many patients cannot, in advance, adequately appreciate the nature of the pain ... In one respect, these patients correctly understand basic facts about procedures that involve pain but, in other respects, their understanding is inadequate.⁵⁴

Discarding a thin view of understanding, this argument perhaps suggests that the two views of autonomy are different only by degree and, unless Dworkin was arguing for ideal rationality, this difference may be less than Beauchamp and Childress believed.

The second problem arises from the requirement of an absence of controlling influences. One group of controlling influences are the internal constraints of phobias and compulsions. The point to note about these constraints is that they impact on the actor's utilisation, rather than on his or her understanding, of information. In Dworkin's model they remove the capacity to reflect critically on first order desires. In *Re MB*, for example, the plaintiff made it clear she wanted the caesarean section but was unable to use this second order desire to overcome her first order fear of needles.⁵⁵ Thus, if Beauchamp and Childress are to take these kinds of constraints into account they must incorporate some

⁵³ Elliott, C. *Bioethics, Culture and Identity: A Philosophical Disease* (1999) New York: Routledge, 91-102.

⁵⁴ *Op cit* n.51, 89.

⁵⁵ *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541, CA.

ability – even if imperfect – to rationalise desires and reject those that do not comport with the actor’s more long term goals.

Another type of constraint arises from our relational existence. This is something that Beauchamp and Childress acknowledged when they stated:

To restrict adequate decision-making by patients and research subjects to the ideal of fully or completely autonomous decision-making strips their act of any meaningful place in the practical world, where people’s actions are rarely, if ever, fully autonomous.⁵⁶

The importance of the relational context of our existence is recognised by Dworkin who argued that:

the conception of autonomy that insists upon substantive independence is not one that has a claim to our respect as an ideal ... it makes autonomy inconsistent with loyalty, objectivity, commitment, benevolence and love.⁵⁷

It is arguable that any valuable or useful conception of autonomy grounded in moral personhood and respect for that personhood – both for the actor and for others – must allow and co-exist with influences, constraints and obligations arising from the network of relationships that envelops us.⁵⁸ Reducing individuals to isolated atomistic existences undermines the concept of autonomy, which provides another reason to reject the particularly thin view of autonomy as self-determination. In the absence of relationships autonomy becomes meaningless and unnecessary. Additionally, it is only through and by relationships that individuals can fully develop and express their autonomy.⁵⁹ As

⁵⁶ *Op cit* n.51, 59.

⁵⁷ *Op cit* n.35, 21.

⁵⁸ Berg, J.W. Appelbaum, P.S. Lidz, C.W. Parker, L.S. *Informed Consent: Legal Theory and Clinical Practice* (2nd ed., 2001) New York: Oxford university Press, 33. See also, Gauthier, C.C. ‘Moral Responsibility and Respect for Autonomy: Meeting the Communitarian Challenge’ (2000) 10(4) *Kennedy Institute of Ethics Journal* 337.

⁵⁹ See Richards, D.A.J. ‘Rights and Autonomy’ (1981) 92(1) *Ethics* 3, 12: ‘Autonomy may be perceived, not as asocial isolation, but in terms of a supportive environment of critical dialogue and reciprocity’.

Nedelsky argued: 'The collective is not simply a potential threat to individuals, but is constitutive of them, and thus is a source of their autonomy as well as a danger to it'.⁶⁰

Growing up in this world of relationships means that our identities and characters are strongly influenced by other people and the things that happen to us. An extreme determinist view of these influences denies us the possibility of shaping our own lives or claiming authorship of our identity. Without the possibility of critical self-reflection this determinism collapses into a fatalist position that everything is beyond our control and we are responsible for nothing. If we are to deny both fatalism and meaningless atomism we must conceive of a third possibility. In her cogent critique of poststructuralist feminism's response to the masculine 'transcendental self-constitution' Patricia Huntington argued for a concept of what she termed 'dialectical autonomy'.⁶¹ This dialectical autonomy requires subjects to shape their identity by forward-looking

critical self-reflection and mediation of historical and social
circumstance ... the self-constituting subject is ... not a perfect master
of her intentional, desiring, unconscious lives; however, she achieves
increasing coherence in thought ... and constancy in behavior in part
by becoming aware of her lack of full control over her motives,
desires and drives.⁶²

It follows from this that, if autonomy is to mean anything more than simple freedom (from external constraints) of action then it must include some notion of critical self-reflection.⁶³

⁶⁰ Nedelsky, J. 'Reconceiving Autonomy: Sources Thoughts and Possibilities' (1989) 1 *Yale Journal of Law and Feminism* 7, 21.

⁶¹ Huntington, P. 'Toward a dialectical concept of autonomy' (1995) 21(1) *Philosophy and Social Criticism* 37.

⁶² *Ibid.*, 50.

⁶³ Berofsky, B. 'Identification, the Self and Autonomy' (2003) 20(2) *Social Philosophy and Policy* 199, 203.

Critical self-reflection, while a form of rationality, differs from the more particular skill of being able to determine that one's choices will in fact further one's goals.⁶⁴ The capacity for both forms of rationality is necessary for the person to be considered autonomous. I have deliberately restricted the requirement to capacity since it is the capacity rather than the use of the ability that grounds responsibility and authorship. Furthermore, critical self-reflection, and perhaps self-regarding rational decision-making should be seen as virtues; character ideals that form the basis for moral aspiration rather than moral duty.⁶⁵ It should also be noted that, by distinguishing the autonomous act from the act of an autonomous person, I am not committed to limiting protection to those decisions that are rational. This will be considered in more detail later.

I have argued that, if it is useful to distinguish the autonomous act from the non-autonomous act of an autonomous person, then autonomy must include some requirement for rational reflection. The capacity for rationality is also necessary for autonomy to achieve its full value (see below) and to avoid the more extreme consequences of determinism: that we have no control over who we are and what we believe. All of these reasons suggest that bare self-determination is a less useful conception of autonomy than those views that incorporate rationality. However, even when conceived as the capacity for rational, critically reflective self-governance, autonomy lacks internal moral content. For example, it may be just as autonomous to act cruelly as to act the Good Samaritan.⁶⁶ This view of autonomy, which may be sufficient for a consumerist free-market competitive ethic,⁶⁷ fails to provide moral justification for action in those areas of life that require cooperation rather than competition. Feinberg, who constructed the autonomous

⁶⁴ Noggle, R. 'The Public Conception of Autonomy and Critical Self-reflection' (1997) XXXV *The Southern Journal of Philosophy* 495, 506.

⁶⁵ See the argument in Noggle, R. *Ibid.*; Fuller, L.L. *The Morality of Law* (2nd ed. 1969) New Haven: Yale University Press, 5.

⁶⁶ Feinberg, J. 'Autonomy', in: Christman, J. (ed) *The Inner Citadel* (1989) New York: Oxford University Press 27, 43.

⁶⁷ *Op cit* n.32, 47.

person as someone with the capacity for rationality,⁶⁸ the ability to be self-reliant when necessary⁶⁹ and the ‘right to decide how to live... [his] life’,⁷⁰ argued that this rational consumerist autonomy is properly constrained by external influences. He stated: ‘The ideal of the autonomous person is that of an authentic individual whose self-determination is as complete as is consistent with the requirement that he is, of course, a member of the community’.⁷¹ However, some commentators - most notably Kant – conceptualised autonomy as possessing internal moral content.

In his *Groundwork of the Metaphysics of Morals*, Kant developed and justified his thesis that the only categorical imperative is: ‘act only in accordance with that maxim through which you can at the same time will that it become a universal law’.⁷² This imperative applies to all rational beings whose rationality presupposes freedom of the will. Kant argued that humans are rational beings but imperfect ones whose rationality is always subject to inclinations and desires. This rational will belongs to the noumenal world of understanding while our non-rational, sensory and emotional self belongs to the phenomenal world. But, it is the will that has intrinsic goodness because if welfare were our proper end we would be governed by instinct rather than reason. Thus, the rational will is an end in itself and, as such, all rational beings should be treated as ends in themselves, ‘never merely as means’.⁷³ This practical imperative is, for Kant, ‘the supreme limiting condition of the freedom of action of every human being’.⁷⁴ Because rational wills are ends in themselves the rational being has an obligation to treat those wills as ends in themselves.

⁶⁸ Feinberg, J. *Harm to Self* (1986) New York: Oxford University Press, 28.

⁶⁹ *Ibid.*, 42.

⁷⁰ *Ibid.*, 54.

⁷¹ *Op cit* n.66, 45.

⁷² Kant, I. (Gregor, M. *Transl.*) *Groundwork of the Metaphysics of Morals* (1998) Cambridge: Cambridge University Press, 31 (4:421).

⁷³ *Ibid.*, 38 (4:429).

⁷⁴ *Ibid.*, 39 (4:431).

The role of the will is to provide laws that guide our actions. Since conditional laws are undermined when the condition ceases to exist it is important to establish an unconditional law, which is Kant's categorical imperative. Because laws influenced by anything other than pure reason are conditional any law must come from the rational being's own will. This grounds Kant's view of autonomy as the 'sole principle of morals':

Autonomy of the will is the property of the will by which it is a law to itself (independently of any property of the objects of volition). The principle of autonomy is, therefore: to choose only in such a way that the maxims of your choice are also included as universal law in the same volition.⁷⁵

Kant's view of autonomy makes it a necessary characteristic of a rational being that underpins all moral duty by requiring the actor to be guided by laws that could be willed as universal, which means that, in practice, all rational beings must be treated as ends in themselves. Thus, Kant envisaged autonomy as essentially relational⁷⁶ and as *the* moral characteristic of a free, rational will. This 'principle-directed' view of autonomy provides the third conception of autonomy that I have considered in this thesis.⁷⁷ To summarise, the other two views are autonomy as freedom of action/choice and autonomy as the capacity for rational/reflective choice. However, I have also argued that, if it is to retain its value, autonomy must include some requirement for rationality and so autonomy as freedom of action is rejected. I have also distinguished the autonomous act from the autonomous person and the autonomous life. These distinctions are important because they justify different degrees of intervention and it is therefore important to determine which type of autonomy the law should protect. Before I can undertake that task I must

⁷⁵ *Ibid.*, 47 (4:440).

⁷⁶ Secker, B. 'The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics' (1999) 24 *Journal of Medicine and Philosophy* 43, 48.

⁷⁷ Engelhardt Jr., H.T. 'The Many Faces of Autonomy' (2001) 9 *Health Care Analysis* 283, 287.

address the other questions posed at the beginning of this chapter. I turn, then, to why autonomy is valued.

The Value of Autonomy

Autonomy has both intrinsic and instrumental value.⁷⁸ The intrinsic value of autonomy arises from its relationship with rationality and its necessity for moral personhood and the ascription of moral responsibility.⁷⁹ As O'Neill suggested: 'ethics can be addressed only to those who can reason, deliberate and act; ... [such] debates must take agency ... seriously'.⁸⁰ If I am to be held responsible, for both the good and bad things I do, then I must have sufficient agency to be counted as the author of those acts. To be counted as the author of an act requires that I have chosen to do the act for my own reasons, irrespective of the existence of possible alternatives.⁸¹ This in turn requires that I am an autonomous individual. If I shot someone because a more physically powerful person forced the gun in my hand and squeezed my finger on the trigger I would not be held responsible for the death. Similarly, if I had been brainwashed or hypnotised into shooting someone I would not be held responsible. Thus, as Levi stated: 'Autonomy's value derives from its place within the matrix of our conception of what it is to be an interacting, responsible, principled, responsive human being'.⁸²

Hurka argued that: 'The ideal of agency is one of causal efficacy, of making a causal impact on the world and determining facts about it. And the autonomous agent, just in virtue of her autonomy, more fully realizes this ideal'.⁸³ The more choices I make the more I influence the world and that influence is more valuable if based on deliberated

⁷⁸ See: Hurka, T. 'Why Value Autonomy?' (1987) 13(3) *Social Theory and Practice* 361.

⁷⁹ Gauthier, C.C. *Op cit* n.58; Haworth, L. *Autonomy: An Essay in Philosophical Psychology and Ethics* (1986) New Haven: Yale University Press, 44-49; Engelhardt *Op cit* n.77, 286.

⁸⁰ *Op cit* n.32, 7.

⁸¹ Frankfurt, H. 'What we are morally responsible for', in: Fischer, J.M. Ravizza, M. (eds) *Perspectives on Moral Responsibility* (1993) Ithaca (NY): Cornell University Press 286, 286.

⁸² Levi, B.H. *Respecting Patient Autonomy* (1999) Chicago: University of Illinois Press, 64.

⁸³ *Op cit* n.78, 366.

reason rather than on simple freedom of choice. Although some autonomous acts are more valuable than others – choosing a career is more important than choosing what fork to use – Hurka’s argument is essentially that autonomy is intrinsically valuable because it is a necessary characteristic of agency.⁸⁴ This argument, however, simply shifts the debate to the importance of agency. The importance of agency is that agents have at least a degree of control. While it does not stop us from being acted upon it does allow us to shape and affect the world and our own lives within it. The alternative to agency is that we are only capable of reaction rather than action; that the environment and our instinctive responses to that environment wholly shape our lives. In such a world praise and blame would be tools of ‘manipulation or training’ and we would have no reason to retain ‘reactive attitudes’ such as gratitude and admiration.⁸⁵ This would undermine ideas of responsibility, personhood and a sense of self.⁸⁶ As Wolf commented:

A world in which human relationships are restricted to those that can be formed and supported in the absence of the reactive attitude is a world of human isolation so cold and dreary that any but the most cynical must shudder at the idea of it.⁸⁷

Thus, if we are to see ourselves as rational agents, and we must if we wish to hold on to reactive attitudes to each other, autonomy is essential.⁸⁸ Furthermore, far from being isolationist, autonomy is crucial to developing social relations that have any meaning beyond purely instinctive behaviour.

Further support may be gained, for this argument that autonomy is intrinsically valuable, from the similarities between the characteristics of personhood that give the individual

⁸⁴ See also: Harris, J. Keywood, K. ‘Ignorance , Information and Autonomy’ (2001) 22 *Theoretical Medicine* 415, 420.

⁸⁵ Wolf, S. ‘The importance of free will’, in: Fischer, J.M. Ravizza, M. (eds) *Perspectives on Moral Responsibility* (1993) Ithaca (NY): Cornell University Press 101, 104-106.

⁸⁶ *Ibid.*, 113-114.

⁸⁷ *Ibid.*, 106.

⁸⁸ Gauthier, C.C. *Op cit* n.58, 344.

intrinsic moral value and the nature of autonomy. The types of features that constitute personhood include:⁸⁹

1. consciousness (of objects and events external and/or internal to the being), and in particular the capacity to feel pain;
2. reasoning;
3. self-motivated activity (relatively independent of either genetic or direct external control);
4. the capacity to communicate, by whatever means, messages of an indefinite variety of type, that is, not just with an indefinite number of possible contents, but on indefinitely many possible topics;
5. the presence of self-concepts and self-awareness.⁹⁰

Consider two recent views of autonomy. Levi characterised the capacity for autonomy as: ‘continuity of self ... [the acceptance of] an intersubjectively accepted set of goods, and ... some threshold for procedural rationality’.⁹¹ Rössler argued that:

a person is autonomous if she reflects upon how she wishes to live, upon the person she wants to be, and then both lives and is allowed to live in that self-chosen way, such that she as an individual is able authentically to identify with her own goals and projects, as well as being actually able to pursue them.⁹²

Both of these conceptions require a rational being that is consciously self-aware and hence would count as a person. If personhood is seen as intrinsically valuable then so

⁸⁹ See: Maclean, A.R. *A Critical Examination of R v Collins and the Pregnant Woman's Right to Refuse Treatment* (1999) Unpublished M.Jur. Thesis, 143.

⁹⁰ Warren, MA. ‘On the Moral and Legal Status of Abortion’, in: Gruen, L. Panichas, GE. (eds.) *Sex, Morality and the Law* (1997) London: Routledge, 302.

⁹¹ *Op cit* n.82, 37.

⁹² Rössler, B. ‘Problems with Autonomy’ (2002) 17 *Hypatia* 143, 146-147.

must autonomy. As Richards suggested: ‘The development of ... [autonomy] is, from the earliest life of the infant, the central developmental task of the becoming of a person’.⁹³

What this means is that morality is contingent on the existence of autonomy, which is the central characteristic of personhood that allows us to be treated as equal members of the moral community, be held responsible for our actions and be capable of relationships based on reactive attitudes. The primary argument against the intrinsic value of autonomy is based on a determinist position that attacks the very possibility of autonomy. However, if autonomy is not wholly undermined and some degree of self-determination is possible then the argument that autonomy is intrinsically valuable holds fast.

Determinism holds that all of our decisions and actions result from the interaction between our genetically controlled characteristics and the environment (including other beings). Every thought I have is a consequence of the interaction between the environment and the physical architecture of the cognitive part of my brain. I am acted upon by external factors and I react to them in a way that would be entirely predictable if only we knew enough about the laws of nature. I am not capable of self-reflection or rationality and the appearance of, and belief in, such behaviour is an illusion caused by chemical reactions that result from the interactions mentioned earlier.

There is insufficient evidence to know whether this extreme form of determinism is true. However, even assuming it is, we behave as if it is not and for some people the belief that one has some control over one’s own life is psychologically valuable. Irrespective of whether autonomy is an illusion, those people with a strong internal locus of control are adversely affected if their autonomy is obstructed by, for example, the withholding of

⁹³ *Op cit* n.59, 7.

information.⁹⁴ It is also arguable that treating people as if they have autonomy is valuable because it may mean that those ‘determined’ to respond to moral obligations will do so if such moral obligations exist. Thus, treating people as if they are autonomous may result in behaviour that is beneficial both to themselves and to others within the community. Similarly, behaving as if people have autonomy allows us to retain reactive attitudes towards them making the world less ‘cold and dreary’ than it might be in their absence.⁹⁵ Finally, it is also arguable that the very idea of scholarship and argument about autonomy suggests that we implicitly believe that we have some degree of autonomy.

Rössler stated that:

The failure to lead, or at least the difficulty of leading, an autonomous life is something we are able to comprehend as such, in its very recalcitrance, only because and insofar as we both do and want to understand ourselves always already as being autonomous ...
Otherwise the possibility of that failure would not always be our irritating and disquieting companion.⁹⁶

This point, that our very concern with autonomy betrays our desire to be autonomous, may be taken one step further. If extreme determinism is true, and it is important to ‘live in accordance with the facts’ then it is important to accept that we have no free will. This acceptance requires us to adopt a particular reactive attitude towards ourselves; that we are blameless for our lives and our conduct. However, extreme determinism precludes reactive attitudes. As Susan Wolf notes:

⁹⁴ Waller, B.M. ‘The Psychological Structure of Patient Autonomy’ (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 257.

⁹⁵ See above, n.85.

⁹⁶ *Op cit* n.92, 157.

In taking any attitude towards ourselves, including the attitude that we are not free or responsible beings, we would be asserting ourselves *as* free and responsible beings.⁹⁷

This means that living in accordance with extreme determinism would prevent us from adopting any attitude towards ourselves, including that, as beings lacking autonomy, we are blameless. Thus, it is paradoxically illogical to argue that we should behave as if extreme determinism were true. Furthermore, even if extreme determinism is true, it is arguable that - illusion or not – ‘Freedom is something we value’ and ‘autonomous freedom [is] the noblest form of freedom’.⁹⁸

Apart from its intrinsic value autonomy is also important for its instrumental value. Two instrumental values have already been mentioned. First, for people with an internal locus of control, respecting autonomy is beneficial to their well-being.⁹⁹ Even when the researchers do not take account of the differing needs of patients with an external locus of control, there are many studies that suggest that the provision of information, which is one aspect of respecting autonomy, is clinically efficacious.¹⁰⁰ It may further be the case that helping those with an external locus of control to become more autonomous may be a valuable long-term strategy providing it is done sympathetically and supportively.¹⁰¹ Second, treating people as autonomous may encourage some to take responsibility, accept their obligations and so act in a morally good way, which may be beneficial both to themselves and to the community in general.

Another instrumental argument is Ladenson’s suggestion, following Dewy, that through reason a person will be better, and more consistently, able to attain goods.¹⁰² This

⁹⁷ *Op cit* n.85, 113.

⁹⁸ *Op cit* n.33.

⁹⁹ *Op cit* n.94.

¹⁰⁰ See n.469.

¹⁰¹ *Op cit* n.94, 263.

¹⁰² Ladenson, R.F. ‘A Theory of Personal Autonomy’ (1975) 86 *Ethics* 30, 43.

subsequently allowed him to argue that the relationship between autonomy and reason means that the more autonomous a person the better. He stated:

Other things being equal, the more autonomous an individual, the greater his ability to attain goods and avoid evils. Consequently the achievement of a high degree of personal autonomy is itself one of the most important goods.¹⁰³

J.S.Mill argued that since each person's self knowledge is usually better than other regarding knowledge, and since the person who cares most for someone is usually him or herself – and this is especially so when considering society's interests in its members – competent persons should be allowed the liberty to decide for themselves on matters that affect their own lives.¹⁰⁴ This argument supports the principle of autonomy in general, but leaves individual irrationally self-harming decisions open to interference. This is because there will certainly be occasions when others can see more clearly than I and are able to make a better decision for me than I would be able to make. Mill's argument did, however, predict a major criticism of medical paternalism that doctors are only competent to know the best clinical choice but, because patients are the experts concerning all other aspects of their lives, the final decision regarding treatment should rest with them.¹⁰⁵ This is particularly so given that, while it may be an end in itself, health's greatest value is instrumental; being healthy allows us to follow our life plans and achieve our goals. Conceived in this way it is self-fulfilment rather than health or welfare per se that is, in a secular world, of fundamental importance. Furthermore, as Feinberg noted:

if choice and reasoned decision are components of self-fulfillment, then one must embrace the conclusion that the right to the

¹⁰³ *Ibid.*, 46.

¹⁰⁴ *Op cit* n.49, esp. 75-85. It should be noted that Mill does not use the term 'autonomy' but the concept is implicit in a lot of what he argues (see especially p.17). Even if it is not, freedom of action and decision making is an important aspect of autonomy.

¹⁰⁵ For example see: Berg *et al*, *op cit* n.58, 18-19, 22-24.

unhampered exercise of choice is an indispensable means to one's own good.¹⁰⁶

It may be argued that, while we may know ourselves better than others do, we still make mistakes and that others should be allowed to prevent us from making or acting on such bad decisions. Excluding decisions based on wrong or inadequate information, the problem from a developmental perspective is that the capacity for rational decision-making may be stunted unless the individual is required to exercise his self-determination and making mistakes is an important part of learning. Thus, self-determination should be encouraged and practised so as to improve on one's autonomous capacity, which is important if rationality is seen as a good thing.¹⁰⁷ It may, of course, be countered that allowing someone to make mistakes is all very well but is self-defeating if the mistake is such that the person's future autonomy or his life will be lost. It should, therefore, at least be justifiable to coercively prevent someone making such an extremely harmful mistake. I will consider this in more detail later but for now it is enough to note that even if that argument is accepted it only requires that we not treat autonomy as an absolute right.

Importantly, autonomy acts as a protection against the 'tyranny' of the state and its institutions,¹⁰⁸ and, as Levi argued: 'one's autonomous status is important for demarcating certain political boundaries between persons'.¹⁰⁹ It is, therefore, essential for a democratic state.¹¹⁰ Furthermore, allowing people the important liberties of freedom of thought and speech is essential for the advancement of knowledge and understanding. Without that liberty, established views would go unchallenged and knowledge would

¹⁰⁶ *Op cit* n.68, 58.

¹⁰⁷ *Op cit* n.49, 65; Levi, B.H. *Op cit* n.82, 17. On both this point and the preceding one, see also: Hurka, T. *Op cit* n.78, 363.

¹⁰⁸ *Op cit* n.49, 8-9.

¹⁰⁹ *Op cit* n.82, 24.

¹¹⁰ Oshana, M. 'How Much Should we Value Autonomy' (2003) 20(2) *Social Philosophy and Policy* 99, 107.

remain static.¹¹¹ Finally, autonomy may also be instrumentally valuable as a means for fostering the development of character. It is arguable that character is, at least partially, reflected in and affected by the choices we make. Thus, as Hurka suggests:

A person who has autonomy can use it to develop her own values ...

But someone with no opportunity for choice cannot develop the same way. His acts only reflect his momentary concerns, without the integration through time that makes for genuine personality.¹¹²

The Limits of Autonomy

If autonomy were to be seen as an absolute right to decide for oneself the consequence would be the risk of chaos with the vulnerable left to the mercy of the strong. In fact, if conceived as a right then it is logically impossible for it to be absolute. If A decided to exercise his or her autonomy by locking B inside his dungeon B would no longer be able to exercise his or her autonomy and thus B could not be said to have a right to autonomy unless A is restrained from exercising his right in this way. Thus, ignoring the problem of ability, any right to autonomy cannot be the freedom to do what one wants.

That trite example suggests that any right to autonomy must be limited by having regard to the autonomy of others. It might be suggested that A has the right to do what he or she wants providing it does not prevent B from doing what he or she wants. This formulation, however, would be overly restrictive and would paralyse much of our life. It may be reasonable if resources were plentiful and we lived completely independent lives. But, in a world in which we must compete for scarce goods and interact with others, autonomy would lose much of its value if A cannot do something simply because it would prevent B from doing it. Imagine if A wants to build his house on a particular spot next to the sea with good access to fresh water and a supply of food. If no one else wants to build there

¹¹¹ *Op cit* n.49, esp. 22-41.

¹¹² *Op cit* n.78, 364.

then he or she is free to do so. But, if B also wants to build there then there is a problem. Neither A nor B may exercise his or her autonomy if it prevents the other from doing so. This means that A can only build there if B does not want to and *vice versa*. However, if both want to build there then neither can and the plot must remain unused. This means that they must each select other plots but the same problem may recur *ad infinitum* meaning that neither can build anywhere. This would be a ridiculous state of affairs and so a middle ground ‘capable of public justification’ must be found,¹¹³ which suggests that any limitation must conform with the ‘morality of duty’ rather than the more individualistic ideal ‘morality of aspiration’.¹¹⁴

The Harm Principle

Perhaps the least contentious ground for limiting autonomy is to prevent harm to others. Mill explicated the most famous version of this principle in his essay *On Liberty*.¹¹⁵ He argued that:

the only purpose for which power can be rightfully exercised over any members of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise.¹¹⁶

¹¹³ *Op cit* n.64, 500.

¹¹⁴ Fuller, L.L. *The Morality of Law* (2nd ed. 1969) New Haven: Yale University Press, 5.

¹¹⁵ *Op cit* n.49.

¹¹⁶ *Op cit* n.49, 14.

This limitation of course depends on what is meant by ‘harm’. Since limiting autonomy may itself be seen as harmful, the outcomes that might justify limiting autonomy should be more than temporary or trivial upsets.¹¹⁷ The limitation must also require that the harm be wrongfully inflicted. One possible way of defining harm is to characterise it as a setback to someone’s interests.¹¹⁸ The problem with this is that, as a justification for limiting autonomy, such a definition would be overly restrictive. Returning to my earlier example of choosing a plot of land to build one’s house on, allowing A to build on the most desirable plot would certainly be a setback to B’s interests if building on that plot was one of B’s autonomous goals. Thus, it would constitute a harm and we could justify limiting A’s autonomy to prevent harm to B. However, as I have shown, this would result in neither being able to build and both would be harmed. This explains why ‘harm’ as a justification for limiting autonomy, must incorporate both damage (setback to interests) and the notion of a wrong.¹¹⁹ The notion of a wrong is something that must be defined independently of autonomy and a full exploration is beyond the scope of this thesis. Suffice it to suggest that someone is wronged if they have a justifiable claim obstructed and that our justifiable claims are defined by the rules determined by the society in which we live.¹²⁰

One difficulty in determining the limits of autonomy is that most, if not all, decisions made by any individual will have an impact on other people. This is true even if the decision seems to be essentially self-regarding. For example, imagine that A is a vegan with strongly held views that humans should not use other animals solely for their own benefit. A has developed a condition that will leave him severely disabled unless he accepts a transplant of tissue taken from a pig. Such a decision would contravene A’s

¹¹⁷ Feinberg, J. *Harm to Others* (1984) New York: Oxford University Press, 12.

¹¹⁸ *Op cit* n.68, 10.

¹¹⁹ *Ibid.*, 10-11. A stronger version of the setback to interests definition of harm, limits the interests to ‘vital ones’: Hayry, H. *The Limits of Medical Paternalism* (1991) London: Routledge, 21.

¹²⁰ Feinberg grounds such claims on welfare interests and directly invadable ulterior interests: *Op cit* n.117, 112.

deeply held autonomous views about the relationship between humans and animals but his decision to refuse treatment that will leave him severely disabled will harm his wife.¹²¹ It will also affect others who have a relationship with A and will place an additional burden on the community's resources. It is arguable that A ought to consider the effect of his decisions on others and he should take them into account when making a decision. If possible A ought to make decisions that will be good for all concerned. It would be especially good of A to make decisions that put others' interests ahead of his own. However, if morality and the meaningfulness of individual existence are to survive state coercion then A should not be prevented from exercising his autonomy unless the affected other has a justified claim that would be obstructed by his choice.

It might be argued that A's wife does have quite a strong claim – arising out of their relationship - requiring that A accepts the necessary treatment to prevent the disability. However, for state coercion to be justified it would need to be clearly established that such a claim would be created when entering into such a relationship. In other words, A would need to consent in advance and this would mean that unless he could predict the need to compromise his principles his consent would not be normatively effective in relation to the pig organ transplant. If his views are deeply held it is unlikely that he would enter such an agreement voluntarily. Being able to define our own relationships, and that includes the obligations that arise from them, is an important part of what it means to be a person. State interference is only warranted where it is not possible for one of the parties to autonomously negotiate the nature of the relationship.

As indicated earlier, choices that are essentially self-regarding may burden the community. If the cost to the community is too high then it may be justifiable to limit individual autonomy. Feinberg used the garrison model to explain this: in a situation when the community's very existence is under threat then the selfish decision of a single

¹²¹ Unless, perhaps, she has a pre-existing autonomous interest in being a carer for A.

person may tip the balance. Under those circumstances the community may be justified in seeking to preserve itself by overriding an autonomous choice.¹²² This justification, however, is simply the harm principle applied to the community rather than to individual others. It depends on seeing the destruction of the community as harm and on the existence of a minimal obligation towards the community that would be breached by failing to assist the community in such times of need. While it is theoretically possible that this model may be relevant in the context of individual medical treatment it does not pertain in present day Britain nor is it foreseeable in the near future. However, it may also be justifiable under the harm principle to limit an individual's autonomy to prevent lesser levels of community harm.

Certain interests may be considered as public interests if they are sufficiently widely held. These interests may be raised as justifiable limits on autonomy either when the specific interests of a sufficiently large number of individuals are harmed or when a "common" interest is harmed.¹²³ Public health threats, such as the risk of transmitting an infectious disease, may justify coercion. Similarly, threats to the environment may be coercively prevented even though it may not be possible to identify an individual directly harmed. The protection of these community interests is simply an extension of the harm principle to cover those harms where the victims are the indeterminate members of the community.

Other Limiting Principles

Hayry suggested that, apart from the harm principle, there are four principles that might justify limiting an individual's autonomy:

- Prudence;
- Offence to others;
- Self harm; and

¹²² *Op cit* n.68, 22.

¹²³ *Op cit* n.117, 222-3.

- Morality.¹²⁴

Although allowing that actions offending good manners or decency may be prohibited if done in public,¹²⁵ Mill generally rejected all of these possible constraints as interfering with the general development of people's ability to decide their own lives and to actually decide for themselves how their life should go, which is what gives life its personal value.¹²⁶ These judgments justify argument, persuasion and remonstrance but not coercion. Certainly if, when it matters, our autonomy is restricted to making decisions that others see as wise it would be fatally undermined as a concept. Apart from the impact such a strategy would have on our ability to identify with any of our choices when we know we could not have chosen otherwise, it also threatens the principle that all moral persons are equal. Dominant views of rationality would hold sway and subjugate the 'incomprehensible' minority.

It might be argued that if autonomy requires rationality then an irrational action is not autonomous and does not, therefore, need to be protected.¹²⁷ Thus, the US President's Commission suggested that: 'A second limitation on self-determination arises where a person's decisionmaking is so defective or mistaken that the decision fails to promote the person's own values or goals'.¹²⁸ This constraint protects the overtly autonomous act but not the other acts of an autonomous person. One problem with this approach is that acts may be autonomous but not obviously so. An example of when this might happen is where actors autonomously choose to act in a way that does not appear to coincide with their goals or interests. Related to this is the problem of incomprehensibility that arises because observers are unable to understand the actor's goals. This follows from a

¹²⁴ Hayry, H. *The Limits of Medical Paternalism* (1991) London: Routledge, 25.

¹²⁵ *Op cit* n.49, 108, 109.

¹²⁶ *Op cit* n.49, 14.

¹²⁷ *Op cit* n.124, 36.

¹²⁸ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Volume One: Report* (1982) Washington (DC), 49.

difference in the conception of the 'good life' and what goals a person ought to aim for.¹²⁹

It is also likely, as Mill claimed, that – subconscious influences notwithstanding – we know ourselves better than others do. While I may not always be able to explain my actions, my own knowledge of my interests and goals and my own understanding of what life means for me will almost certainly be better than some other person's appreciation of those crucial decision-making factors. Thus, an external judge of rationality may easily be mistaken about the logic of my decision.

It may further be argued that we learn best by being allowed to make mistakes. If I am only allowed to make rational decisions I will not be allowed to make mistakes and my ability to reason will improve less quickly. This argument can only apply to those mistakes that will not cause permanent and significant harm to my ability to be autonomous. It would be self-defeating to argue that I should be allowed to make mistakes so that I can learn better how to make decisions if, as a result, I am unable to exercise that rationality. Related to this argument is perhaps the stronger point that since no one is infallible and I am the person who will have to live with the consequences I should be the one who makes the decision. If, because you profess an expertise, I choose to rely on your judgment I am responsible for the decision and should accept the consequences with equanimity. Certainly, I have no justifiable reason to blame you for my misfortune. However, if you force a choice on me against my will and I am harmed as a consequence that harm will be amplified precisely because you chose to act against my will. Just as stifling free speech suggests infallibility,¹³⁰ so too does preventing free choice. Such an unwarranted profession of infallibility makes a bad outcome seem all the worse especially as it is I rather than you who will have to live with the consequences.

¹²⁹ *Op cit* n.64, 505.

¹³⁰ *Op cit* n.49, 22.

Apart from when the harm principle is invoked, limiting autonomy on the basis of morality is problematic. The reality of moral relativity and the existence of a pluralistic society make it difficult to base rules on particular moral principles. Again the problem of a dominant view is raised and allowing such moral judgments to justify coercive law hints at an arrogant intolerance. As Hayry noted: ‘there are an infinite variety of interpretations of what is moral, and to a person defending any one of them, its opponents will always appear more or less irrational’.¹³¹ If a particular view of morality is enforced this implies that the followers of a different morality are somehow less equal. If living by a particular code is not harmful to others then the value of such a code can only be coercively denied by a society that sees those individuals as less worthy of respect. Since moral equality is one of the assumptions behind this thesis, harmless moral (or ‘immoral’) beliefs/actions cannot justify limiting autonomy.

It is arguable that offensive actions fall within the purview of the law. It may be legitimate, as Mill argued (see above), to restrict offensive activities by banning them from public display. In general, however, it would be a greater invasion of liberty and autonomy to coercively prevent an action seen by some as offensive. What counts as offensive is, to a large extent, simply a matter of opinion. Categorising something as offensive is an appeal to individual sensibilities and is not subject to reason but to feelings and, as such, it is less objective than the more legitimate harm principle. Although it is arguable that someone may have an interest in not being offended, ‘by falling short of harm to the interests the law ascribes to the standard person, they are deemed to be less serious harms than those that would come from restricting the liberty of others’.¹³² To infringe one person’s autonomy because another finds the idea of it offensive is to treat the actor as less equal because it subjugates his autonomy to the irrational emotions of the other; it becomes a conflict between two different wants.

¹³¹ *Op cit* n.124, 126.

¹³² *Op cit* n.117, 51.

Even though it may be rational to have an interest in not being offended, the content of that interest is populated by feelings. If the offensive actions solely further the actor's interest in being offensive, then there is a conflict of equal interests. Other autonomous interests, however, will usually be weightier than the interest in not being offended and setbacks to those other interests may be more permanent than the relatively temporary impact of offensiveness. The interest in not being offended may be infringed by offensive behaviour but the offence will not persist beyond the incident. The setback caused to others by banning the 'offensive' activity may, however, have a much more permanent and total impact. In the context of medical care this argument is particularly apt. The types of treatment that may be seen as offensive include operations like abortion and sex change.¹³³ The impact of preventing an abortion because such operations offend a section of society would be huge, both for the individual woman and for society. History demonstrates the misery and harm caused to women through having to deal with unwanted pregnancy when abortion is unlawful.

The Protection of Future Autonomy

I will consider the issue of paternalism and the restriction of autonomy to prevent harm to self in more detail in the next chapter following a discussion of the principle of beneficence. For the time being I will confine the present debate to an examination of whether it is legitimate to restrict present autonomy in order to protect the autonomy of the future self. One argument that would support restricting present autonomy in order to protect future autonomy relies on a utilitarian position that if autonomy is a good thing then it should be maximised and what really matters is not how much autonomy I can exercise now but how much I am able to exercise over my whole life. This may mean that present autonomy should not be respected if it would undermine my future autonomy.

¹³³ Of course, if the fetus is seen as a person then the harm principle may be raised as an argument against allowing abortion. Also, abortion may be criticised on moral grounds.

Levi noted a similar argument, which is simply that ‘one’s future capacity for autonomy should be maximised at the expense of one’s present exercise of autonomy’.¹³⁴ Parfit’s reductionist argument, based on the relative unimportance of personal identity, that ‘we ought not to do to our future selves what it would be wrong to do to other people’, forms the basis for the third argument.¹³⁵ If the harm principle justifies restricting autonomy to protect others from harm then, if my psychological connectedness to my future self is no greater than it is to current third parties, just as my autonomy may be justifiably restricted to prevent harm to others so it may be constrained to protect my future self.

As I noted earlier, for autonomy to be constrained the harm principle requires the act to be wrongful. What this implies is that for harm to future autonomy to count as a justifiable limit I must owe myself a duty not to cause such a setback to my autonomy. This is problematic not least because if I owe myself the duty there is no good reason why I cannot waive it and that undermines any such duty. This consequence may be avoided if I am held to be the subject of the duty but the duty is owed to the community (or state). However, for such a duty to be justifiable, the harm caused by infringing my present autonomy must be less than the harm that would otherwise be caused to my future autonomy. Furthermore, any claim that I owe a duty to protect my future autonomy must survive the following arguments.

The starting point is that many choices restrict my future choices. To use Parfit’s railway analogy, if I chose the right – rather than the middle or left – track I lose all of the opportunities associated with the middle and left track. In this way, every time I exercise my autonomy I restrict my future autonomy. Avoiding making choices cannot solve this problem because it would wholly undermine the value of autonomy and, since many choices are lost by inaction, it would not guarantee protection of future autonomy. Thus,

¹³⁴ *Op cit* n.82, 84.

¹³⁵ Parfit, D. *Reasons and Persons* (1984) Oxford: Clarendon Press, 320.

if present autonomy is to be restricted, as Levi argued (see above), it must be to protect future *capacity* for autonomy.

Levi based his objection to restricting present autonomy on ‘John Dewey’s claim that to sacrifice the present for the future is to empty the present of all meaning’.¹³⁶ This sacrifice is one that ‘involves uncoupling ends and means in such a way that one’s present activities no longer reflect the principles that ground one’s values, upon which one’s priorities, and in that sense “meaning”, are based’.¹³⁷ A classic example of this would be ignoring the Jehovah’s Witness’ refusal of blood in order to prevent her suffering permanent harm or death from major blood loss.

One important implication of Levi’s argument is that it appears to address only those instances in which the exercise of autonomy concerns one’s values, goals or life plans. If autonomy is conceived of as simple self-determination, then Levi’s argument only applies to the most important decisions and then only if they are rational choices. This accords with Levi’s conception of autonomy¹³⁸ but does mean that his argument would justify non-interference only where the decision itself was autonomous rather than respecting all the primarily self-regarding decisions of an autonomous person. Because his argument protects only autonomous decisions it fails to justify non-interference where the actor decides irrationally or simply makes a mistake. It may be argued that there is no good reason to protect such decisions if they will damage the actor’s future autonomy. However, being self-determining is, as I discussed earlier, an intrinsically important aspect of authorship, responsibility and moral personhood. It is our actions as autonomous persons rather than our autonomous actions that ground these crucial parts of

¹³⁶ *Op cit* n.82, 84. The argument depends on accepting that valuing the capacity for autonomy requires us also to value being able to exercise that autonomy. Just as having money but no opportunity to spend it seems pointless, so too is having an unusable capacity for autonomy.

¹³⁷ *Ibid.*, 85.

¹³⁸ *Ibid.*, 35-37.

who we are. This means that not only should others respect our autonomous choices but also our non-autonomous choices.

It may be argued that, since the capacity for autonomy is so important, only autonomous choices should be respected, as these will – if truly autonomous and hence rational – take account of the effect on future capacity. However, it is an empty respect for someone to say that his decisions will be respected but only if they are objectively right. If taken to an extreme these objective judgments would be applied not just to our decisions but also to our goals and life plans and would be the moral equivalent of Henry Ford's famous restriction that the customer could choose whatever colour he liked as long as it was black. In fact, it may be psychologically worse as alternatives may be apparently available only to be whisked from under our noses if we make the mistake of opting for the 'wrong' one. The argument that non-autonomous decisions should be respected is given further support by recourse to one of Mill's justifications for liberty (see earlier). This is that we know ourselves better than others know us, which makes us the expert regarding our own lives. While others may inform us of the likely effect of a chosen action, it is for us to determine the relative importance of that consequence. It is perhaps worth noting that Mill's argument that we should be allowed to make mistakes because it is the best way to learn would not apply where the consequence was catastrophic. There seems little point in learning a lesson if the consequence of that lesson is to so undermine autonomy that the actor is unable to utilise any new knowledge.

In concluding his argument, Levi stated that: 'There is no sense in which I can be acting out of respect for your exercise of autonomy and at the same time undermining your present exercise of autonomy ... There is no larger frame of reference for my respect beyond your exercise of autonomy right there and then'.¹³⁹ I would go further than this and suggest that a respect for autonomy requires respect for both autonomous choices and

¹³⁹ *Ibid.*, 87-88.

the non-autonomous decisions of autonomous persons. This position, however, is still vulnerable to Parfit's arguments regarding the protection of future selves, which I will now briefly address.

Future Selves

Parfit argued that identity is important only in so far as it is constituted by psychological continuity and connectedness. The importance of these latter two factors he persuasively established by considering scenarios involving split brains.¹⁴⁰ Thus, he argued that when his brain is split into two parts (left and right) and each half is placed in a new body the question of his existence is irrelevant. The more important one is whether he shares a psychological connectedness with Lefty and Righty. Since, in a normal life, connectedness decreases over time (I share a greater psychological connection with my 30 year old self than with my 10 year old self) it is not irrational to act for instant pleasure even if that would cause harm to my future self. However, as the connectedness decreases so my future self becomes less like me and more and more like someone else. As such it makes little sense to deny my future self the protection afforded to others who may be wrongly harmed by my actions. This would suggest, amongst other things, that my present autonomy might be constrained to protect my future self's autonomy.

Levi, offered five reasons why Parfit's view should not be followed.¹⁴¹ First he suggested the familiar point that the present self is the one best placed to be considered expert about the best interests of the future self. As I noted earlier, this will not always be the case and at best it only provides a conditional argument in favour of respecting present autonomy. Levi's second argument was that for the vast majority of our decisions the person most directly affected is sufficiently psychologically connected to the decision-maker to be considered the same self. This is perhaps the most telling counter-argument in the context

¹⁴⁰ See Part III of Parfit, D. *Op cit* n.135, 199-345.

¹⁴¹ *Op cit* n.82, 88-91.

of contemporaneous decision making. For some, adopting a narrative view of human life provides the necessary connection.¹⁴² Dworkin, for example, argued that the best justification for autonomy is that it is through the exercise of personal choice that we construct our own identity. On this ‘integrity’ view, autonomy is causally necessary for authorship and the development of a unique character.¹⁴³ The narrative thread that connects the individual stages of the human being’s life creates the necessary unity of identity, which means that any duty owed to the future self is a duty owed to myself and may thus be waived.

Korsgaard constructed a similar argument against Parfit’s view. She persuasively argued that the entity that unifies a human life is the ‘Agent’, which may be broadly equivalent to Kant’s ‘Will’. In Platonic terms, the agent unifies the three parts of the soul: appetite, reason and spirit.¹⁴⁴ Thus:

When you deliberate about what to do and then do it, what you are doing is organizing your appetite, reason, and spirit, into the unified system that yields an action that can be attributed to you as a person ... Whatever else you are doing when you choose a deliberative action, you are also unifying yourself into a person.¹⁴⁵

Agency ‘is important because our conception of what a person is depends in a deep way on our conception of ourselves as agents’.¹⁴⁶ Thus, Korsgaard suggested that any choice authored by the Agent has a special significance. Furthermore:

¹⁴² Quante, M. ‘Precedent Autonomy and Personal Identity’ (1999) 9(4) *Kennedy Institute of Ethics Journal* 365, 372; Rich, B.A. ‘Personhood, Patienthood, And Clinical Practice: Reassessing Advance Directives’ (1998) 4 *Psychology, Public Policy, and Law* 610, 614.

¹⁴³ Dworkin, R. *Life’s Dominion* (1993) London: Harper Collins, 223-224.

¹⁴⁴ Korsgaard, C.M. ‘Self-Constitution in the Ethics of Plato and Kant (1998) 3 *The Journal of Ethics* 1, 7.

¹⁴⁵ *Ibid.*, 22.

¹⁴⁶ Korsgaard, C.M. ‘Personal Identity and the Unity of Agency: A Kantian Response to Parfit’ (1989) 18(2) *Philosophy and Public Affairs* 101, 103.

the extent that you regulate your choices by identifying yourself as the one who is implementing something like a particular plan of life, you need to identify with your future in order to be *what you are even now*. When the person is viewed as an agent, no clear content can be given to the idea of a merely present self.¹⁴⁷

It is, therefore arguable that the qualitative changes in our person resulting from our Agent-authored choices do not affect the identity of that person, which is only fragmented by external influences. Thus, barring some radical discontinuity, I remain the same person throughout my autonomous life and any duty I owe to myself is waivable. Korsgaard's argument has the further consequence of limiting external interference, since major interference with the Agent will fracture the person's unity.

Levi's third argument was that, any protection of future selves should apply across the board and not just to medical decision-making. Thus, 'major life decisions, such as having children, going into massive debt for a purchase, undergoing plastic surgery, or becoming a professional boxer' - and many other decisions, including everyday ones - should be subject to the test of great imprudence.¹⁴⁸ This raises the issues of who would be qualified to make such decisions and whether anyone could ever make such decisions. This point has particular force in light of Korsgaard's argument about agency as it would seriously undermine an individual's integrity if every major decision in life was subject to the constraint of 'objective' rationality.

Levi's fourth argument was that, any future self is likely to share values, interests and goals with the present self as these will have evolved from those possessed by the present self. This argument may apply to the future selves that develop gradually, especially those unified by the 'Agent', but will be far less relevant where the future self is created by a

¹⁴⁷ *Ibid.*, 113-114

¹⁴⁸ *Op cit* n.82, 89.

devastating event (i.e. where psychological continuity is disrupted by, for example, head trauma). Finally, he noted that such restrictions would be far more extreme than those placed on parents with respect to self-regarding decisions that affect their children. This, he suggested, ‘is at the very least counterintuitive to think that we should place restrictions on our future selves that we would not place on parents out of concern for wholly distinct human beings’.¹⁴⁹

Hetta Hayry made an even more direct criticism and argued that Parfit’s view, while it may not be refutable, remains intellectually unconvincing.¹⁵⁰ She added further criticism to any suggestion that, even if the reductionist view would lead to a more prudent and altruistic community, obligations to future selves should not be legally coerced as our deeply held beliefs about our individuality would be ‘likely to counteract any legislative and socio-political attempts towards regulating behaviour which people see as self-regarding’.¹⁵¹

All of these arguments suggest we should be allowed to make our own choices even if they are irrational. As per Mill, others may be allowed - or even have a duty – to advise, persuade, and remonstrate, but if autonomy is the guiding principle then the final decision should remain with the individual. However, autonomy is not the sole principle and others need to be considered in the final balance. Before tackling the relevance of other moral principles and approaches, because I have argued that it is essential to a sufficiently textured conception of autonomy, it is necessary to consider rationality in more depth.

¹⁴⁹ *Ibid.*, 91.

¹⁵⁰ *Op cit* n.124, 131-136.

¹⁵¹ *Ibid.*, 137.

Which Rationality?

The Oxford English Dictionary defines rationality as: ‘The quality of possessing reason; the power of being able to exercise one’s reason’.¹⁵² This begs the question of what counts as reason. O’Neill suggested that there are perhaps two points that would be widely accepted, even by those sceptical of the possibility of reason. These are: ‘that anything that could count as reasoned would make no arbitrary moves’; and ‘anything reasoned ... [has] a certain authority in guiding thinking and acting, which is quite generally discernible, and so does not presuppose any views – or prejudices – which are not, or might not be, generally shared’.¹⁵³ Nagel provided a similar explication: ‘The essential characteristic of reasoning is its generality. If I have reasons to conclude or to believe or to want or to do something, they cannot be reasons just for me – they would have to justify anyone else doing the same *in my place*’.¹⁵⁴

There are two aspects of decision-making that raise issues of rationality: the choice of ends and the means of achieving those ends. Both of these decisional elements are things that the law might be concerned with and there are broadly two possible approaches. First, the law could adopt what Gaut called the ‘recognitional model’. For Gaut, the general authority for rational action is that the agent ‘represents the action as good’. In the recognitional model, the ‘good’ is determined independently of the agent’s actions.¹⁵⁵ The second possibility is the ‘constructivist’ approach in which ‘the good simply is constituted as the object of rational choice’.¹⁵⁶

If the law were to adopt the recognitional model then there must be some objective and non-arbitrary justification of ‘the good’ that provides the necessary authority and gives

¹⁵² Oxford English Dictionary 2004, available at: <http://dictionary.oed.com/>.

¹⁵³ O’Neill, O. *Bounds of Justice* (2000) Cambridge: Cambridge University Press, 12.

¹⁵⁴ Nagel, T. *The Last Word* (1997) New York: Oxford University Press, 5 (emphasis added).

¹⁵⁵ Gaut, B. ‘The Structure of Practical Reason’, in: Cullity, G. Gaut, B. (eds.) *Ethics and Practical Reason* (1997) Oxford: Clarendon Press 161, 161-162.

¹⁵⁶ *Ibid.*, 162.

the rational actor a motivational reason to adopt that good as an end. As Gaut suggested, ‘we can construe practical reason as the capacity to recognize and be motivated by what has objective value’.¹⁵⁷ However, given the problem of recursion, it seems unlikely that the good life is something that can be ‘intrinsically reasoned or reasonable’.¹⁵⁸ Gaut attempted to do this by drawing a connection between the good life and our biology. According to her argument, ‘value is a teleological, biological category’,¹⁵⁹ and it is therefore plausible to objectively determine the ‘goodness’ of an end based on its biological function. The ‘good life’ can thus be discovered ‘by experiencing which lives go well and badly, drawing on individual experience and the accumulated wisdom of the past, and by deliberating individually and collectively in the light of this experience’.¹⁶⁰ This is fine, as far as it goes, but it only provides a very limited view of the good life, which is that part ‘determined by her [the agent’s] nature: by her capacities, tendencies and needs’.¹⁶¹ Unless the good life is to be determined solely in terms of biological function, and even that may be open to a degree of interpretation, then we still need some way of choosing between competing philosophies, which problematically tends to ‘involve begging the question regarding the ranking of values and/or of right making principles’.¹⁶²

An alternative is the constructivist model, which may take one of two forms. In the neo-Humean form the agent’s motivation comes from internal states that are neither rational nor irrational and are ‘at least partly constituted by ... desire’.¹⁶³ The question of rationality is then purely instrumental: whether the act will satisfy the desire. Unlike Hume, the neo-Humeans add the normative requirement that the desire itself must be

¹⁵⁷ *Ibid.*, 183.

¹⁵⁸ *Op cit* n.153, 14.

¹⁵⁹ *Op cit* n.155, 184.

¹⁶⁰ *Ibid.*, 187.

¹⁶¹ *Ibid.*, 185.

¹⁶² *Op cit* n.77, 292.

¹⁶³ Cullity, G. Gaut, B. ‘Introduction’, in: Cullity, G. Gaut, B. (eds.) *Ethics and Practical Reason* (1997) Oxford: Clarendon Press I, 4.

reflected on in a rational and knowledgeable way to determine one's ultimate desire. Acting to promote this ultimate desire is rational even though the ultimate desire itself is not amenable to analysis on the basis of rationality.¹⁶⁴ This effectively allows individuals to determine the 'good' for themselves, provided they have reflected on that end. This approach is found in Frankfurt's and Dworkin's division of desires into first and second order with rationality judged on the basis of consistency with the second order desire.¹⁶⁵ This model of rationality, which would accord with a liberal ethic, is not without its detractors.¹⁶⁶

Perhaps the major criticism is that, while this view of rationality allows for value judgments it remains self-referential: whether the means is rational is determined entirely against the subjective end chosen by the actors themselves. Kennett argued that

moral requirements must be shown to be a species of reasons for actions that are available and applicable to all of us: not in virtue, simply, of our individual aims and interests and allegiances, but in virtue, first, of our shared rational capacities for critical reflection and, second, of our capacities for action in accordance with the outcome of such reflection even when it conflicts with our individual desires and interests.¹⁶⁷

This means that, if she is correct, morality in this model is irrelevant to the question of rationality.

The second constructivist approach is the Kantian model.¹⁶⁸ In this approach, morality is rational and to fail to act morally is to act irrationally.¹⁶⁹ For Kant, the autonomous will is

¹⁶⁴ *Ibid.*, 7-8.

¹⁶⁵ *Op cit* n.35, 20. Frankfurt, H. *Op cit* n.50.

¹⁶⁶ See, e.g. Kennett, J. *Agency and Responsibility: A common-sense moral psychology* (2001) Oxford: Clarendon Press, 64-71.

¹⁶⁷ *Ibid.*, 99-100.

¹⁶⁸ *Op cit* n.163, 3-5.

rational and, as a consequence of rational deliberation, any self-willed autonomous law must obey the categorical imperative and be willed as universal.¹⁷⁰ Working from Kant's approach, Korsgaard argued, *contra* Hume, that there is a distinction between actual desires and rational desires and that we ought to pursue our rational desires rather than just our actual desires.¹⁷¹ This distinction requires that we have some way of distinguishing what is rational, i.e. what we ought to do, from simply what we desire to do and, if this is the case, there must be 'normative principles directing the adoption of ends'.¹⁷² According to Kant, the normative principle is that any self-legislation must also be capable of being willed as universal. Although Kant provided two helpful reformulations of this imperative – treat people as an end in themselves and not merely as a means,¹⁷³ and 'every rational being should be regarded as an autonomous legislator in a kingdom of ends'¹⁷⁴ – this approach to grounding the authority of morality in rationality may be accused of being 'a contingent psychological matter' and empty of any substance.¹⁷⁵

Each of the three approaches to rationality has its supporters and its detractors. The choice between the first two perhaps comes down to whether one sees the good as prior to the right or vice versa.¹⁷⁶ The difficulty with giving primacy to the good arises from the question of why a particular view of the good should be authoritative,¹⁷⁷ and it may lead

¹⁶⁹ *Op cit* n.166, 98.

¹⁷⁰ *Op cit* n.72, 39 (4:431).

¹⁷¹ Korsgaard, C.M. 'The Normativity of Instrumental Reason', in: Cullity, G. Gaut, B. (eds.) *Ethics and Practical Reason* (1997) Oxford: Clarendon Press 215, 230.

¹⁷² *Ibid.*, 231.

¹⁷³ *Op cit* n.72, 39 (4:429). (see, Brink, D.O. 'Kantian Rationalism: Inescapability, Authority and Supremacy', in: Cullity, G. Gaut, B. (eds.) *Ethics and Practical Reason* (1997) Oxford: Clarendon Press 255, 268).

¹⁷⁴ *Op cit* n.72, 39 (4:431-3).

¹⁷⁵ Brink, D.O. *Op cit* n.173, 272.

¹⁷⁶ See, Sandel, M.J. *Liberalism and the Limits of Justice* (2nd ed., 1998) Cambridge: Cambridge University Press, xi.

¹⁷⁷ It may be argued that the objective ends view of rationality completely undermines the whole idea of autonomy. This is not necessarily the case, but space does not permit a discussion of this issue. For a defence of the view that the two are compatible see: Varelius, J. 'Autonomy, Subject-Relativity, and Subjective and Objective Theories of Well-being in Bioethics' (2003) 24 *Theoretical Medicine* 363.

to ‘intolerance and the suppression of opinions’ with autonomy valued as a means to achieve a societally imposed view of ‘self-perfection’ rather than for its autobiographical role in determining character and identity.¹⁷⁸ The problem with seeing individuals as having the right to determine their own good is that it allows a moral vacuum and underplays the importance of a person’s social relationships within the context of a community. We are all dependent on others, to a greater or lesser extent, throughout our life. Without the nurturing and support from others we would be free but that freedom would be relatively impotent. As Gauthier noted: ‘No one can attain even ... [the] minimal human goods alone. They require families and communities that protect, nurture, and support individual well-being and provide for these needs, when necessary’.¹⁷⁹ Given that we could achieve nothing without the support of others we must rely on those others for their help. If others are to provide assistance then they must have some reason for doing so and this means that the claim must at least be accepted as reasonable.

The third view of rationality, that links morality and rationality through the constraint of universalisability, has the necessary sensitivity to others to recognise the socially embedded nature of rationality and autonomy. As such, it is, I submit, the preferable view provided it can be given more substance than exists in Kant’s formal imperative. Kant’s imperative forms the basis for O’Neill’s argument that the individual’s ability to reason must be judged against ends, norms or commitments that it is ‘*possible* for others to follow’.¹⁸⁰ Thus, ‘Reasoning is defective when reasoners misjudge or misrepresent what others can follow’.¹⁸¹ This model perhaps lies somewhere in between the objective-ends and the subjective-ends models of rationality. While it allows individuals to determine the good for themselves, this is open to scrutiny and is only deserving of respect if the ends are accessible to others. This means that the end does not need to be one that the judge

¹⁷⁸ *Op cit* n.110, 119; *Op cit* n.143, 224.

¹⁷⁹ Gauthier, C.C. ‘The Virtue of Moral Responsibility in Healthcare Decisionmaking’ (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 273, 277.

¹⁸⁰ *Op cit* n.153, 24.

¹⁸¹ O’Neill, O. *Towards Justice and Virtues* (1996) Cambridge: Cambridge University Press, 58.

would accept, but it does need to be one that he *could* accept. The identity of those others will depend on context, but could be anyone asked for assistance to enable reasoners to achieve their goals. Whether a particular end is accessible may be influenced by what Gadamer has termed the ‘sensus communis’, which is ‘the sense that founds community’.¹⁸² In this way, the model is sensitive to the objective ends view of rationality. However, because it focuses on what *could* be acceptable, it is also tolerant of more subjective ends.

The final question regarding rationality that I will consider in this chapter is: how much rationality should be expected? If too high a level is required then few people will be capable of autonomy, but if the level is set too low then people will be required to make decisions when they lack the capacity to make them wisely. One possible approach would be to require what Hurley calls loose reason-responsiveness (being weak-willed).¹⁸³ The gist of this is that the person is capable of responding to “all-things-considered” reasons, but will often respond to specific reasons to act that are not strong enough to outweigh the reasons not to act. This means that there must be a reasonable pattern of responsiveness to “all-things-considered” reasons even though the person would not always act on those reasons. It is a matter of judgment to decide exactly how often a person must act on “all-things-considered” reasons to be deemed competent, but it would not be unreasonable to suggest that they should make such decisions more often than not.

Conclusion

In this chapter I explored the nature, the value and the limits of autonomy. I noted that there are broadly three conceptions of personal autonomy: self-determination; rational self-determination; and moral rational self-determination. I suggested that it was also important to distinguish between the autonomous person, the autonomous act and the

¹⁸² Gadamer, H-G. *Truth and Method* (2nd ed., 1975) London: Sheed & Ward, 21.

¹⁸³ Hurley, S.L *Justice, Luck, and Knowledge* (2003) Cambridge (Mass): Harvard University Press, 55-57.

autonomous life. Because simple self-determination obscures these distinctions, and because it fails to engage the justification that autonomy enables moral responsibility, I rejected it. Furthermore, since autonomy must take into account its relational nature any useful conception must acknowledge the need for rational self-reflection. This leaves autonomy as rational-self-determination or as moral rational self-determination. I declined to make a final choice between these two conceptions at this point, although I recognised that the choice may need to be made. I will address this issue in chapter three, when I explore the relevance of the HCP-patient relationship.

I suggested that autonomy has both intrinsic and instrumental value. The intrinsic value arises primarily because of the necessity of autonomy for the ascription of moral personhood and responsible agency. It follows from this that autonomy is intrinsically valuable because it allows us to adopt the reactive attitudes that instil life with the warmth of humanity. The instrumental values of autonomy are that it is beneficial to the well being of those with an internal locus of control. It is also important because respecting autonomy allows people to get better at attaining goods and to learn from their mistakes. Furthermore it allows people to develop their character and to shape their lives and identities. Finally, it serves as a layer of protection against the tyranny of the state.

Although autonomy is both intrinsically and instrumentally valuable, it is not protected absolutely. The main limit on personal autonomy is to prevent harm to others. Other potentially limiting factors, such as offence to others and moralism, are insufficient – at least in the context of healthcare provision - to justify restricting individual autonomy. Imprudence and the possibility of self-harm only justify the use of remonstrance, pleading and rational persuasion. The most difficult situation is where the choice risks harm that is catastrophic for the individual's future autonomy, but even here I suggested that any interference should fall short of force or coercion. Furthermore, this protection

for autonomy extends to both autonomous and non-autonomous acts provided the person has the capacity for autonomy.

Finally, I briefly considered the question of which version of rationality should inform the concept of autonomy. I noted that both the constructivist and the recognitional models of rationality have their strengths but also their weaknesses. Because of this, I suggested that the law should follow the third approach as developed by O'Neill, which holds that individual rationality should be judged against ends, norms and commitments that are accessible to others. Furthermore, I suggested that there should be a moderate requirement for rationality that expects only a loose responsiveness to reasons.

In this first chapter, I have examined the concept of autonomy and discussed its nature, value and limits to come to some limited conclusions, which I will develop further in subsequent chapters. I have not yet considered the internal and external constraints on autonomy that arise in the particular context of healthcare. These include the patient's illness, psychological differences that affect an individual's capacity for autonomy,¹⁸⁴ the power imbalance in the doctor-patient relationship and perhaps the institutional discourse of healthcare. These important constraints have implications for the way doctors and patients interact,¹⁸⁵ which I will address in chapter three. In the next chapter I will explore some of the other relevant moral principles and approaches that may interact with autonomy. This will include consideration of beneficence and paternalism, which will allow further discussion of the problematic issue of autonomy and self-harm. I will then go on to explore the relevance of justice. This will particularly focus on the relevance of autonomy to the individual's responsibility for outcome. Finally, I will also consider the importance of character and virtue ethics and the relevance of consequences.

¹⁸⁴ Waller, B.M. *Op cit* n.94; Bergsma, J. 'Cancer and autonomy' (2002) 47 *Patient Education and Counseling* 205, 206.

¹⁸⁵ See: Secker, B. *Op cit* n.76.

Chapter Two: The Relevance of Beneficence, Justice and Virtue

In chapter one I considered the concept of autonomy, which may be seen as the driving force of consent. In this chapter, I will examine some other moral principles and approaches that may be relevant to determining how the law should regulate consent to medical treatment. I will be focusing on the relevance of beneficence, justice and virtue. In this chapter I do not attempt to provide a complete model of how these different concerns interact. That is something I will address in chapters three and four. Instead, my aim is to provide sufficient background to enable the subsequent development of a more textured model.

I have little to say about the principle of non-maleficence, the essence of which is to do no harm. As Szasz noted, this is - if taken too literally - ‘an absurd’ prescription.¹⁸⁶ Much of what the professional does necessarily risks or causes harm and the obligation is, if interpreted literally, an impossible one. On this view, it is only if the obligation is considered in tandem with the obligation of beneficence that it makes any real sense. An alternative approach is to use a normative concept of harm that, following Feinberg, requires the act, which causes the set-back to the victim’s interests, to be wrongful.¹⁸⁷ Most of the specific duties that arise from this, such as ‘do not kill ... [or] cause pain ... [or] incapacitate’,¹⁸⁸ are relevant only in so far as consent provides the necessary justification to prevent the act being wrongful. Thus, other than reinforcing the general duty to respect the other’s autonomy, it adds little to the consent debate and will not be considered further.

¹⁸⁶ Szasz, T. ‘The Moral Physician’, in: *The Theology of Medicine* (1977) Syracuse (NY): Syracuse University Press 1.

¹⁸⁷ *Op cit* n.68, 10-11.

¹⁸⁸ *Op cit* n.51, 117.

It will be noted that I am saying nothing explicitly about the role of consequences. This is because, as far as consent is concerned, the discussion in chapter one on the limits of autonomy and the concepts of beneficence and paternalism largely exhaust the issue. Consequences do have an additional relevance, which is the resource implication of any particular approach to consent. The more demanding the approach, the greater the resources required to meet those demands and the fewer resources there will be available for other purposes. Since respect for patient autonomy is only one of many competing goods it is important to bear in mind the effects on those goods of any diversion of resources necessary to enhance patient autonomy. This is a difficult political question that I will return to later. For now, I will begin by discussing the role of beneficence, the issue of paternalism and the relationship between beneficence, paternalism and autonomy.

Beneficence

The principle of beneficence, which ‘refers to a moral obligation to act for the benefit of others’,¹⁸⁹ has a long and close association with medical practice. The duty forms part of the Hippocratic Oath and, as the British Medical Association (BMA) noted: ‘Doctors are trained to recognise that they have a duty to benefit others and to avoid the risk of harm unless this is outweighed by potential benefit to the patient’.¹⁹⁰ This duty, of acting to benefit the patient, appears to be an important and reasonable duty that makes the HCP-patient relationship a caring one and demands that the professional’s role is more than just salesman or technician. Although the duty to benefit the patient seems an intuitively good thing, it is important to determine the limits of the duty and consider how it interacts with the obligation to respect autonomy. Importantly, does the HCP’s duty of beneficence affect the patient’s right to autonomy, or does the patient’s right to autonomy define the extent of the professional’s duty of beneficence?

¹⁸⁹ *Ibid.*, 166.

¹⁹⁰ BMA. *Medical Ethics Today: Its Practice and Philosophy* (1998, 1993) London: BMJ Publishing, 154.

For Beauchamp and Childress, the duty of beneficence includes the following general rules:¹⁹¹

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
4. Help persons with disabilities.
5. Rescue persons in danger.

The first thing to note about these rules is that the first two arguably reflect an interaction between beneficence and autonomy. If the patient has a right to autonomy then the first rule requires the HCP to protect and defend that right, which certainly includes an imperative not to infringe the right. This requires the professional to act in a way that not just respects the patient's formal right to consent but also reflects the spirit behind that requirement. The second rule requires that the professional acts to prevent harm from occurring to the patient. The effect of this rule depends on how harm is defined. If harm is defined, as was discussed in chapter one, to mean a wrongful setback to interests, then it is arguable that breach of the patient's autonomy constitutes harm. This means that the HCP's duty of beneficence incorporates an obligation to avoid or to prevent an infringement of the patient's autonomy.¹⁹² However, this has not always been the way in which the duty of beneficence has been conceived.

The traditional goals of medicine are to preserve, protect and/or restore the patient's health.¹⁹³ This perhaps makes it understandable that the emphasis of the duty may be focused on benefits to the patient's health as objectively determined by the healthcare profession. Sometimes this clinical view will coincide with the patient's, or else the patient will defer to the professional's expertise. At other times, however, it may conflict

¹⁹¹ *Op cit* n.51, 167.

¹⁹² See Gillon, R. 'Ethics needs principles – four can encompass the rest – and respect for autonomy should be "first among equals"' (2003) 29 *Journal of Medical Ethics* 307, 310.

¹⁹³ See the Declaration of Geneva 1948 (as amended 1983).

with the patient's belief of what constitutes a benefit. This apparent conflict, between HCPs' approach to their duty of beneficence and patient autonomy arises because of the focus on health and life as the primary object of the professional's duty. The problem with this approach is that it fails to respect the patient as an holistic person since it concentrates on just one aspect of that person's life.¹⁹⁴ It fails to distinguish between 'the health of an individual qua organism and the health of an individual qua person'.¹⁹⁵ Thus, the conflict is 'apparent' because it arises not from beneficence *per se* but from beneficence seen through a 'clinical gaze'.¹⁹⁶ Within an institutional discourse that defines beneficence by reference solely to medical effects on health the patient is disempowered and 'stripped of social identity, and reinscribed ... with the passive role of being just a body ready for bio-medical processing'.¹⁹⁷

As Brock noted, health is just one aspect of well-being,¹⁹⁸ it is of instrumental rather than intrinsic value,¹⁹⁹ it is not wholly objective and may often be adequately achieved by more than one route.²⁰⁰ Since well-being arguably involves the person's sense of self and constraints on, or a lack of respect for, that person's autonomy may adversely affect this by creating a feeling of powerlessness, a duty of beneficence ought to require respect for the individual's autonomy.²⁰¹ Well-being may also be affected by both the effect of treatment choices and the consequential effects of disempowerment on the patient's goals and life plan. Furthermore, the physician's duty of beneficence should not be allowed to

¹⁹⁴ Byrne, P. 'Divergence on Consent: A Philosophical Assay', in: Dunstan G.R. Seller, M.J. (eds) *Consent in Medicine: Convergence and divergence in tradition* (1983) London: King Edward's Hospital Fund 45, 51.

¹⁹⁵ Richman, K.A. *Ethics and the Metaphysics of Medicine: Reflections on Health and Beneficence* (2004) Cambridge (Mass): The MIT Press, 28. The term 'health' as applied to the person rather than the organism is roughly equivalent to Brock's use of 'well-being'.

¹⁹⁶ Foucault, M. *The Birth of the Clinic* (1973) New York: Vintage Books, 145.

¹⁹⁷ McGrath, P. 'Autonomy, Discourse, and Power: A Postmodern Reflection on Principlism and Bioethics' (1998) 23(5) *Journal of Medicine and Philosophy* 516, 521.

¹⁹⁸ See also: Draper, K. 'The Personal and Impersonal Dimensions of Benevolence' (2001) 36(2) *Nous* 201, 219.

¹⁹⁹ See also: Richman, K.A. *Op cit* n.195, 20.

²⁰⁰ Brock, D.W. *Life and Death* (1993) New York: Cambridge University Press, 25-26.

²⁰¹ The idea of 'beneficence in trust': Pellegrino, E.D. Thomasma, D.C. *The Virtues in Medical Practice* (1993) New York: Oxford University Press, 53.

override his duty of ordinary humanity and part of this duty is to respect the other as an equal moral person.²⁰² As Kant wrote: ‘I cannot do good to anyone according to my conception of happiness (except to young children and the insane), but only according to that of the one I intend to benefit’.²⁰³ Thus, the duty of beneficence is one that should take account of and perhaps be defined by the patient’s autonomy.²⁰⁴

Paternalism

Brock argued that: ‘The physician’s ultimate responsibility is to use his or her medical skills to serve patients’ overall well-being in this broad sense, to facilitate patients’ pursuit of their plans of life’.²⁰⁵ If this is the case, it raises the question of whether the HCP is justified in overriding a competent patient’s decision when that decision appears to conflict with the patient’s long term goals or life plan. This is where the distinction between an autonomous decision and a self-determining decision of an autonomous person becomes particularly important. If a decision is autonomous, it will, by definition, accord with the patient’s life plan. If it is merely self-determining then it may not.

Although Rothman suggested that beneficence was redefined as paternalism during the rise of rights-based movements in the 1960s and 1970s, this is to misrepresent the relationship between the two concepts.²⁰⁶ Beneficence and paternalism overlap, in that both involve acting for another’s benefit, but beneficence is constrained by the beneficiary’s will, while paternalism is not. An act of morally problematic paternalism may be defined as one that incorporates the following two elements:²⁰⁷

²⁰² This of course assumes the capacity for autonomy.

²⁰³ Kant, I. *The Doctrine of Virtue: Part Two of the Metaphysics of Morals* vi 453 (1964) New York: Harper & Row, 122.

²⁰⁴ I am saying nothing here about the duty of beneficence to those who lack sufficient capacity, which is important but not relevant to the present thesis.

²⁰⁵ *Op cit* n.200, 27.

²⁰⁶ Rothman, D.J. ‘The Origins and Consequences of Patient Autonomy: A 25-Year Retrospective’ (2001) 9 *Health Care Analysis* 255, 257.

²⁰⁷ These elements are gleaned or adapted from: Arneson, R.J. ‘Mill versus Paternalism’ (1980) 90(4) *Ethics* 470; Dworkin, G. *Op cit* n.35, 121-129; Levi, B.H. *Op cit* n.82, 16; Feinberg, J. *Op cit* n.68, 3-26; Buchanan, A. ‘Medical Paternalism’ (1978) 7(4) *Philosophy and Public Affairs* 370.

1. it is for the benefit of the another person; and
2. it is done contrary to the other's will in such a way as to undermine that other person's self-determination either by:
 - a. overriding; or
 - b. circumventing that person's self-determination by withholding information or deliberately providing misinformation.

The act may – but does not have to – interfere with the other person's liberty and it does not necessarily have to involve an infringement of a right, as shown by Dworkin's example of the husband who hides his sleeping pills from his suicidal wife.²⁰⁸ In this context, however, I am concerned with those acts that do infringe the other person's right to self-determination. I am not here concerned with those acts of 'soft' paternalism, which do not violate autonomy because the other person lacks capacity and is therefore not competent to make the decision.²⁰⁹ Nor am I concerned with the type of paternalism that Hayry terms strong, hard paternalism due to 'moral prudentialism' rather than a concern for the best interests of the person per se.²¹⁰ I believe that the arguments presented in the previous chapter about the value of autonomy are sufficient to show that such extreme paternalism is unjustified. The question I seek to answer here is whether professional paternalism (using Hayry's nomenclature; weak, hard paternalism) can be justified when the competent patient makes a harmful and irrational decision.²¹¹

One objection to paternalism is that professionals are not infallible and may be mistaken in their judgment that a patient's decision is irrational. In this respect it is important to emphasise the distinction between a decision that is difficult to comprehend and one that is truly irrational. Procedures may be established to reduce the risk but even the use of ethical committee oversight, for example, will be unlikely to eliminate this problem. One

²⁰⁸ *Op cit* n.35, 122.

²⁰⁹ *Op cit* n.51, 181; *Op cit* n.124, 64.

²¹⁰ *Ibid.*, 76.

²¹¹ Culver, C.M. and Gert, B. argue that a decision is only irrational if it causes self-harm: *Philosophy in Medicine* (1982) New York: Oxford University Press, 20-41.

of the dangers that such an approach has is that it risks subjugating minority beliefs and values to the dominant majority. As Hayry argued, judgments about other person's best interests often collapse into moralism.²¹² Apart from raising questions of moral equality, this creates problems because: 'there are an infinite variety of interpretations of what is moral, and to a person defending any one of them, its opponents will always appear more or less irrational'.²¹³ Regarding others as irrational because they do not share the same view of the morally good life may predispose to paternalism.²¹⁴

The second problem arising from the professional's fallibility is that it will be the patient who is left to live with the consequences of a bad decision. Although compensation can alleviate some of the consequences, in most cases it is a poor substitute for a good outcome. Where a paternalistic decision goes wrong this may be more likely to lead to disappointment, disillusionment and resentment.²¹⁵ If there is a risk of a decision being harmfully wrong then it should be the person who has to live with the consequences who makes the decision. Again, the risk of mistake can be reduced through procedural requirements but it is unlikely to be completely eliminated and thus, the HCP should avoid paternalistically interfering with the patient's self-determination. Even if patients' irrational decisions are correctly identified their impulsiveness may be a central part of their characters and, if patients are to be held responsible then they should be allowed to make their own decisions.²¹⁶ As Arneson suggested, patients can always choose to place the decision in someone else's hands if they are worried that his impulsiveness or irrationality will be harmful.²¹⁷ Even if someone regrets their impulsiveness it remains rational to prefer to live with the consequences of one's irrational choices rather than

²¹² *Op cit* n.124, 13-15.

²¹³ *Ibid.*, 126.

²¹⁴ *Op cit* n.77, 285.

²¹⁵ Coulter, A. *The Autonomous Patient: Ending paternalism in medical care* (2002) London: The Stationery Office, 107.

²¹⁶ Lavin, D. 'Practical Reason and the Possibility of Error' (2004) 114 *Ethics* 424, 425.

²¹⁷ Arneson, R.J. 'Mill versus Paternalism' (1980) 90(4) *Ethics* 470, 488.

have other people impose their opinion of what might be good for them.²¹⁸ For the sake of further argument, however, assume that the HCP is correct, both in his or her judgment that the patient's decision is irrational and in his or her clinical decision regarding the best treatment choice.²¹⁹

Hayry suggested that, under the liberal position, paternalistic intervention is potentially justifiable: 'If an apparently autonomous decision does not really match the person's true wishes'.²²⁰ She went on to argue that, only soft paternalism – which does not infringe autonomy – and 'weak hard paternalism', which involves 'persons whose decisions are seriously vitiated', are justifiable. However, the danger is that the decision to override the individual's will falls under the category of strong hard paternalism that, as Haryry argued, is never justified.²²¹ As she insightfully noted, in these cases concern for the other person's best interests tends to collapse into moralism (see above). Offence, hurt or irritation is never enough, unless indicative of underlying harm, to justify infringing another's autonomy. Her persuasive approach was based on the intrinsic value of autonomy to human happiness, which allowed her to argue that 'the best interests of the recipients cannot in the long run be served by 'strong' paternalistic measures'.²²²

It might be argued that Hayry's view is fine as far as defining the general position but that hard paternalism may still be justifiable in the short term to prevent irrational harm if such decisions are made on a case-by-case basis. The problem with this argument is that it is impossible to isolate cases in this way. As soon as such cases occur they begin to create a more general position and it becomes natural to use each case as a precedent for a new situation with slightly different circumstances so that such a casuistic approach soon

²¹⁸ Scoccia, D. 'Paternalism and Autonomy' (1990) 100 *Ethics* 318, 323.

²¹⁹ It may be argued, alternatively, that the probability of patient mistake and the likelihood of physician correctness are such that we may behave *as if* the physician *is* correct and the patient *is* wrong.

²²⁰ *Op cit* n.124, 68.

²²¹ *Ibid.*, 71

²²² *Ibid.*, 77.

starts to resemble a general principle. This may not completely defeat the casuistic, consequentialist approach if sufficient safeguards can be established to prevent the slippery slide into a general principle. However, overriding a person's decision may undermine their confidence in the security of their autonomy. Once one's decision-making has been overridden it implies that the same could happen again, which is problematic - especially when it is a decision that actually matters and the stakes are high – since it threatens to undermine the whole value of autonomy. As Arneson noted, in interpreting Mill's arguments, '[t]he consequences of coming to rely on the dispensation of paternalistic aid are mischievous, as are the consequences of dispensing paternalistic aid and the consequences of observing paternalistic aid dispensed to others'.²²³

A further point supporting a non-paternalist position arises from the risk of bad luck. With the best will in the world things sometimes go badly. Most, if not all, medical interventions carry some risk, often of quite serious consequences. Since the patient will have to live with those consequences it should be the patient who controls whether or not the treatment is undergone. Requiring that control of the decision rests with the patient does not affect the position that it is possible, and perfectly reasonable, for the patient to abdicate from making the decision and leave it almost entirely up to the physician.²²⁴

It may be argued, by a non-paternalist, that overriding a competent person's decision shows a lack of respect for that person because personhood is grounded in the capacity to be autonomous. However, it is equally possible to argue that caring about the other person's welfare demonstrates a respect for that person and, since welfare includes both autonomy and health balancing one value against the other does show respect for that person. If one value is balanced against the other then both are given respect. This is perhaps especially the case where the preservation of health protects the individual's

²²³ *Op cit* n.217, 481.

²²⁴ Such abdication, if voluntary, has no effect on responsibility, which remains with the patient.

capacity for autonomy.²²⁵ It is only if one believes that it is moral personhood – rather than the individual as a whole – that deserves respect that the health of the individual becomes a matter for that person alone to control. In other words, whether paternalism is justified when a person makes an irrational choice depends on the value one places on autonomy. As Husak noted: ‘It seems beyond doubt that many paternalistic interferences promote the good or welfare of the agent who is coerced’.²²⁶ Thus, if weak hard paternalism is to be condemned it ultimately must be on deontological rather than teleological grounds: ‘the essence of the best general objection to paternalism is that such interferences treat persons as less than fully autonomous agents’.²²⁷

The higher the value given to autonomy the less the individual’s health can be taken into account and the less justifiable paternalism becomes. Since autonomy has intrinsic value and is of fundamental importance for ascribing moral personhood and responsibility it is certainly a defensible position that it should take precedence when in conflict with welfare. At this point, the paternalist may argue that an irrational decision is not autonomous and therefore does not need to be respected. However, as I have already noted, since it is the patient who must live with the physical consequences of the choice he or she ought to be allowed control over the decision. Furthermore, if one is to respect the autonomous individual, rather than autonomy as an abstract concept, then it is arguable that even the non-autonomous decisions of an autonomous person should be respected.²²⁸ If this last point is accepted, then the same arguments apply regardless of whether autonomy is seen as rational self-determination or moral rational self-determination. It is only where the question of respect is focused on the decision itself rather than on the person making the decision that the distinction is relevant. Thus, contra

²²⁵ Husak, D.N. ‘Paternalism and Autonomy’ (1981) 10(1) *Philosophy and Public Affairs* 27. 29.

²²⁶ *Ibid.*

²²⁷ *Ibid.*, 28.

²²⁸ *Op cit* n.217, 488-489.

Husak, it is unnecessary to ‘inquire into the content of morality’,²²⁹ since it is enough that the person is capable of engaging with the moral issues.

Although one should respect the choices of an autonomous person this does not mean that the precedence for autonomy requires others to abandon the individual to their decision.²³⁰ Rather, they should seek to foster and support the other’s autonomy, especially where there is a special obligation to the other party. Ulrich even suggested that this ‘may be one of the most important roles of the healthcare professional’.²³¹ I will discuss this in more detail in chapter three. However, for now it is sufficient to suggest that a respect for autonomy, far from preventing value judgments – even if it is possible to do so – arguably requires the HCP to attempt to persuade the patient that their choice is mistaken. Provided that professionals treat their patients as moral equals, stick to using rational argument and avoid autonomy undermining techniques such as withholding information then they will be respecting their patients’ autonomy far more than if they simply accept the patient’s initial decision regardless of how good or bad it is. If the patient’s decision is truly autonomous then he or she will resist the professional’s reasonable efforts to persuade him. HCPs must obviously be sympathetic to the condition of their patients as their ability to resist persuasion may be undermined by illness. But, if HCPs are sensitive to this, they can, by what Savulescu referred to as ‘non-interventional paternalism’, improve their patient’s exercise of autonomy and do all that is justified towards protecting their patient’s health. As Savulescu concluded:

We ought not to compel competent people to do what is best even if what they desire is substantially less than the best. However, allowing competent people to act on their judgment of what is best for their own lives does not imply that doctors should not form for themselves

²²⁹ *Op cit* n.225, 38-39.

²³⁰ Hayry, M. ‘Prescribing cannabis: freedom autonomy and values’ (2004) 30 *Journal of Medical Ethics* 333, 335.

²³¹ Ulrich, L.P. *The Patient Self-Determination Act: Meeting the Challenges in Patient Care* (1999) Washington (DC): Georgetown University Press, 150.

judgments about what is best. Nor does it imply that doctors should not try to convince their patients by rational argument that what they are advocating is the best course. Indeed a doctor ought to form such judgments for his own sake as a moral agent and for his patient's sake as an autonomous agent.²³²

Beauchamp and Childress suggested that controlling the timing of disclosure of information is a further situation in which paternalism may be justified. It might be argued that autonomy requires the HCP to disclose personal information, such as test results, at the earliest practical opportunity. However, where such disclosure may overburden or unduly distress a patient, it is arguable that professionals should use their discretion to decide on the best time and kindest way to inform their patients. This limited form of paternalism is arguably justified²³³ provided the professional intends to and does disclose the information before it becomes relevant to any decision the patient might need to make. However, there is an obvious danger here, which is exemplified by Beauchamp and Childress' discussion. They suggested that the paternalism is justified if the information is disclosed prior to surgery,²³⁴ but medical decisions are not the only ones that the information may be relevant to. For this reason, if this type of paternalism is to be justified, it needs to be tightly constrained so that the professional discloses the information at the earliest practical opportunity when any distress may be minimised.

Beauchamp and Childress' actual example involved inconclusive test results that hint at a dangerous pathology.²³⁵ It is, however, arguable that this is not a case of paternalism at all. In the situation they describe the professional should honestly disclose his uncertainty, which is arguably necessary as part of seeking the patient's consent for the

²³² Savulescu, J. 'Rational non-interventional paternalism: why doctors ought to make judgments of what is best for their patients' (1995) 21 *Journal of Medical Ethics* 327, 330-331.

²³³ *Op cit* n.51, 186.

²³⁴ *Ibid.*, 186.

²³⁵ *Ibid.*, 185-186.

necessary repeat test. Since the first test has not provided sufficient certainty regarding the possible pathology it would be perfectly truthful, and respecting of the patient's autonomy, to simply inform the patient that the results were inconclusive and another test needs to be performed. There is no need to disclose the possible pathology unless it is sufficiently likely that a repeat test is unnecessary. If there is still sufficient doubt in the professional's mind that the pathology exists then it is both unkind and unnecessary to mention the possibility. It may, of course, become necessary if the patient refuses consent to the second test, but if the patient is willing to undergo the second test on the basis of an inconclusive first test then the failure to disclose the suspicion has not infringed the patient's autonomy since it was unnecessary for the decision. Such an approach would not be paternalistic.

The Role of Justice

Justice is relevant in any situation where conflict may not be resolved through the cooperative relationship of care or love. In something as impersonal as the state, Justice is essential. As Ryan argued, 'The legitimacy of a state rests upon its claim to do justice'.²³⁶ Although justice may be said to be concerned with fairness there are both different senses of justice and different conceptions of what it means to be fair.²³⁷ Ulrich, for example, defined the principle of justice as requiring that:

One should give to persons what they are owed, what they deserve, or what they can legitimately claim, treating equals equally unless there is a morally relevant difference requiring persons to be treated unequally; consideration must often be given to a proper allocation of benefits and burdens within the social context.²³⁸

²³⁶ Ryan, A. 'Introduction', in: Ryan, A. (ed.) *Justice* (1993) Oxford: Oxford University Press, 1.

²³⁷ Nathan suggests that, 'The range of conceivable principles of justice is terrifyingly vast': *The Concept of Justice* (1971) London: McMillan Press, 29.

²³⁸ *Op cit* n.231, 153.

This basic approach derives from Aristotle who noted that: ‘Justice is considered to mean equality. It does mean equality – but equality for those who are equals, and not for all. Again, inequality is considered to be just; and indeed it is – but only for those who are unequal, and not for all’.²³⁹ Similarly, Beauchamp and Childress suggested that the Formal Principle of Justice is that ‘Equals must be treated equally, and unequals must be treated unequally’.²⁴⁰

One of the assumptions that grounds this thesis is that all members of the relevant community should be treated as *prima facie* equals, which means that any different treatment of individuals must be justifiable on the basis of a morally relevant difference between those individuals.²⁴¹ This also means that individuals should not be treated differently on the basis of morally irrelevant factors. This view of justice still leaves the work of determining what counts as morally relevant. As Stone noted, ‘Recognition of ... human equality ... is ... a necessary step toward raising the questions of justice, towards asking when persons shall be treated unequally or equally according to their badges of entitlement’.²⁴² This is what Beauchamp and Childress referred to as the ‘Material Principles of Justice’, which include many different outcome measures that might justify different treatment: e.g. need; effort; merit; contribution and free market competitiveness.²⁴³ Furthermore, since treatment may be different in kind or in degree, it is not enough to simply point to a morally relevant difference. There also needs to be some way of evaluating the value of the difference between individuals so that the effect of treating that person differently is proportionate to that value.²⁴⁴ I am not, however, concerned with constructing a particular theory of justice, which would constitute a thesis in itself. Nevertheless, it is necessary to have at least a working definition of justice in

²³⁹ Aristotle, *Politics III* (1998) Oxford: Oxford University Press, 103 (1280a7).

²⁴⁰ *Op cit* n.51, 227.

²⁴¹ *Op cit* n.231, 156.

²⁴² Stone, J. ‘Justice not Equality’, in: Kamenka, E. Erh-Soon Tay, A. (eds) *Justice* (1979) London: Edward Arnold 97, 102.

²⁴³ *Op cit* n.51, 228.

²⁴⁴ *Op cit* n.237, 14-15.

order to determine how the principle of justice interacts with autonomy and consent. The approach briefly outlined above forms the starting point for my discussion of how justice is relevant to consent to medical treatment.

‘Justice ... presupposes conflict’,²⁴⁵ and it is most pressing when the conflict is between claims of comparable value. There are three points at which justice must interact with autonomy and consent to resolve any discord. First, justice is relevant to the question of whose autonomy should be respected as well as the degree and limits of that respect. Second, justice is relevant to the availability of resources that might be necessary to support the individual’s autonomy. Third, justice is important when considering the question of responsibility for outcome. Before I can outline these three interactions it is necessary to determine to whom this duty of justice applies. As I noted above, it certainly applies to the state and to the institutions and agents that comprise the state and allow it to function as a machine to support and promote social co-operation. However, it is arguable that it also applies to individuals as much as it does to the state,²⁴⁶ which is reflected in the idea of justice as a virtue (see below). Although one of the functions of the state is to achieve the collective justice that would otherwise be impracticable, this does not reduce the duty of individuals simply to pay their taxes and abide by the state’s laws. If it is the individual’s obligation to act justly that justifies at least some state intervention then why should the state intervention wholly relieve them of any further duty of justice? As Murphy suggested: ‘once we accept that the principles that govern the ideal design of ideal institutions essentially describes a means to an end, the oddness of thinking that justice is concerned with some means to that end but not others becomes rather evident’.²⁴⁷

²⁴⁵ Kamenka, E. ‘What is Justice?’, in: Kamenka, E. Erh-Soon Tay, A. (eds) *Justice* (1979) London: Edward Arnold 1, 17.

²⁴⁶ See, Murphy, L.B. ‘Institutions and the Demands of Justice’ (1998) 27(4) *Philosophy and Public Affairs* 251.

²⁴⁷ *Ibid.*, 282.

The demands that the principle of justice makes of particular individuals or institutions depend on the context in which those individuals and institutions are interacting. This is not to suggest that context necessarily alters what counts as just, merely that in order to determine whether two cases are, in a morally relevant way, the same or different, the cases must be seen in context. As Kamenka argued, ‘Justice requires the ability to generalize though not without the complexity of the concrete’.²⁴⁸ In the discussion that follows I will set out what justice might require in regulating autonomy and consent. I will then consider the more particular demands of justice and autonomy in the context of the HCP-patient relationship in chapter three.

Justice and Respect for Autonomy

Since autonomy, as I argued earlier, is essential for moral responsibility and, through this and its association with moral personhood, is intrinsically valuable, then it would be unjust to deny any autonomous individual the same respect for his or her decisions as we allow other autonomous persons. As Tsanoff suggested, ‘A just social order ... is one which safeguards duly the individual in the possession of what is his own, his property and other rights’.²⁴⁹ If autonomy is judged worthy of legal protection, which it currently is,²⁵⁰ then the principle that the different treatment of certain individuals or groups must be justifiable means that, *prima facie*, each person deserves an equal respect for their autonomy. This raises the question of what counts as a sufficient reason to respect a person’s autonomy less. Since the right to (respect for) autonomy is predicated on the ability of the individual to be at least rationally self-determining, it is arguable that where that ability is impaired then it is just to treat the individual differently. In fact, it may be unjust not to treat them differently because it would require them to be responsible when they lack the necessary capacity. However, where individuals have the necessary ability

²⁴⁸ *Op cit* n.245, 13.

²⁴⁹ Tsanoff, R.A. ‘Social Morality and the Principle of Justice’ (1956) 67(1) *Ethics* 12.

²⁵⁰ For example under Article 8 of the European Convention on Human Rights (ECHR) and the Human Rights Act 1998.

to be rational and are capable of making autonomous choices then it would be unjust not to allow them to do so. It is, of course, for society to determine the level of capacity required and how that capacity should be tested, but those important concerns are beyond the scope of this thesis, which is limited to an examination of the rules that apply to those persons deemed legally competent.

One of the arguments sometimes raised against the current emphasis on patient autonomy is that, because of their illness, patients are incapable of exercising their autonomy.²⁵¹ If the patient's ability to be autonomous has genuinely been diminished to the point at which they lack the capacity to make a rational decision then it is just to treat them differently from the patient who has retained sufficient capacity.²⁵² However, not all patients will suffer from such a reduction in autonomy that they cannot be supported and empowered to make a reasoned decision. Where patients still retain sufficient capacity to make rational decisions then it would be unjust to treat them differently, unless there is some other reason that would justify different treatment. This brings the argument back to the question of whether paternalism is ever just.

As I have already argued, it may be just to act paternalistically where the individual's capacity for autonomy is sufficiently diminished to make it reasonable to protect them against their own inability to make rational decisions. However, where the person has sufficient capacity - even where it may be diminished by illness - it would be to treat them as an inferior, and hence to act unjustly towards them, to override a decision except where it falls within the penumbra of the harm principle. Husak suggested that not all paternalistic acts imply inferiority. However, he was only able to do this by arguing that one can be paternalistic towards oneself.²⁵³ Unless one accepts Parfit's argument

²⁵¹ Tauber, A.I. 'Historical and Philosophical Reflections on Patient Autonomy' (2001) 9 *Health Care Analysis* 299, 311.

²⁵² This point depends on there being a just test of capacity.

²⁵³ *Op cit* n.225, 43-45.

regarding the present and future selves, this is an idiosyncratic approach to paternalism, which is concerned with how one may treat, or be treated, by others. As I noted earlier, paternalism requires the act to be against another person's will and thus, by definition, one cannot act paternalistically towards oneself: Odysseus was acting prudently and autonomously, not paternalistically, when he instructed his sailors to bind him to his ship's mast so that he could listen to the sirens' song.²⁵⁴

I suggested earlier that, where the individual is capable of achieving the degree of autonomy necessary for moral responsibility, the ordinary duty of beneficence is generally constrained by the individual's autonomy. I further argued that, while it may be just to (temporarily) infringe a person's liberty, it is not justifiable to infringe autonomy in order to protect the individual from a potentially catastrophic choice. These arguments support the fact that in ordinary life we are largely allowed the freedom to take risks that could lead to permanent harm or death. This holds even where that choice will impact on others and defeat our obligations to them. Thus, the mother or father of a young family remains free to climb dangerous mountains, parachute out of planes or join the army. The question that remains is whether the context of healthcare provision provides a good reason to make an exception to this freedom to make self-determining decisions. I will return to this question in chapter three.

There is one final point to make here, which is that it is also a matter of justice what sanctions the law provides when an individual has been treated unjustly whether by another individual or by an institution.²⁵⁵ There are two issues that fall to be justly determined: the reparation that should be made to the victim; and the penalty that should be imposed on the individual or institution that has transgressed the victim's rights. Both of these are highly context dependent since: 'justice is disclosed as the principle of

²⁵⁴ *Op cit* n.35, 14-15.

²⁵⁵ *Op cit* n.249.

thorough and balanced recognition of all the factors and values involved in a complex personal situation, as opposed to any abstractly rigid or one sided adjudication'.²⁵⁶ This explains why it is necessary to situate consent within the context of the HCP-patient relationship rather than simply importing the rules that govern consent in other areas of social life.

Justice, Resources and Support for Autonomy

The capacity for autonomy depends both on the liberty to make decisions and on the resources and support necessary to enable decisions. This reflects the negative and positive aspects of the right to autonomy.²⁵⁷ The positive right to autonomy may be further split into two aspects: the support necessary to enable a decision and the resources required to make a decision meaningful. Because a rational decision is based on reason it requires access to understandable information. This creates an onus to provide the information and the support to enable people to understand it and so make possible a rational decision. Given that different people have different abilities it is arguable that justice requires those that are less able are given more support. This is so whether the lesser ability is innate or due to other influences, such as illness, stress, disempowerment, a lack of confidence or a lack of education. Since justice requires us to act so as to benefit the disadvantaged then it arguably requires the provision of necessary support to foster and improve the ability of the less able to be autonomous. If autonomy is necessary for moral community and responsibility then autonomy is the trigger for *prima facie* equality. If equality is to mean anything then it must at least require that the community supports and fosters each individual's ability to be autonomous – to enable them to exercise their innate capacity - and hence to be an equal member of the moral community.

²⁵⁶ *Ibid.*, 16.

²⁵⁷ Berlin, I. *Four Essays on Liberty* (1969) Oxford: Oxford University Press.

This need to support at least reasonable autonomy is further supported by the arguments for behaviour-based systems of distributive justice. If resources are to be distributed on the basis of desert,²⁵⁸ merit, or the competitive free market then it would be unjust to significantly disadvantage a section of the community in order to further disadvantage them by rewarding those who were better placed to succeed because they started with a greater ability to be autonomous.²⁵⁹ Since we cannot return to a starting point for distribution, the best we can do is to respond to the needs of those whose autonomy is constrained by factors that may be relieved by additional support.²⁶⁰ This obviously has implications for the ability of patients to be autonomous and for the duty of healthcare professionals to further that end (see chapter three).

Apart from the requirement to support the ability to make decisions, justice is also relevant to the issue of resource allocation. Without the choices available to the individual the right and the capacity to make decisions are empty. The relevance of this is that there is a clear distinction between the obligations to protect the freedom to be autonomous and the obligation to provide the individual with meaningful choices. The freedom to be autonomous is instantiated through the protective rights, such as the right to bodily integrity, and the derivative right to control those protections through the device of consent. As I will discuss in chapter four, consent is primarily a device of negative not positive autonomy. As I argued above, there is a positive obligation on the community to empower individuals to exercise that consent, and the driving force for this positive obligation is formal justice combined with the right to negative autonomy, which is the minimum liberty necessary for moral responsibility. However, justice and positive autonomy rather than negative autonomy drives the right to choice through the availability of scarce resources. The relevance of this will become apparent in chapter

²⁵⁸ Which some writers insist is the purest notion of justice: see e.g. Slote, M.A. 'Desert, Consent, and Justice' (1973) 4(2) *Philosophy and Public Affairs* 323, 327; Campbell, T.D. 'Humanity before Justice' (1974) 4 (1) *British Journal of Political Science* 1.

²⁵⁹ *Op cit* n.237, 32-36.

²⁶⁰ Campbell, T.D. *Op cit* n.258, 12-13.

four when I discuss the concept of consent in detail. For now it is sufficient to note that there are many different outcomes that may be used to determine a just distribution of these resources. These include *welfare need* and the *capacity to benefit*, both of which engage the healthcare professional's duty of beneficence.

Justice and Responsibility for Outcome

This final interaction between justice, autonomy and consent is perhaps the most complex: it engages issues of agency, luck, responsibility, corrective and distributive justice. Whenever an agent acts to cause a change in the world that change may be for the better or worse and may affect only the agent or it may also impact on others. Sometimes the change will be exactly as the agent intended, sometimes things will end badly because the agent has been careless, and sometimes the outcome will depend on good or bad luck. The question is who should carry the responsibility for the outcome and, particularly for the purposes of this thesis, what effect does consent have on that responsibility?

As I noted earlier, autonomy is a prerequisite for moral responsibility and if that responsibility is to mean anything then it means that autonomous agents should accept responsibility for the consequences of their actions. This is a reasonable starting point: if we want to be treated as responsible then we should accept responsibility. However, as I suggested above, sometimes things happen that are outside the control of an autonomous agent and these accidents of good or bad luck may alter the outcome. Since the agent is not responsible for the luck should they be held responsible for the outcome?

The situation is further complicated when a second agent acts by giving consent to the first agent. Who should be responsible for the outcome of the act when both agents have exercised their autonomy? I have indicated that the two relevant forms of justice are distributive and corrective. Distributive justice is concerned with the proportionate distribution of benefits and burdens, and freedoms and responsibilities. Corrective

(rectificatory, commutative) justice is concerned with ‘equalising’ losses and gains caused by an unfair or wrongful transaction.²⁶¹ Although these two forms of justice are traditionally seen as distinct types, as Komenka commented, ‘in ... [the law’s] operations commutative and distributive justice cannot be sharply distinguished’.²⁶² This connection was also recently noted by Lord Steyn who claimed, in *McFarlane v Tayside HB*, that tort law was ‘a mosaic in which the principles of corrective justice and distributive justice are interwoven’.²⁶³

I have argued elsewhere that distributive justice and corrective justice are more closely linked than other commentators have previously acknowledged.²⁶⁴ My argument follows Honoré who argued that distributive justice is as concerned with the fair distribution of responsibility for outcome as it is with a fair distribution of resources, rights or freedoms.²⁶⁵ If society is seen as an animated structure, which acknowledges the possibility of future interactions between members of the society then the losses and gains that result from those interactions may be allocated on the basis of distributive justice principles. When regarded in this way, it is arguable that corrective justice is simply one way of sharing responsibility for outcome. It does this by associating responsibility for outcome with agency and moral accountability. Under a system of corrective justice the agent is allowed to keep the benefits of any action but the loss lies where it falls unless the agent is morally blameworthy.²⁶⁶ This is a type of distributive justice based on desert, but it is a particular approach to desert to that favours the actor over any other person that may be affected by the act. There are other, less one-sided, approaches to desert and other

²⁶¹ Aristotle. *Ethics*, V. ii-iii 1130b-1132a (Thomson, J.A.K. transl.), (London 1976), 176-180.

²⁶² *Op cit* n.245, 4.

²⁶³ *McFarlane v. Tayside Health Board* [2000] 2 AC 59, 83.

²⁶⁴ Maclean, A.R. ‘Distributing the Burden of A Blessing’ I (2004) *Journal of Obligation and Remedies* 23.

²⁶⁵ T. Honoré, ‘The Morality of Tort Law – Questions and Answers’, in: *Responsibility and Fault* (2002) Oxford: Hart Publishing 67, 79.

²⁶⁶ It may be noted that tort/delict are imperfect systems of corrective justice because the element of fault inherent in those branches of law is based on objective rather than subjective criteria.

material principles of justice, such as need, that might be relevant to determining a fair allocation of responsibility for outcome.

The relevance for this thesis of concluding that corrective justice is simply a species of distributive justice is that it questions the current association of consent to medical treatment and responsibility for outcome. However, consent and responsibility for outcome are not inherently linked. The association is one of convention dependent on assumptions about agency and responsibility that rely on the more atomistic Liberal conception of autonomy. Once the relevance of luck²⁶⁷ (both to moral and non-moral issues)²⁶⁸ and the interdependent nature of socially situated individuals are acknowledged the issue of outcome responsibility is more complex than a simple direct causal association with agency. This is not to deny the importance of agency and autonomy but merely to suggest that, when luck²⁶⁹ and the relational nature of autonomy are acknowledged, autonomy is insufficient justification to necessarily transfer all responsibility with consent.

Dickenson suggested that the problem of ‘moral luck’²⁷⁰ may be overcome by transferring responsibility for outcome with consent. It is necessary to restrict the health care professional’s responsibility in this way because, where the procedure has been competently performed, a bad outcome is simply bad luck. ‘Thus’, she concluded, ‘an absolutist interpretation of consent protects both doctor and patient: the doctor from moral luck, and the patient from invasion of autonomy’.²⁷¹ But why is it, simply because the health care professional has not acted in a way that is morally blameworthy, that they

²⁶⁷ *Op cit* n.183, 1.

²⁶⁸ Dickenson, D. *Risk and Luck in Medical Ethics* (2003) Cambridge: Polity Press, 1-23.

²⁶⁹ I refer here to a ‘thick’ conception of luck. Hurley argues that ‘thin’ luck is simply that for which we are not responsible. She also suggests that luck is simply confusing and it is better to talk in terms of ‘choice’, ‘control’, ‘alternate sequences’ and ‘regression’: *Op cit* n.183, 106-117.

²⁷⁰ A term coined by Bernard Williams to reflect the paradox that morality requires us to be responsible for our actions but luck is a pervasive causal influence on all outcomes, which appears to undermine the possibility of moral responsibility: Williams, B. ‘Moral Luck’, in: *Moral Luck* (1981) Cambridge, Cambridge University Press 20.

²⁷¹ *Op cit* n.268, 85.

should be shielded from all responsibility for outcome? The patient has also acted in a way that is morally blameless, but we are expected to accept that not only should they suffer the physical consequences of the harm, they should also bear the financial responsibility. There is a distinction here between responsibility for outcome and moral responsibility and consent cannot be made to bear the full weight of determining both issues. Rather, it is a determination that should engage not just consent, but also agency and justice.

Consider the situation if you were to ask to borrow my brand new bicycle and I consent to you using it. While you are riding the bicycle one of the tyres is punctured. This may be seen as largely a matter of bad luck because, while you had control over the bicycle and choice as to when and where to ride it, you lacked the knowledge to enable you to predict where the nail was that would cause the puncture.²⁷² However, I also had some control over the situation because it was my bicycle and I could have refused you permission to use it. Who then should bear the expense and inconvenience of mending the puncture? Certainly, if you had taken my bicycle without asking then, barring some humanitarian emergency that might excuse your conduct, many people would, I suspect, agree that you should make right any damage. This is because only your agency is engaged and you have wrongfully caused a loss. You alone are morally responsible for the fact that the bicycle was in a position to get the puncture, and under the principle of corrective justice you deserve to bear the cost of that loss. But, where you have my consent you have not acted wrongly and so the principle of corrective justice is no help. If responsibility for outcome automatically transfers with consent then no other facts will be relevant and it should be left for me to deal with the puncture. However, just because no one has acted wrongly does not necessarily mean that there are no factors that might influence the answer to the question and I suspect that people's responses to the question of

²⁷² This is not to suggest that the possibility of a puncture was unforeseeable.

responsibility for outcome would be more mixed than for the example where you took the bicycle without consent.

Perhaps the most relevant factor would be your purpose in borrowing the bicycle.

Consider the following possibilities. In the first variation you are a courier and you borrowed my bicycle so that you could make a delivery and carry on earning while your own bicycle was being repaired. In the second case I have asked you to deliver some food to my elderly mother. In the third case you have borrowed the bicycle to help you in your work as a volunteer at the local children's home where you were supposed to be taking the children out for the day for a bicycle ride into the country. In the final variation, I am a sixteen-year-old schoolboy with a Saturday job while you are earning £50,000 a year and, instead of a puncture, the wheel was buckled.

In the first case it seems reasonable to suggest that since you stood to benefit then you should be responsible for the puncture. In the second situation, since you are benefiting me by fulfilling one of my obligations to my mother, it likewise seems fair that I should deal with the puncture. The third case is more difficult since you are acting to benefit a third party. In this case, one might argue that because your act is charitable then you should not suffer the added burden of dealing with the puncture. However, because charity is supererogatory it does not seem fair that I should necessarily be left with the cost of the puncture. Since the children's home is gaining considerably from your help and my loan of the bicycle, perhaps the home should take responsibility for the loss.

Alternatively, the burden could be shared.²⁷³ The final variation is of a different type. In this case there is a huge difference in the resources that the two parties have and it seems reasonable to suggest that since you have a greater capacity to bear the cost that it would be fair for you to pay to have the buckled wheel replaced. It may still be relevant to ask

²⁷³ The idea of sharing the cost of a bicycle puncture may strike one as faintly ridiculous but it is really the principle that I am arguing here. We could equally well be talking about a more expensive loss.

who stood to benefit from the bicycle loan, but the important point is that the fact I gave consent does not appear to be determinative in all of these situations. This is not to suggest that autonomy and consent are irrelevant: merely that consent simply determines whether the act was wrong and it is really principles of justice that do the work. I will consider the particular relevance of this for consent to medical treatment in chapter four.

The Relevance of Virtue

In contrast to deontology and teleology, which are concerned with the right kind of action, virtue ethics are concerned with character: with ‘determining what sort of person one should strive to be’,²⁷⁴ and this is necessarily dependent on an account of the good life that provides a goal or *telos* for ‘any coherent and complex form of socially established cooperative human activity’.²⁷⁵ While these different approaches are often presented as an either-or choice, there is a third option, which is to recognise the importance of both character traits and right action.²⁷⁶ Since action is to at least some extent controlled by the actor’s character and the way we judge character is by observing a person’s behaviour,²⁷⁷ the two seem mutually interdependent and it makes sense to be concerned with both. This thesis is primarily concerned with the regulation of consent, which is essentially a set of rules governing behaviour rather than character. This is because the law tends to operate through rules that create rights and obligations, the stock in trade of action rather than character. Because the law is concerned with adjudicating between individuals when one is affected by the other’s behaviour it must be more concerned with action than with character. However, simply because behaviour is the primary focus of the law this does not mean that character should be ignored. In criminal law, for example, the convicted person’s character may influence the punishment. Thus,

²⁷⁴ Paul, E.F. Miller, F.D. Paul, J. ‘Introduction’ in: Paul, E.F. Miller, F.D. Paul, J. (eds) *Virtue and Vice* (1998) Cambridge: Cambridge University Press vii.

²⁷⁵ MacIntyre, A. *After Virtue* (2nd ed., 1985) London: Duckworth, 184-186.

²⁷⁶ Sher, G. ‘Ethics, Character and Action’, in: Paul, E.F. Miller, F.D. Paul, J. (eds) *Virtue and Vice* (1998) Cambridge: Cambridge University Press 1.

²⁷⁷ *Ibid.*, 4-7.

the focus in this brief discussion will be on how attention to the actor's character may be relevant to consent.

A feature of principles and rules is that they underdetermine action and require that the actor interpret them appropriately. As Loughlin noted: 'There is an inherent vagueness in the ordinary use of language and, because of this, rules – even if we accept that they have a core settled meaning – are often surrounded by a penumbra of uncertainty'.²⁷⁸ In one sense this may be an advantage since there is often more than one acceptable approach. However, the problem is that this indeterminacy, while it gives scope for individuality, also means that it is possible to wrongly interpret the rule. Rules of behaviour are rarely so precise that they avoid the need for judgment.²⁷⁹ Judgment is not something that can be legislated for as it depends on the presence of virtues such as prudence, wisdom, temperance, justice, courage,²⁸⁰ and – at least in healthcare – compassion, empathy and caring for - and about - others.²⁸¹ Smith and Newton argued that: 'Ethical behavior is not ... a function of a willingness to find and apply rules, but of mature judgment and a finely tuned moral character, which ultimately must be intuitively recognized rather than exhaustively defined'.²⁸² Even staunch defenders of the principles approach acknowledge that virtues 'are needed ... for moral obligations to be instantiated and sustained in the moral life of real people'.²⁸³

Oakley suggested that 'reference to character is essential in the justification of right action'. Thus, 'An action is right if and only if it is what an agent with a virtuous

²⁷⁸ Loughlin, M. *Sword & Scales: An Examination of the Relationship Between Law and Politics* (2000) Oxford: Hart Publishing, 84.

²⁷⁹ *Op cit* n.153, 123-124; *Op cit* n.201, xi.

²⁸⁰ Foot, P. *Virtues and Vices* (2002) Oxford: Clarendon Press, 1-18.

²⁸¹ Clement, G. *Care, Autonomy, and Justice: Feminism and the Ethic of Care* (1998) Boulder (Col.): Westview Press. Clement argued for caring as a universal ethic, in combination with justice. Loewy argued for a less prominent role for caring, but still suggested that it is necessary to temper the harshness of pure reason: Loewy, E.H. *Moral Strangers, Moral Acquaintance, and Moral Friends: Connectedness and its Conditions* (1997) Albany (NY): State university of New York Press, 121-125.

²⁸² Smith, D.G. Newton, L.H. 'Physician and Patient'(1984) 5 *Theoretical Medicine* 43, 56.

²⁸³ *Op cit* n.192, 309.

character would do in the circumstances'.²⁸⁴ In the approach adopted here, this would translate as "the interpretation of the rule is that which would be made in the circumstances by an agent with a virtuous character". Another feature of virtue ethics is that the good is prior to the right. Deontology, however, prioritises the right. In this combined approach, I submit that it is neither necessary nor possible (as is evidenced by the lack of consensus on the issue) to definitively prioritise either. Rather the good and the right might be seen as iteratively and symbiotically related to each other: the good informs the right which in turn informs the good.

Oakley also suggested that 'The virtues are objectively good'.²⁸⁵ While this claim may be problematic in relation to persons in general, because it requires somebody with the authority to say that subjective opinion is irrelevant, it is less problematic when applied to someone in their professional role where the professional community is defined, at least in part, by its goal (or set of goals).²⁸⁶ Where that professional community has been given a social mandate to operate then it is arguable that the society granting the mandate has the authority to determine the professional virtues. Where a person voluntarily enters such a profession then they take on the ethical obligations of that community. As MacIntyre contended: 'To enter into a practice is to accept the authority of those standards ... It is to subject my own attitudes, choices, preferences and tastes to the standards which currently and partially define the practice'.²⁸⁷

The importance of the virtuous professional was recognised by the Bristol Royal Infirmary Inquiry, which emphasised: 'the values of caring, of comforting, of supporting and of truthfulness and honesty'.²⁸⁸ However, because people may not be, and cannot be

²⁸⁴ Oakley, J. 'A virtue ethics approach', in: Kuhse, H. Singer, P. (eds) *A Companion to Bioethics* (1998) Oxford: Blackwell Publishing 86, 88.

²⁸⁵ *Ibid.*, 90.

²⁸⁶ *Op cit* n.201, xiii. 13, 21; *Op cit* n.268, 25.

²⁸⁷ *Op cit* n.275, 190.

²⁸⁸ *Op cit* n.2, Chapter 23 [36].

relied on to be, perfectly virtuous,²⁸⁹ rules of behaviour are needed. But the rules require interpretation and so exist symbiotically with the need for judgment and hence a virtuous disposition. In other words, while neither deontological rules nor virtuous dispositions are sufficient by themselves, iteratively combining the two approaches may resolve the weaknesses of both. As Pellegrino and Thomasma argued: ‘Virtue-based ethics link principles and obligations as abstract entities to the circumstances of our personal lives through the virtue of prudence’.²⁹⁰ By highlighting the relevance and need for virtue, the law can at least add symbolic importance to the development of, and emphasis on, the dispositions as an aspect of the professionalism of medicine.

As I will discuss in subsequent chapters, the essence of consent to medical treatment is that patients give their permission for HCPs to perform the relevant intervention. This function of consent naturally lends itself to regulation through a number of rules that require certain behaviour from the professional. However, as I have argued above, implementation of these rules requires interpretation, which is where the professional’s character becomes relevant because character inclines or motivates an individual to act in a particular way.²⁹¹ HCPs could, for example, adopt a formalistic approach to the rules and do the minimum required in order to satisfy the obligation without any thought as to how well such an approach suits the individual patient. Alternatively, they might adopt a paternalist approach and use the indeterminacy of the rules to allow them to manipulate the patient’s decision. For example, the obligation to inform patients would be met by disclosing the relevant risks, but the mode and order of presentation of those risks are likely to influence the patient’s decision. Risks can be underplayed by using descriptors such as ‘only’ or ‘less than’, while they might be overplayed by the use of terms such as

²⁸⁹ For example, the use of “hello” nurses to satisfy the waiting time standard required by the Patient’s Charter: *Op cit* n.215, 92.

²⁹⁰ *Op cit* n.201, 23-24.

²⁹¹ Slote, M. ‘The Justice of Caring’, in: Paul, E.F. Miller, F.D. Paul, J. (eds) *Virtue and Vice* (1998) Cambridge: Cambridge University Press 171, 173.

‘more than’ or ‘as many as’. However, if the patient’s autonomy is to be truly respected then the HCP should adopt an ethically sensitive purposive approach to the rule.

Getting the HCP to approach the rule in an ethically sensitive way cannot be achieved by refining the rules. Furthermore, a highly regulated approach may lead to an overly restricted relationship where the rules replace rather than support trust and encourage formalism rather than empathy. Allowing a reasonable amount of professional autonomy in applying the rules may be more conducive to a caring relationship than a more restrictive approach. However, if professionals are to be afforded that degree of latitude then it is important to encourage them to develop the relevant virtues that will incline them to interpret the rules appropriately so as to determine²⁹² the HCP-patient relationship as one that fits both the caring practice of medicine and the respectful practice of the wider community. Engaging with the virtues will allow the law to support the professionalism of HCPs, which may avoid treating the patient as a consumer and may encourage a more nuanced interaction between two autonomous persons.²⁹³ The interaction between autonomy and virtue may be more symbiotic than Engelhardt claimed when he suggested that, ‘Understandings of autonomy are integral to accounts of human flourishing or virtue ... Autonomy as determination by what is most truly oneself is integral to self-realization. Such self-realization allows one to act fully in accord with one’s self and the good one affirms’.²⁹⁴ I return to this in chapter three, where I discuss the professional-patient relationship.

Virtues may also be relevant to the patient’s role in the clinical encounter. Although patients are not required to interpret rules, it would be helpful if they had the inclination to act in certain ways. It is easy to imagine how the tendency to honesty, openness, empathy, courage and prudence may be valuable in the discursive process leading up to

²⁹² *Op cit* n.275, 192.

²⁹³ *Op cit* n.284, 87.

²⁹⁴ *Op cit* n.77, 290.

the consent decision. If patients have obligations arising out of the professional-patient relationship, as I will argue in chapter three, then there is no theoretical reason why the law should not also be concerned with encouraging them to be virtuous, or at least to act in a way that would be consistent with what might be expected of the virtuous patient.

Conclusion

In this chapter I have explored the ethical issues that interact with autonomy and consent to medical treatment. I have focused on beneficence, paternalism, justice and virtue and suggested that beneficence is best seen as a duty constrained by the patient's autonomy.

In this way, paternalism towards the competent patient is unjustified except in the limited sense of intervening to ensure that the patient is acting as autonomously as possible. This would allow, and might perhaps require, the healthcare professional to challenge an apparently irrational decision and to try to persuade the patient to decide otherwise if the likely outcome will be significantly harmful. It may also justify the healthcare professional controlling the timing of any disclosure, provided that the delay does not undermine any significant decisions that the patient must make.

I suggested that justice is relevant in three ways. First it is engaged when deciding whose autonomy should be respected. Second, it is relevant to the provision of resources to support autonomy, both in a negative and a positive sense. Third, it is germane to the question of responsibility for outcome. In this last regard, I suggested that responsibility for outcome, as distinct from moral accountability and responsibility, is determined by the principle of justice rather than by autonomy and consent, although consent is necessary as a qualifying requirement that enters the individual into the distributive equation.

Finally, I also discussed the relevance of virtue. I argued that attention to individual virtue is necessary because of the indeterminacy of rules. I suggested that virtues and

deontological rules exist in an iterative and symbiotic relationship, where both are important to the morality of individual acts. The relevant virtues are determined by the *telos* or goal of the community, which is less problematic for a professional community that has been given a social mandate to exist and practice predicated on certain societally determined goals.

In the next chapter I will situate these ethical issues within the context of the healthcare professional relationship. This will provide sufficient texture for a more sensitively nuanced approach to the concept of consent, which will be addressed in chapter four.

Chapter Three: The Healthcare Professional-Patient Relationship: Setting the Context for Consent

A model must incorporate respect for the personhood and self-determination of the patient and should enhance dialogue between the two parties of the relationship.²⁹⁵

Consent is not unique to healthcare and, while it may serve parallel functions in different contexts, it is arguable that the regulation of consent should be sensitive to the setting. For example, the requirements for a valid consent in the context of sexual relationships are influenced by the necessary absence of formality,²⁹⁶ which is not the case for consent to health care interventions. Furthermore, because consent must always involve at least two agents it is not a free-floating device that can exist in the absence of a relationship. The way HCPs approach consent indicates their attitude towards their patients, which should reflect a moral sensitivity to the issues discussed in the first two chapters, and is central to the relationship between them and their patients.²⁹⁷ Thus, it is important to situate consent within the context of the relationship between the patient and the HCP.²⁹⁸

Positing consent as central to the professional–patient relationship emphasises its communal aspect. Micah Hester argued that community may be seen as a functional process of participation and interaction,²⁹⁹ and it is notable that consent derives from the

²⁹⁵ *Op cit* n.282, 55.

²⁹⁶ Excluding commercial sex.

²⁹⁷ *Op cit* n.128, 32. See also: Messer, N.G. ‘Professional-patient relationships and informed consent’ (2004) 80 *Postgraduate Medical Journal* 277, 278; Montgomery, J. ‘Time for a Paradigm Shift? Medical Law in Transition’ (2000) 53 *Current Legal Problems* 363, 387; Kaufert, J.M. O’Neil, J.D. ‘Biomedical Rituals and Informed Consent: Native Canadians and the Negotiation of Clinical Trust’ in: Weisz, G. (ed.) *Social Science Perspectives on Medical Ethics* (1990) Dordrecht: Kluwer Academic Publishers 41.

²⁹⁸ *Op cit* n.201, 54; Hermeren, G. ‘Informed Consent from an Ethical Point of View’ in: Westerhall, L. Phillips, C. (eds.) *Patient’s Rights – Informed Consent, Access and Equality* (1994) Stockholm: Nerenius & Santerus Publishers, 39, 46.

²⁹⁹ Micah Hester, D. ‘What Must we Mean by “Community”? A Processive Account’ (2004) 25 *Theoretical Medicine* 423, 433.

Latin *con sentire* (feel together), suggesting an element of communion between the parties. The idea of *community* is further emphasised if *communication* is seen as an important part of consent. Thus consent, or at least the process leading up to consent, may be seen as a community interaction. Although Micah Hester suggested that: ‘A turn to processive community demands that participation, and not consent, be the primary concern of physicians and patients alike’,³⁰⁰ this is to isolate the final act of permission (see chapter four) from the other elements of consent. If consent is seen as requiring both the communication of permission and a preliminary agreement, then it more readily may be seen as a communal act requiring the participation of both parties. Even the final event of seeking permission may be seen as a communal enterprise since it reflects mutuality through a respect for the equal status of the other.

The importance of setting consent within the context of a relationship is that the relationship itself is a source of obligations and responsibilities. Given that autonomy and beneficence are meaningless in the absence of a social context and that the social context centres on the relationship between the relevant parties, it is essential to explore the relationship between the patient and the HCP. It is through this examination that the rights and obligations of the two parties can be resolved. This is important because it allows a more sensitive approach to determining consent and the rules required to regulate consent in this context.

The Professional–Patient Relationship

The most important contact of people as patients is with the professionals providing their care.³⁰¹ Although they may only need to enter into a single relationship – for example, where their GP can provide the necessary treatment – on many occasions they will be cared for by a number of professionals. Sometimes their care will progress vertically, by

³⁰⁰ *Ibid.*

³⁰¹ Stirrat, G.M. Gill, R. ‘Autonomy in medical ethics after O’Neill’ (2005) 31 *Journal of Medical Ethics* 127, 128.

referral from one professional to another, but at other times there may be a more horizontal progression with many professionals being involved cooperatively in caring for the patient. It may, therefore, be a simplification to discuss the professional-patient relationship as if it exists in isolation as a discrete relationship. Nevertheless, since every interaction is conducted within the context of such a relationship, it provides a focus for discussion.

Montgomery argued that paradigms of regulating consent should move away from ‘a relationship between individuals ... [and] move towards models recognizing the importance of institutions’.³⁰² Sensitivity to the relevance of the institution is essential since the organisation of the institution inevitably influences the professional-patient relationship through time and resource constraints imposed on the professional.³⁰³ However, this does not mean that the process and regulation of consent can ignore the importance of individual professional-patient relationships. To do so would be to ignore the human side of healthcare. Individual relationships, even where short-lived or where responsibility for the patient is shared, are both desirable and unavoidable. Care, compassion and empathy are characteristics of humans not institutions and it has been found that the professional-patient relationship is one of the dominant concerns of the patient,³⁰⁴ and has been recognised as an ‘essential’ element of medical communication.³⁰⁵ Thus, the professional-patient relationship remains the most appropriate context for defining the procedural and regulatory approach to consent, provided that approach is sensitive to the institutional and political constraints.

³⁰² See: Montgomery, J. *Op cit* n.297, 395.

³⁰³ Potter, S.J. McKinlay, J.B. ‘From a relationship to encounter: an examination of longitudinal and lateral dimensions in the doctor-patient relationship’ (2005) 61 *Social Science and Medicine* 465; Provis, C. Stack, S. ‘Caring Work, Personal Obligation and Collective Responsibility’ (2004) 11(1) *Nursing Ethics* 5.

³⁰⁴ Burkitt Wright, E. Holcombe, C. Salmon, P. ‘Doctors’ communication of trust, care, and respect in breast cancer: qualitative study’ (2004) 328 *British Medical Journal* 864, 866-867.

³⁰⁵ Makoul, G. ‘Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement’ (2001) 76(4) *Academic Medicine* 390.

Although a number of models have already been used to represent the moral relationship between the doctor and his patient,³⁰⁶ they reflect the end products of the authors' attempts to balance the various values that are thought to be relevant to the relationship. Furthermore, the doctor-patient relationship is usually presented as analogous to other relationships such as priest-parishioner or seller-consumer. However, there is no reason why it should be defined in these terms. It is a unique relationship that may involve aspects - but is unlikely to share all the features - of any one of these models. As such, it may be better to simply identify the interests, values and obligations that form the basis for the relationship.

By definition, a relationship involves at least two parties. It is possible to *be in* a relationship where the other party is not of equivalent moral status, for example, the parent and young child or baby, or the carer and a mentally incapable person. These relationships are one sided and the imbalance between the two parties justifies the dominant party treating the weaker party paternalistically. The origin of the term derives from the paradigm of the caring father and his child. However, as the child gradually develops the ability to be autonomous so the relationship between the parent and the child changes, eventually reaching one where the two parties are of equal moral status. The House of Lords in *Gillick v W. Norfolk and Wisbech AHA* acknowledged this change of moral status in recognising 'that parental rights are derived from parental duty and exist only so long as they are needed for the protection of ... the child'.³⁰⁷

As the child matures and develops an increasing capacity to be autonomous so the nature of the relationship between the parent and the child should change. If the parent and child are to *have* a relationship, rather than simply *be in* a relationship, each must recognise the

³⁰⁶ The reference here to the doctor-patient relationship, as opposed to the professional-patient relationship, reflects the focus of the literature. Only one of the models – the educational model - takes into account the relevance of other healthcare professionals. See, e.g. Veatch, R.M. 'Models for Ethical Medicine in a Revolutionary Age' (June 1972) 2 *Hastings Center Report*, 5.

³⁰⁷ *Gillick v W. Norfolk and Wisbech AHA* [1986] AC 112, 184, per Lord Scarman, HL.

other as an autonomous agent: the parent as fully autonomous, the child as a person with developing autonomy, eventually becoming fully autonomous. An essential aspect of moral agency is that the person is responsible for his or her actions. To gain a sense of responsibility, that allows him or her to exercise moral agency, a person's capacity for autonomy must be recognised by the other agents that exist in relationships with that person.³⁰⁸ But, part of being autonomous in a moral or relational sense is the recognition of the other as a moral agent and the acknowledgement and acceptance of the moral obligations that arise out of the relationship. Through this mutual recognition, which is an important influence on the individual's sense of dignity and agency,³⁰⁹ each party allows the other to fully participate in the relationship, which is necessary for the parties to *have* a relationship.

The point of approaching consent through the professional-patient relationship is to emphasise the importance of social dependency and obligations but equally to recognise that any relationship involves individuals. As Tauber suggested:

“autonomy” ... must find its place in the flux of social demands and claims that balance the needs of individuals and their society in a complex dynamic relationship. Neither atomistic autonomy nor the ethics of responsibility can claim hegemony, for they are mutually interdependent and a complete account of the moral axis in patient care requires that they be integrated.³¹⁰

This recognition that autonomy involves both individuals and relationships emphasises the distinction between *being in* a relationship and *having* a relationship. When one of the parties to the relationship is not respected as a moral agent then that person may *be in* the

³⁰⁸ Benson, P. 'Feeling Crazy: Self-Worth and the Social Character of Responsibility' in: Mackenzie, C. Stoljar, N. (eds.) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (2000) New York: Oxford University Press 72, 78-88.

³⁰⁹ This may be particularly important for the less dominant party to the relationship: Werner, A. Malterud, K. 'It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors' (2003) *57 Social Science and Medicine* 1409, 1415.

³¹⁰ Tauber, A.I. 'Sick Autonomy' (2003) *46(4) Perspectives in Biology and Medicine* 484, 490.

relationship but he or she does not *have* a relationship, which requires mutual recognition of the other's agency and hence allows mutual participation. In the context of the patient-professional relationship, this is important because it requires both parties to recognise the moral agency of the other. Thus it empowers the patient to be autonomous and it maximises the outcome of that autonomy because, through the patient's respect, the professional is empowered to exercise his or her expertise to further the patient's goals. Thus, where the patient and professional have a relationship this is likely to improve the outcome and, because the two parties will be working together, it should also lead to greater satisfaction for both parties. There is evidence to support both of these claims.³¹¹ Furthermore, patients place a high value on a good relationship with their HCP,³¹² and, as Scheffler noted, 'we would be hard pressed to find any type of relationship to which people have attached value or significance but which has never been seen as generating ... [special] responsibilities'.³¹³ Since it requires both parties to recognise and respect the moral agency and expertise of the other party,³¹⁴ it is arguable that having a relationship is morally better than simply being in a relationship. Finally, if patients expect professionals to care and to engage with them in anything more than a purely functional manner then it is reasonable to expect the patient, as a moral agent, to accept the reciprocal obligations that flow from *having* such a caring relationship.

Since it is only those relationships that one has reason to value that generate special obligations, the patient may decide that he or she does not value the relationship.³¹⁵ This relieves the patient of the special obligations that are examined in more detail below. The professional, however, does not have the same degree of freedom. As I will discuss later,

³¹¹ *Op cit* n.303, 476-477. Speeding, E.J. Rose, D.N. 'Building an effective doctor-patient relationship: From patient satisfaction to patient participation' (1985) 21(2) *Social Science and Medicine* 115.

³¹² *Op cit* n.304, 866-867.

³¹³ Scheffler, S. 'Relationships and Responsibilities' (1997) 26(3) *Philosophy and Public Affairs* 189, 190.

³¹⁴ Provis, C. Stack, S. *Op cit* n.303, 8.

³¹⁵ *Op cit* n.313. 205.

by voluntarily entering the profession, the professional's autonomy is constrained by the values of the profession. As long as the profession values the professional-patient relationship then so must the professional.³¹⁶

Perhaps the two things that characterise any relationship are that relationships are based on 'need',³¹⁷ and they create bilateral obligations.³¹⁸ In the absence of obligation any relationship between individuals is purely formal and has no substance: there may *be a* relationship but they do not *have a* relationship.³¹⁹ In a survey of cohabiting or married couples, Eekelaar and Maclean found that the formality of marriage was seen as neither 'necessarily, or even characteristically ... a significant source of personal obligations'.³²⁰ Rather, the situation of having a relationship grounded the perceived obligations to the other. For a relationship to be 'good' – or, in other words, mutual - certain other characteristics are important. First, is the need for trust.³²¹ While this need not be absolute or equal, it would be a poor relationship in which trust was wholly lacking and, as McCullough has suggested, 'trust ... should be understood as a foundation for the physician-patient relationship'.³²² Similarly, both parties should respect the other, which is – in turn – necessary for maintaining the trust essential to a good relationship.³²³

Putting these elements together, the third characteristic is the need for each party to feel,

³¹⁶ The caveat to this is that where a patient chooses not to value the relationship then this gives the professional a good reason to end the relationship and transfer the patient's care to another professional.

³¹⁷ Cassell, E.J. *The Healer's Art* (1985) Cambridge (Mass): MIT Press, 195.

³¹⁸ Pellegrino, E.D. 'Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship' (1994) 10 *Journal of Contemporary Health Law and Policy* 47, 51.

³¹⁹ See the non-reductionist view of relationships, which posits that the intrinsic value of a relationship is what generates the special obligations – rather than any more instrumental justification: *Op cit* n.313.

³²⁰ Eekelaar, J. Maclean, M. 'Marriage and the Moral Bases of Personal Relationships' (2004) 31(4) *Journal of Law and Society* 510, 536.

³²¹ *Op cit* n.310, 491; *Op cit* n.301, 128; Hall, M.A. 'Law, Medicine and Trust' (2002) 55 *Stanford Law Review* 463, 470; Clark, C.C. 'Trust in Medicine' (2002) 27(1) *Journal of Medicine and Philosophy* 11, 14; Byrne, P. 'What May a Patient Properly Expect of his Doctor?' in, Dunstan G.R. Seller, M.J. (eds) *Consent in Medicine: Convergence and divergence in tradition* (1983) London: King Edward's Hospital Fund 26, 31.

³²² McCullough, L.B. 'Trust, Moral Responsibility, The Self, and Well-Ordered Societies: The Importance of Basic Philosophical Concepts for Clinical Ethics' (2002) 27(1) *Journal of Medicine and Philosophy* 3, 5. I will return to trust again later.

³²³ Mechanic, D. 'In my chosen doctor I trust' (2004) 329 *British Medical Journal* 1418, 1419.

and be, (at least) morally responsible to the other.³²⁴ A fourth characteristic of a mutual relationship is empathy.³²⁵ A final characteristic of a good relationship is care,³²⁶ which may be for the other party, for the relationship itself or for both the relationship and the other party.

While the most central relationship is that of professional and patient, both parties exist in their own network of relationships and so each brings a complex system of obligation, responsibility and dependence. When the potential demands and benefits of the professional-patient relationship are added to this system it is clear that situating autonomy is not straightforward and whatever solution is reached it will only be capable of limited justification and is unlikely to receive unanimous approval. Nevertheless, any attempt to construct an institutional regulation of consent should recognise the relevance of the professional-patient relationship and its context within the web of both professional and social relationships that surround it. The aim is to acknowledge, embrace and take advantage of the benefits offered by the various social relationships that support the patient. However, as well as supporting the dependent patient, relationships that are not wholly one sided also bring obligations and responsibilities.

If patients are to rely on the support of others, as they must, then it is fair to expect them to meet at least some reasonable obligations in return, and hence to *have*, not just *be*, in a relationship with the HCP. Any obligations must take account of the patient's ability to meet them and must also be sensitive to the danger that the patient's autonomy might be rendered impotent if the duty is too onerous.³²⁷ Thus, the rules of consent should situate respect for individuals, their autonomy and their self-determined choices within the

³²⁴*Op cit* n.179.

³²⁵Quist, N. 'The Paradox of Questions and Answers: Possibilities for a Doctor-Patient Relationship' (2003) 14 (1/2) *The Journal of Clinical Ethics* 79, 81

³²⁶*Ibid.*, 81.

³²⁷Cohen, J. 'Patient Autonomy and Social Fairness' (2000) 9 *Cambridge Quarterly of Healthcare Ethics* 391, 396.

context of their community-based social relationships. In this way, the concerns of the individual, those in close relationship and the wider community can be balanced without sacrificing the individual, his or her dependants or the community.³²⁸

The Professional's Obligations Within the Professional-Patient Relationship

The first thing to note is the trite caution that professionals are 'only human'. The limits of 'human capacity to cope with others' distress' and 'our inability to process more than a small portion of the data we encounter' should be incorporated into any determination of what may be expected from healthcare professionals.³²⁹ These limits may make it difficult, and perhaps impossible for some, to develop excellence in both the technical and the empathic aspects of medical care. Thus, as Gregg Bloche and Quinn suggested, 'Were we to treat empathic, holistic connection with patients as the lodestar of clinical effectiveness, we would need to strike some compromises as regards our expectations of technical efficacy'.³³⁰ This means that, in constructing the rules of consent, and the consequential obligations, care must be taken not to make the demands on professionals so great that it undermines their ability to satisfy the required technical demands.

Professional obligations arise from two sources. First, they have obligations that fall equally on all moral agents, which derive from the recognition that all agents equally are ends in themselves. Second, professionals have obligations that derive from their role and relationship with the patient.³³¹ Perhaps the most important general duty is to respect the other person's autonomy, which provides a reason to trust those persons and give *prima facie* respect to their decisions.³³² Furthermore, any interference with an autonomous

³²⁸ Micah Hester, D. 'Narrative as Bioethics: The "Fact" of Social Selves and the Function of Consensus' (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 17, 20-21.

³²⁹ Gregg Bloche, M. Quinn, K.P. 'Professionalism and Personhood' in Thomasma, D.C. Weisstub, D.N. Herve, C. (eds.) *Personhood and Health Care* (2001) Dordrecht: Kluwer Academic Publishers 347, 351-352.

³³⁰ *Ibid.*, 350.

³³¹ *Op cit* n.313, 200.

³³² Rogers, W.A. 'Is there a moral duty for doctors to trust patients?' (2002) 28 *Journal of Medical Ethics* 77, 77-78.

person's decision must be justified. The need for justification is strongest where the decision is clearly autonomous. However, even where the decision appears to be non-autonomous, humility (the acknowledgement of fallibility) requires that any interference is proportionate and justified.

The obligation to respect the patient's decision is a negative duty, but a respect for autonomy may also entail positive duties.³³³ Although the libertarian may reject the existence of positive duties they are widely acknowledged both in principle³³⁴ and practice.³³⁵ In any case, it is arguable that this positive obligation arises not from professionals' general moral duty, but rather from their role as healer in the context of the professional-patient relationship.

Realising one's autonomy requires at least minimal choice and the resources necessary to act on that choice.³³⁶ Within the professional-patient relationship it is professionals who control the resources necessary for patients to exercise their autonomy,³³⁷ including availability of treatment choices,³³⁸ access to other professionals, and the information necessary to make a rational decision. While an ever-increasing amount of information is readily available, through technologies such as the Internet, without assistance to process it patients may end up overwhelmed and unable to use it. Paradoxically, although autonomous decisions should be informed, more is not necessarily better and too much

³³³ *Op cit* n.318, 49.

³³⁴ *Op cit* n.51, 63.

³³⁵ See, eg *Osman v UK* (2000) 29 EHRR 245.

³³⁶ *Op cit* n.110, 104. Although autonomy is theoretically possible in the absence of choice, this is only the case where the agent was unaware of the lack of choice and would have chosen the available option in any case.

³³⁷ The professional's access to some of these resources – the tangible goods – is restricted by the chain of health care management that exists above him.

³³⁸ For example, certain drugs are only available on prescription.

information – especially if unfiltered – may undermine autonomy.³³⁹ On the other hand, it has been shown that, where information is desired it can be empowering.³⁴⁰

Within the professional-patient relationship both parties should possess the power required to exercise their roles.³⁴¹ Professional power comes from a number of sources, including their knowledge base, their control of the treatment options and their social role as healer.³⁴² While this power is necessary it may have a profound effect,³⁴³ and it should be used in a way that respects patients and empowers them to exercise their autonomy in arriving at a mutually acceptable treatment plan.³⁴⁴ The implication for consent is that the professional, who possesses the expertise and information necessary to the treatment decision, is the dominant party in the relationship.

Since communicative acts, or processes, are ‘to some degree at least, cooperative efforts’,³⁴⁵ both parties have responsibilities, but - as the dominant party – it behoves the professional to facilitate the patient’s involvement.³⁴⁶ As Pellegrino suggested, ‘It is the physician’s obligation to enhance, empower and enrich the patient’s capacity to be autonomous’.³⁴⁷ Where HCPs are supportive of patient autonomy this has been shown to increase the patient’s willingness to be self-determining, which may improve that patient’s co-operation with a treatment regime and hence improve the clinical outcome.³⁴⁸

In a survey of 410 patients McKinstry found that: ‘Patients’ preferences for shared or

³³⁹ Grice, H. P. ‘Logic and Conversation’. In Hamish, R. M. (ed) (1994) *Basic Topics in the Philosophy of Language*. Harvester Wheatsheaf: New York 57, 61.

³⁴⁰ Krupat, E. Fancey, M. Cleary, P.D. ‘Information and its impact on satisfaction among surgical patients’ (2000) 51 *Social Science & Medicine* 1817, 1824.

³⁴¹ Goodyear-Smith, F. Buetow, S. ‘Power Issues in the Doctor-Patient Relationship’ (2001) 9 *Health Care Analysis* 449, 459.

³⁴² Brody, H. *The Healer’s Power* (1992) New Haven: Yale University Press, 16-17.

³⁴³ Osuch, J.R. ‘The Power of the Doctor, The Vulnerability of the Patient, and Informed Consent’ (2004) 61 *Surgical Neurology* 494.

³⁴⁴ *Op cit* n.309, 1417.

³⁴⁵ *Op cit* n.339, 60.

³⁴⁶ Wear, S. ‘Patient Autonomy, Paternalism, and the Conscientious Physician’ (1983) 4 *Theoretical Medicine* 253, 255.

³⁴⁷ *Op cit* n.318, 51.

³⁴⁸ Valimaki, M. *et al.* ‘Self-determination in Surgical Patients in Five European Countries’ (2004) 34(4) *Journal of Nursing Scholarship* 305, 309.

directed versions of scenarios were significantly associated with ... their perception of their own doctor as one who shared or directed [decision-making]'.³⁴⁹ A supportive approach recognises that, as a capacity, 'Autonomy does not just spring into existence, but rather must be practiced and wilfully maintained'.³⁵⁰ Thus, patients must be supported and encouraged if they are to exercise their autonomy effectively.³⁵¹

Autonomy does not require patients to make every decision themselves and, since HCPs are experts, it may be reasonable for patients to defer to their judgment because they reasonably believe HCPs have greater capacity to make the decision.³⁵² In such a case, professionals should ensure that patients understand the implications of ceding the decision and should also enquire whether there is any information the patient desires. There are two reasons for this. First, consent is not the sole reason for needing information. Knowing, for example, how long it will take to recover or when they will be able to return to work is necessary to allow patients to organise their life or to know what to expect.

Second, patients may defer decisions not because they see themselves as unable to make them, but because it is more efficient and expedient to do so. In this case, they may require authoritative reasons why they should accept the professional's decision. This 'dialogic authority' differs from persuasion in that reasons are provided to explain the decision rather than to convince the other that one choice is better than another.³⁵³

Professionals do not need to bring the patient round to their way of thinking; they simply need to justify the patient 'suspending judgment'.³⁵⁴ Even where 'dialogic authority' is

³⁴⁹ McKinstry, B. 'Do patients wish to be involved in decision making in the consultation? A cross sectional survey with video vignettes' (2000) 321 *British Medical Journal* 867, 868.

³⁵⁰ Meyers, C. 'Cruel Choices: Autonomy and Critical Care Decision-Making (2004) 18(2) *Bioethics* 104, 108.

³⁵¹ *Ibid.*, 116-119.

³⁵² Cunliffe, J. Reeve, A. 'Dialogic Authority' (1999) 19 *Oxford Journal of Legal Studies* 453, 458.

³⁵³ *Ibid.*, 459-463.

³⁵⁴ *Ibid.*, 462.

rejected and patients choose to make their own decision, this does not reduce HCPs to technical advisers as their clinical autonomy, their duty to respect patient autonomy and their duty of beneficence all require them to try and persuade patients to accept their preferred treatment choice (see chapters one and two). This is particularly so where the patient's decision appears irrational and risks irremediable harm to the patient's future autonomy. In these circumstances, it may be more respectful to at least question if not override the decision than abandon the patient to his or her fate.³⁵⁵

In chapter two I argued against allowing HCPs the authority to override an irrational decision. Further to that argument, the knowledge that one's self-determination might be overridden may undermine the trust necessary to sustain the professional-patient relationship and risks causing patients to avoid seeking healthcare. In the US, for example, compulsory drug testing or compelling pregnant women to undergo non-consensual treatment caused some to go into hiding or give birth at home.³⁵⁶ However, just because people should ultimately be free to be wrong and make irrational decisions this does not mean that they should be abandoned. As Mill noted:

It would be a great misunderstanding of this doctrine to suppose that it is one of selfish indifference, which pretends that human beings ... should not concern themselves about the well-doing or well being of one another ... Human beings owe to each other help to distinguish the better from the worse and encouragement to choose the former and avoid the latter.³⁵⁷

³⁵⁵ *Op cit* n.230, 335.

³⁵⁶ Chavkin, W. Allen, M.H. Oberman, M. 'Drug Abuse and Pregnancy: Some Questions on Public Policy, Clinical Management, and Maternal and Fetal Rights' (1991) 18 *Birth* 107, 111; Rhoden, N.K. 'The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans' (1986) 74 *California Law Review* 1951, 2028. See also: Beck, J.C. 'When the Patient Threatens Violence: An Empirical Study of Clinical Practice after Tarasoff' (1982) 10(3) *Bulletin of the AAPL* 189, in which psychiatric patients accepted the disclosure of confidential information where it was justified and discussed with them in advance.

³⁵⁷ *Op cit* n.49, 84.

An alternative approach would be to challenge decisions, ensure that patients are not making decisions on the basis of misinformation or a misunderstanding,³⁵⁸ and attempt to persuade them that their reasoning is flawed or their goal or belief is unjustified.³⁵⁹ This may be seen as a compromise that tries to balance a respect for autonomy with a respect for the individual's welfare and his or her potential for future autonomy.³⁶⁰ However, it is also arguable that it is more respectful to autonomy than simply allowing the individual to risk a catastrophic choice.

In *Rochdale Healthcare NHS Trust v C*,³⁶¹ C refused a caesarean section because she would rather die than go through another one after a previous caesarean left her with a painful scar and a bad back. Even though it may be reasonable to value the avoidance of pain it seems irrational, unless the pain is unbearable, to give that goal a greater weight than continued life. It is only by challenging such a decision that the HCP can be sure that the patient has reflected on, or at least had the opportunity and resources to reflect on, the values and goals that guided his or her decision. Furthermore, requiring patients to explain their goals may cause them to reconsider their beliefs and perhaps change their decisions. Alternatively, their explanation may satisfy the observer that the decision was autonomous.

It may be objected that the professional, lacks the authority to interfere with a competent patient's decision.³⁶² However, to fully respect another individual's autonomy arguably requires positive obligations - especially when in a caring relationship - as well as the simple negative duty not to obstruct the decision. In this context there may be a balance

³⁵⁸ Beste, J. 'Instilling Hope and Respecting Patient Autonomy: Reconciling Apparently Conflicting Duties' (2005) 19(3) *Bioethics* 215, 221.

³⁵⁹ This accords with the 'justified-belief standard [which] captures the common-sense conception of reasonable': *Op cit* n.36, 254.

³⁶⁰ Respect for the person is arguably a wider duty than simply respecting that person's autonomy. See, Lysaught, M.T. 'Respect: Or, How Respect for Persons Became Respect for Autonomy' (2004) 29(6) *Journal of Medicine and Philosophy* 665.

³⁶¹ *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274.

³⁶² See: McLean, S.A.M. *A Patient's Right to Know: Information disclosure, the doctor and the law* (1989) Aldershot: Dartmouth, 22.

between the two duties as there is a certain amount of conflict between non-interference, which protects the liberty aspect of autonomy, and the interference necessary to ensure that individuals possess the resources, and have the opportunity, to exercise their autonomy.³⁶³ Care must be taken to ensure that the interference does not become obstructive, but – while professionals should be sensitive to the circumstances (the potential consequence of the decision, the power imbalance, patient vulnerability and the fragile nature of a sick person’s autonomy) – it seems reasonable to suggest that they should question an apparently irrational decision.

This argument is premised on the presumptions that most patients want to make reasonable decisions, that they do not see the professional-patient relationship as antagonistic and that they are willing to engage in a discussion of the decision and attempt to reach a ‘mutually acceptable agreement’.³⁶⁴ All of these presumptions may be normatively justified as features of a trusting relationship between autonomous – and hence responsible – moral agents.

Persuasion, which is the use of reason to convince the other to accept the correctness of one’s position, is a form of influence that may be justified by either of two arguments.³⁶⁵ The ‘negative strategy’ argues that the professional’s influence is allowed because it is important to combat the negative effect of the patient’s sickness on his or her autonomy.³⁶⁶ The ‘positive strategy’, which is the primary approach I have adopted, is based on the argument that a true respect for autonomy requires more than simply abandoning patients to whatever choice they make.³⁶⁷ As Barilan and Weintraub argued:

³⁶³ Quill, T.E. Brody, H. ‘Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice’ (1996) 125(9) *Annals of Internal Medicine* 763.

³⁶⁴ Philipp, E.E. Johnson, E.S. ‘Considerations Governing A Doctor’s Advice to his Patient’ in, Dunstan G.R. Sellar, M.J. (eds) *Consent in Medicine: Convergence and divergence in tradition* (1983) London: King Edward’s Hospital Fund 89.

³⁶⁵ Tomlinson, T. ‘The Physician’s Influence on Patients’ Choices’ (1986) 7 *Theoretical Medicine* 105, 109.

³⁶⁶ *Op cit* n.346, 263-264.

³⁶⁷ *Ibid.*, 262.

‘Abiding by unexplored expressed wishes does not necessarily amount to respect for persons, since respect for persons, is much more than submission to social boundaries’.³⁶⁸

Through the use of dialogue and persuasion the tension between the individual and the community³⁶⁹ may be resolved without undermining the individual’s autonomy.

Cassell suggested: ‘What patients believe to be in their own best interests may well require the active participation of the physician to discover’.³⁷⁰ This is not an argument for professionals to substitute their own views for those of their patients as the patients’ goals, and hence their best interests, ‘can almost never be known without the patient’s knowledgeable participation’.³⁷¹ But, where patients have not formalised their thoughts concerning their second order desires or long term goals, they may need both support and facilitation to determine the most appropriate decision. Similarly, intervention, such as pointing out logical inconsistencies or irrational reasoning,³⁷² may also be necessary where patients have formalised their goals but are mistaken in how best to achieve them. Thus, not only is persuasion morally permissible it is also the physician’s duty. However, the limits of persuasion may blur with those of manipulation, at which point patient autonomy is undermined rather than enhanced.

The ultimate aim of the manipulator is to ‘motivate’ the other person to do something that will serve the manipulator’s goal rather than respecting the other person’s right ‘to choose his own operative goals and purposes’.³⁷³ This may also be the aim of rational persuasion,

³⁶⁸ Barilan, Y.M. Weintraub, M. ‘Persuasion as Respect for Autonomy: An Alternative View of Autonomy and the Limits of Discourse’ (2001) 26(1) *Journal of Medicine and Philosophy* 13, 20.

³⁶⁹ *Op cit* n.63, 202.

³⁷⁰ Cassell, E.J. *The Nature of Suffering and the Goals of Medicine* (1991) New York: Oxford University Press, 77. See also: Schneider, C. Farrell, M. ‘The Limits of Informed Consent’, in: Freeman, M. Lewis, A. (eds.) *Law and Medicine: Current Legal Issues Volume 3* (2000) Oxford: Oxford University Press 107, 122-123.

³⁷¹ Cassell, E.J. *Op cit* n.370, 77.

³⁷² Tauber, A.I. *Patient Autonomy and the Ethics of Responsibility* (2005) Cambridge (Mass): MIT Press, 150.

³⁷³ Rudinow, J. ‘Manipulation’ (1978) 88 *Ethics* 338, 346; Kligman, M. Culver, C.M. ‘An Analysis of Interpersonal Manipulation’ (1992) 17 *The Journal of Medicine and Philosophy* 173, 183.

which might be directed at either the means of achieving a particular goal or at the reasonableness of the goal itself. However, perhaps what distinguishes manipulation from persuasion is that the manipulator seeks to avoid the open use of honest reasons to convince the other. Instead, ‘there is something unsavoury about it ... it is often self-serving and involves deception’.³⁷⁴ (In the present context, it is important to note that manipulation does not have to be self-serving and could be motivated by feelings of beneficence towards the other.³⁷⁵) In addition to deception, which includes both lying and withholding information, the manipulator’s tools include playing on the other person’s fears, inducing a feeling of guilt, taking advantage of the other’s good nature and the offer of exploitative inducements. All of these avoid the use of reason and, by utilising the patient’s weaknesses, undermine autonomy.³⁷⁶ Furthermore, especially when done for “beneficent” reasons, withholding or manipulating information demonstrates a lack of trust in the patient, which may fatally undermine a therapeutic relationship.³⁷⁷

On the other hand, rational decision making may reasonably take fear, guilt, good will and inducements into account and it is not always easy to distinguish between, for an example, an appropriate appeal to patients’ obligations to others and the manipulative use of the guilt they will feel should they fail those others. One example of where the use of an inappropriate sense of guilt may occur is where patients decline to ask questions, or engage in further dialogue, for the expressed reason that they do not want to bother the busy physician. If patient autonomy is valued then it is part of the professional’s duty to spend a reasonable length of time in dialogue and allowing patients to cut short any discussion because they feel guilty about taking up the professional’s time is exploitative and may be used as a tool of manipulation.

³⁷⁴ Kligman, M. Culver, C.M. *Ibid.*, 175.

³⁷⁵ Rudinow, J. *Op cit* n.373, 344.

³⁷⁶ *Op cit* n.365, 114.

³⁷⁷ *Op cit* n.332, 78.

Another difficulty arises because what may be offered as honest information may still mislead. As Tomlinson argued: ‘Given the complexity of the beliefs, attitudes, anxieties, and expectations that will lie in the background of any listener, it may be virtually impossible to transmit information in a form that carries no potentially misleading reverberations’.³⁷⁸ Knowing this, professionals could adopt one of two strategies. They could either disclose what they honestly believe to be the truth even where they suspect that the patient will misinterpret it. Alternatively, they could present the information in a way that will cause the patient to achieve a more reasonable picture. Both strategies could be justified as respecting the patient’s autonomy and the situation is complicated because, unless one discloses all information in a neutral fashion, which is arguably impossible, it will always be necessary to make judgments about what to disclose and how to disclose it. Thus, the boundary between the two approaches is blurred, which makes it difficult to draft a rule explicitly permitting one while preventing the other.

Although both strategies arguably respect autonomy, there are problems with the second approach. First, it shows a lack of trust in the patient’s openness to rational persuasion and hence reflects a diminished respect for that person’s autonomy. Second, it relies on the assumption that the HCP can reliably predict that the patient will misinterpret the information. Third, if the patient does interpret the information differently, it assumes that the HCP’s interpretation is the correct one. Where there is reasonable doubt it may be more respectful to trust the patient and provide a more open disclosure. However, provided the information is merely non-specific rather than a lie, the rationally autonomous patient will be astute enough to notice the lack of specificity and ask for more detail. Giving non-specific information may be a more sensitive approach because it allows the patient, provided sufficiently empowered, to determine the detail of the

³⁷⁸ *Op cit* n.365, 116.

information required.³⁷⁹ This approach may be acceptable provided it satisfies certain constraints.

First, any exceptions would need to be well publicised so as to ensure that all patients are aware that seeking certain types of information is their responsibility. Second, because of the power dynamics of the professional-patient relationship and, in many cases, the patient's vulnerability, healthcare providers and professionals would need to be sensitive to their patients' disadvantage and facilitate the exercise of their responsibility.

Acknowledging this duty further supports the suggestion that this is a more sensitive means of communication rather than deception or a lack of candour. Third, if the manoeuvre is to respect patient autonomy, and arguably their welfare, then any lack of candour should be intended to advance patients' ends and not those of the professionals.

Fourth, creating rules to delimit those circumstances when a lack of candour would be acceptable raises all the usual problems of how those rules might be open to interpretation.

As O'Neill noted: 'Rule-following ... provides no criterion of "right" continuation: all rules are incomplete, and to "follow" them is to interpret them in a certain way. No rule can have written into it a determination of what it would be to follow it. Rules do not lay down complete answers'.³⁸⁰ While rules may be drafted to prohibit lying, deception and other forms of manipulation, they will inevitably be open to interpretation and will rely on the physician's character, in the form of virtues with concomitant imperfect duties, to implement those rules within the spirit of the justification that underlies them. This acknowledges that there may be, for example, occasions where the professionals' duty of beneficence and their personal knowledge are enough to justify the 'manipulation' of their patients' prejudices in order to instil a true belief about the decisional relevance of

³⁷⁹ See also, Jackson, J. *Truth, Trust and Medicine* (2001) London: Routledge.

³⁸⁰ *Op cit* n.181, 79.

the proposition. The law can formulate precise duties regarding the more overt forms of pejorative manipulation and can guide HCPs toward the appropriate dispositions and interpretation but, because manipulation is ‘generally relatively sophisticated’ and relies on insight into the history and context of the situation,³⁸¹ there will always be difficult cases that depend on the professional’s character. As Wear, following Ingelfinger, has suggested: ‘the only “real protection” for patients is the conscientious and compassionate physician’.³⁸²

In addition to the ordinary duty to respect the patient as a person, HCPs have role specific obligations arising from their privileged position and the professional-patient relationship.³⁸³ Perhaps the most widely accepted specific duties are those of beneficence and non-maleficence. In chapter two I argued that the duty of non-maleficence only made sense when incorporated into the duty of beneficence, which is constrained by the duty to respect autonomy. The duty of beneficence requires professionals to act for the benefit of the patient,³⁸⁴ which is a vague and general obligation requiring further explication. In chapter two I suggested that beneficence should be directed holistically at the patient as a person rather than solely at the patient’s health. An additional constraint is that the benefit of the intervention should be balanced against its costs, both to the individual patient and to the wider community.³⁸⁵ Thus, even if a particular treatment would benefit the patient, HCPs are under no duty to provide it if the costs outweigh the benefit. This, caveat of ‘utility’ has obvious implications for the post-modern consumer clamour for choice and justifies the role played by bodies like the National Institute for Health and Clinical Excellence which determine the use of treatments on just such a basis.

³⁸¹ Rudinow, J. *Op cit* n.373, 346.

³⁸² *Op cit* n.346, 254; Ingelfinger, F.J. ‘Informed (but uneducated) consent’ (1972) 287 *New England Journal of Medicine* 465, 466.

³⁸³ *Op cit* n.313, 200.

³⁸⁴ *Op cit* n.51, 166.

³⁸⁵ *Ibid.*, 166.

The interaction between the professional's duties of beneficence and respect for the patient's autonomy requires professionals to act in a way that not just respects the patient's formal right to consent but also reflects the spirit behind that requirement. If harm is seen as a wrongful set-back to the other person's interests, the duty again requires that professionals are concerned to justify any intervention by gaining the competent patient's consent. In addition to this, they should pay heed to the patient's other interests. The most basic interests of health and life should be protected, but not necessarily at the expense of the patient's other interests. Going beyond the sphere of medical goods takes professionals outside their area of expertise and their lack of knowledge regarding the patient's values, goals and interests means that they must engage the patient co-operatively in the decision-making process or provide the patient with the necessary information and cede the decision.³⁸⁶

Although both respect for autonomy and the duty of beneficence require HCPs to involve patients in decisions that affect them this does not mean that patients should be abandoned to their decision. Both duties also require HCPs to try and persuade them to change their decision if it appears unwise;³⁸⁷ in particular, the rules of beneficence require that HCPs act to prevent harm and to rescue patients from danger.³⁸⁸ As discussed earlier, the duty of beneficence does not justify the professional in absolutely overriding the patient's autonomy, nor does it justify coercion or dishonest manipulation of the patient's will. It does, however, support the same kinds of interference required by a respect for patients' autonomy to ensure that: patients are competent; have an adequate understanding of the facts and potential consequences (both to themselves and relevant others); and have given the matter appropriate consideration. The obligation to challenge an apparently unwise decision, required by both the principles of beneficence and respect

³⁸⁶ Veatch, R.M. 'Doctor Does not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients' (2000) 25(6) *Journal of Medicine and Philosophy* 701, 703-705.

³⁸⁷ See also: Barilan, Y.M. Weintraub, M. *Op cit* n.368, 19. The caveat is that the doctor should, in determining the best course of action, take the patient's goals and values into account.

³⁸⁸ *Op cit* n.51, 167.

for autonomy, is further supported by the virtue of care. As Smith and Pettegrew asked rhetorically: '[c]an a caring doctor, fully committed to a relationship with the patient, fail to argue with the patient for a wiser choice?'.³⁸⁹

The rules of beneficence that require HCPs to 'remove conditions that cause harm to others' and 'help persons with disabilities' also support the HCPs' duty to respect their patients by empowering them to exercise their autonomy or by helping them return to an autonomous state.³⁹⁰ For many patients their desire and ability to be autonomous will be affected by their illness.³⁹¹ One study even found that when doctors become patients they also prefer the treating physician to take the primary role in decision-making, and this tendency increased with the severity of the sickness.³⁹² This is compounded by the power imbalance between professional and patient, the alien environment of the hospital and the individual's social conditioning,³⁹³ which may all diminish the competent patient's ability to exercise his or her autonomy by encouraging heuristic decision-making that often relies on intuition and 'folk-wisdom' and precluding the rational reflection ideally required by autonomy.³⁹⁴

While the effects of illness may completely undermine the autonomy of some patients, other patients will be less severely compromised. As Barilan and Weintraub pointed out, illness has not prevented those afflicted from producing great works of literature and philosophy.³⁹⁵ Furthermore, even where patients' autonomy is diminished it may be

³⁸⁹ Smith, D.H. Pettegrew, L.S. 'Mutual Persuasion as a Model for Doctor-Patient Communication' (1986) 7(2) *Theoretical Medicine* 127, 137-138.

³⁹⁰ See chapter two. *Op cit* n.51, 167.

³⁹¹ *Op cit* n.317, 25-46; Leino-Kilpi, H. *et al. Patient's Autonomy, Privacy and Informed Consent* (2000) Amsterdam: IOS Press, 67-69; Schneider, C.E. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (1998) New York: Oxford University Press, 75-87.

³⁹² Ende, J. Kazis, L. Moskowitz, M.A. 'Preference for autonomy when patients are physicians' (1990) 5(6) *Journal of General Internal Medicine* 23.

³⁹³ See, e.g. Dodds, S. 'Choice and Control in Feminist Bioethics' in Mackenzie, C. Stoljar, N. (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (2000) New York: Oxford University Press 213, 228-230.

³⁹⁴ Schneider, C. Farrell, M. *Op cit* n.370, 120-122.

³⁹⁵ *Op cit* n.368, 24. They name Kafka, Keats, Orwell and Chekhov.

possible to encourage, support or facilitate their autonomy. In fact, it is arguable that one of the most important functions of medicine is to restore the patient's autonomy.³⁹⁶ This does not mean that patients should be forced to exercise autonomy, especially where it is undermined by illness. However, where at least some of these effects may be countered, the professional's duty of beneficence and role within the professional-patient relationship require him or her to enhance the patient's autonomy by creating a sympathetic environment, encouraging the patient to participate and providing the support and time necessary to enable that participation.³⁹⁷ This is important because it is the patients who will necessarily bear the physical and psychological consequences that follow any healthcare decisions.³⁹⁸

Cassell argued that the doctor's primary role is 'the care of the sick'.³⁹⁹ Because the unifying consequence of sickness is the loss of control that patients experience, this translates into an obligation to 'return control to his patient'.⁴⁰⁰ Where a quick and effective cure is available then perhaps the best way to do this is simply to treat the patient. In other cases, however, the doctor must educate patients and teach them how to regain as much control as possible in the face of their sickness.⁴⁰¹ Since autonomy and control are intrinsically connected, Cassell's beneficence-based argument adds further weight to the autonomy-based arguments that professionals should be honest with patients.⁴⁰² Deception and manipulation are arguably wrong because they undermine autonomy and trust. However, if discovered they also undermine the patient's sense of control. Thus, if professionals are to help their patients exercise maximal control over their sick bodies, honesty is crucial.

³⁹⁶ Cassell, E. 'The function of medicine (1977) 7 *Hasting Center Report* 16.

³⁹⁷ Doyal, L. 'The Moral Foundation of the Clinical Duties of Care: Needs, Duties and Human Rights' (2001) 15 (5/6) *Bioethics* 520, 530-531.

³⁹⁸ Marta, J. 'Whose Consent is it Anyway? A PostStructuralist Framing of the Person in Medical Decision-Making' (1998) 19 *Theoretical Medicine* 353, 364.

³⁹⁹ *Op cit* n.317, 18.

⁴⁰⁰ *Ibid.*, 163.

⁴⁰¹ *Ibid.*, 149-163.

⁴⁰² *Ibid.*, 222.

Interacting with the patient is complicated by the fact that not all patients want to exercise their autonomy. The desire to act autonomously is affected by a number of demographic variables such as age, sex, and culture.⁴⁰³ These differences may be explicable on the basis of two psychological variables: the locus of control and self-efficacy.⁴⁰⁴ The locus of control is a sense of how much influence individuals have over their lives: those with an external locus of control see their lives much more as the subject of fate and largely outside their own control, while those with an internal locus of control see their lives as primarily shaped by themselves.⁴⁰⁵ This has a number of consequences.

First, persons with an external locus of control may be reluctant to engage in autonomous decision-making, especially in the fragile state of sickness, with its attendant loss of control,⁴⁰⁶ and the intimidating environment of the hospital. Second, they may find it hard, even in ideal circumstances, to make autonomous decisions. Third, persons with an internal locus of control may find it more difficult and stressful to deal with the loss of control caused by their sickness. Consequently, it may be psychologically beneficial to support their autonomy as far as possible. Also following from this, it may be both more distressing and more harmful to those with an internal locus of control if insensitively paternalistic professionals undermine what autonomous capacity they do have.⁴⁰⁷ On the other hand, it may be equally harmful or distressing to unduly pressure or compel patients with an external locus of control to exercise their autonomy.

The issue is more complicated because people do not fall neatly into one of these two types. While individuals may in general tend towards one or other of these types, this

⁴⁰³ Leino-Kilpi, H. *et al.* *Op cit* 391, 64.

⁴⁰⁴ *Op cit* n.94.

⁴⁰⁵ Bergsma, J. *Op cit* n.184; *Op cit* n.94.

⁴⁰⁶ *Op cit* n.317, 44.

⁴⁰⁷ I suggest it may be harmful in the sense that someone with an internal locus of control may see paternalism as a greater set-back to his interests than might someone with an external locus of control.

tendency may be affected by surrounding circumstances.⁴⁰⁸ Waller noted that, in addition to having an internal locus of control, autonomy requires that individuals have a ‘sense of effective control’ or ‘self-efficacy’, which is their ‘sense of having the ability to successfully carry out a task’.⁴⁰⁹ A negative self-efficacy may undermine the positive effect on autonomy of an internal locus of control and may cause stress and a feeling of helplessness. However, patients’ self-efficacy may be influenced by the surrounding circumstances and by the attitude and behaviour of healthcare professionals. For example, the patient’s desire for information or to engage in the decision-making process may be underestimated.⁴¹⁰

Waller suggested: ‘Rather than assuming that the patient does not want to exercise control, we must first help the patient become comfortable in her (initially alien) surroundings, inform ... and empower the patient with sufficient knowledge to exercise confident (self-efficacious) control’.⁴¹¹ This may be more difficult where the patient tends towards an external locus of control in which case professionals would need to be sensitive to the patient’s psychological disposition and vary their support and involvement accordingly as some may be overwhelmed if given control and deserted.⁴¹² Nonetheless, since psychological traits are not static, and are tendencies rather than absolutes,⁴¹³ it may be worthwhile supporting and enabling patients to be as autonomous

⁴⁰⁸ Bergsma, J. *Op cit* n.184, 206, 209.

⁴⁰⁹ *Op cit* n.94, 258.

⁴¹⁰ In a recent Department of Health survey of NHS patients it was found that 46% of patients who responded wanted greater involvement in treatment decisions: *NHS patients survey programme 2001/02: key findings* (2003), available at: http://www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/NationalSurveyOfNHSPatients/NationalSurveyInpatients/NationalSurveyInpatientsArticle/fs/en?CONTENT_ID=4016444&chk=dVFdy3. Last accessed 17th July 2006. A similar result was obtained in the 2005 inpatient survey: see the briefing paper available at: http://www.healthcarecommission.org.uk/_db/_documents/acute_inpatient_05_briefing.pdf. Last accessed 17th July 2006.

⁴¹¹ *Op cit* n.94, 258.

⁴¹² Schneider, C.E. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (1998) New York: Oxford University Press, 115.

⁴¹³ Bergsma, J. *Op cit* n.184, 209.

as possible. As such, any rules or guidelines regulating consent should be sensitive to these two psychological characteristics.

The professional-patient relationship, as a caring relationship, can benefit the patient's health.⁴¹⁴ To be effective in this, the relationship at least needs to be cooperative and requires mutual trust if it is to be most effective. The need for patients to trust professionals, which encourages shared decision-making,⁴¹⁵ and is essential to the whole process of care,⁴¹⁶ obliges the professional to act in a trustworthy way.⁴¹⁷ As Rhodes suggested: 'all reasonably farsighted physicians must recognize that in order to practice medicine, they must *seek trust and deserve it*'.⁴¹⁸ Because patients in many circumstances must trust professionals by virtue of the professional's role and their own vulnerability,⁴¹⁹ the obligation to be trustworthy is owed not just to their patients, but also to present and future colleagues. This reinforces the professionals' duty to be open, honest,⁴²⁰ non-manipulative, proficient, and concerned for their patients.⁴²¹

A caveat to the professionals' duty to be trustworthy is that, while they should avoid deception, their duty of beneficence may justify controlling the timing of disclosure, particularly of distressing information.⁴²² This does not mean that professionals can withhold the information but it would allow them to decide when and how to disclose. Any such decision, if it is to respect the patient's autonomy, should arguably involve

⁴¹⁴ Adler, H.M. 'The Sociophysiology of Caring in the Doctor-Patient Relationship' (2002) 17 *Journal of General Internal Medicine* 883, 885-886.

⁴¹⁵ Kraetschmer, N. Sharpe, N. Urowitz, S. Deber, R.B. 'How does trust affect patient preferences for participation in decision-making?' (2004) 7 *Health Expectations* 317.

⁴¹⁶ *Op cit* n.317, 223; Hall, M.A. 'Law, Medicine and Trust' (2002) 55 *Stanford Law Review* 463, 470.

⁴¹⁷ *Op cit* n.372, 171.

⁴¹⁸ Rhodes, R. 'Understanding the Trusted Doctor and Constructing a Theory of Bioethics' (2001) 22 *Theoretical Medicine* 493, 495.

⁴¹⁹ Clark, C.C. *Op cit* n.321, 13-15.

⁴²⁰ *Op cit* n.2, Chapter 23 [6-7].

⁴²¹ *Op cit* n.418, 496-498.

⁴²² Gordon, E.J. Daugherty, C.K. "'Hitting you Over the Head": Oncologists' Disclosure of Prognosis to Advanced Cancer Patients' (2003) 17(2) *Bioethics* 142, 162-163.

negotiation, placing a degree of responsibility on the patient to request further information when the professional makes a tentative offer.

As a final point, a recent study has suggested that patients' most important concern appears to be the need to trust their doctor.⁴²³ In a qualitative study of 39 breast cancer patients, Burkitt Wright *et al* found that the patient's desire for information primarily related to maintaining trust and hope, rather than as a tool to enable them to be the decision-maker. Trust was undermined where the patients felt they had been misled and, conversely, trust was enhanced where the doctor was perceived as being open. For this subset of patients: 'what patients sought diverged from the current emphasis on providing information. It was a function not of amount of information but of the nature of information and manner of presentation'.⁴²⁴ Although this study provides helpful insights into the needs and desires of patients it may be that some of the patients' concerns are influenced by their underlying pathology. Thus, the results may not be applicable to non-cancer sufferers. Nevertheless, the study does emphasise the central importance of trust and respect.

The Patient's Obligations Within the Professional-Patient Relationship

While patient autonomy generates obligations for healthcare professionals, accepting the role of moral agent also imposes obligations on the patient. These arise because of the socially situated nature of autonomy and from the more specific context of the professional-patient relationship.⁴²⁵ As suggested earlier, relationships create bilateral obligations and the professional-patient relationship is no different.⁴²⁶ Furthermore, a non-reciprocal relationship is more likely to fail the parties and thus lose the benefits that

⁴²³ *Op cit* n.304, 867.

⁴²⁴ *Ibid.*, 866-867.

⁴²⁵ Draper, H. Sorrell, T. 'Patients' Responsibilities in Medical Ethics' (2002) 16(4) *Bioethics* 335; Meyer, M.J. 'Patients' Duties' (1992) 17 *The Journal of Medicine and Philosophy* 541, 542; English, D.A. 'Moral Obligations of patients: A Clinical View' (2005) 30(2) *The Journal of Medicine and Philosophy* 139, 147.

⁴²⁶ Messer, N.G. *Op cit* n.297, 279.

justify the relationship's existence.⁴²⁷ It might be argued that the patient's vulnerability relieves him or her of at least some of the obligations that would normally arise in a relationship and - because of the imbalance of knowledge and power - justifies an asymmetry of responsibility in the HCP-patient relationship;⁴²⁸ however, it is insufficient to always justify a denial of the consequential duties.⁴²⁹

Vulnerability makes someone susceptible to exploitation and it would be reasonable for the law to protect them from that eventuality, but, as Draper and Sorrell argued, vulnerability *per se* does not make someone incapable of wrongdoing, nor does it 'insulate them from responsibility'.⁴³⁰ Although the balance of power may lie with the professional, patients are not completely impotent and may, for example, manipulate the professional or abuse the provision of state-funded healthcare.⁴³¹ Furthermore, the patient's power may be bolstered by the rise in self-help groups, the increased involvement of lawyers and the scrutiny of medicine by the media.⁴³² Just as the healthcare professional's power within the relationship demands responsibility, so does the patient's.

Perhaps the primary obligation arising from autonomy is the duty to respect others as persons⁴³³ or ends in themselves, which is necessary to allow others a fair opportunity to exercise autonomy. It requires patients to give due concern to the impact of their

⁴²⁷ *Op cit* n.414, 885-886.

⁴²⁸ Kelley, M. 'Limits on Patient Responsibility' (2005) 30(2) *The Journal of Medicine and Philosophy* 189.

⁴²⁹ Illness may make patients incapable of fulfilling their obligations and any formal obligations would need to be modified accordingly: English, D.A. *Op cit* n.425, 149.

⁴³⁰ Draper, H. Sorrell, T. 'Patients' Responsibilities in Medical Ethics' (2002) 16(4) *Bioethics* 335, 339.

⁴³¹ *Op cit* n.341, 455.

⁴³² Kelleher, D. Gabe, J. Williams, G. 'Understanding medical dominance in the modern world' in: Kelleher, D. Gabe, J. Williams, G. (eds.) *Challenging medicine* (1994) London: Routledge xi, xvi-xvii.

⁴³³ *Op cit* n.430, 340.

behaviour on others.⁴³⁴ More specifically, because they have entered into a personal relationship, they should treat the professional with respect. Just as competent patients come to the professional–patient relationship as autonomous persons, so do the professionals.⁴³⁵

Three types of autonomy are relevant.⁴³⁶ First, the professionals’ personal autonomy means that they come to the relationship with their own values, interests and goals. Second, the values and goals of the autonomous profession influence and constrain their personal autonomy,⁴³⁷ which results in, third, the restricted “clinical autonomy”,⁴³⁸ which provides the professional with both the power and the responsibility ‘to act according to the shared standards of that profession’.⁴³⁹ The relevance of the professionals’ personal autonomy is that, within the constraints of the general duty to respect others, their profession, the contractual obligations of their employment, and the duties arising by virtue of their roles as healer, they should be allowed to bring those personal values and goals to the decisional process. It would, perhaps, be impossible for professionals to prevent their deeply held values from affecting their interpretative judgment. However, the importance of these constraints requires them to be alive to that possibility. It is also

⁴³⁴ Such a duty may also be justified by arguing that each person owes an obligation to other members of the community to act in a morally responsible way: Gauthier, C.C. ‘The Virtue of Moral Responsibility’ (2005) 30(2) *The Journal of Medicine and Philosophy* 153.

⁴³⁵ Cassell, E.J. *Op cit* n.370, 74.

⁴³⁶ *Op cit* n.318, 52.

⁴³⁷ Dupus, H.M. ‘Professional Autonomy: A Stumbling Block for Good Medical Practice. An Analysis and Interpretation’ (2000) 21 *Theoretical Medicine* 493, 495.

⁴³⁸ Although the profession’s autonomy, and hence clinical autonomy, has recently come under threat resulting in a shift to more patient-centred care, and while unregulated professional autonomy may be undesirable, it remains important to allow professionals a degree of autonomy. This clinical autonomy is necessary to provide professionals with the power to fulfil their roles as healers and respond to the individual variation that limits the value of over regulated, protocol driven healthcare. See: Irvine, D. ‘Patient Centred Professionalism – Decision Time’. The 2003 Duncan Memorial Lecture. Available at: www.kingsfund.org.uk/PDF/duncanmemorial.pdf. Last accessed 06.01.2006); Hoogland, J. Jochemsen, H. ‘Professional Autonomy and the Normative Structure of Medical Practice (2000) 21 *Theoretical Medicine* 457; Horner, J.S. ‘Autonomy in the Medical Profession in the United Kingdom – an Historical Perspective’ (2000) 21 *Theoretical Medicine* 409; *Op cit* n.341; MacDonald, C. ‘Relational Professional Autonomy’ (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 282; Thompson, P. ‘Home Birth: Consumer Choice and Restriction of Physician Autonomy’ (1987) 6(6) *Journal of Business Ethics* 481; *Op cit* n.318; May, T. ‘Rights of Conscience in Health Care’ (2001) 27(1) *Social Theory and Practice* 111.

⁴³⁹ MacDonald, C. *Ibid.*, 284.

one reason why their behaviour should be supported and guided by reasonably specific principles and rules. Ideally, perhaps, they should also be encouraged to become virtuous professionals.⁴⁴⁰

The professionals' personal autonomy may cause them to see the patient's decision as unwise or even morally wrong and, excluding the emergency situation, it may justify them refusing to provide the requested treatment. As May suggested: 'In protecting a patient's rights to treatment options, we must be careful not to hold the health care professional hostage to the patient's values by forcing the provision of services that would not otherwise be offered, simply because the patient holds certain beliefs or values'.⁴⁴¹ This mirrors the patient's right to refuse treatment and, just as professionals should respect that decision, so patients should respect the professionals' stance.

However, while it may justify a refusal to treat this does not absolve them of their professional duty to care for their patients,⁴⁴² which at least requires the professional to support their patients and help them find another professional who may be willing to provide the treatment.

Given the imbalance in power, it may not be fair to allow the professional, who has voluntarily entered the profession, absolute rights of conscience. May argued that the balance between the doctor's and the patient's autonomy should be grounded in allowing doctors the right to refuse to participate in a *type* of treatment they find morally offensive. While this does not allow them to refuse treatment simply because they believe it to be a riskier or less beneficial alternative,⁴⁴³ it does not require HCPs to provide treatment that is not "medically indicated",⁴⁴⁴ and it remains the professionals' prerogative to prioritise

⁴⁴⁰ Doukas, D.J. 'Where is the Virtue in Professionalism?' (2003) 12 *Cambridge Quarterly of Healthcare Ethics* 147.

⁴⁴¹ May, T. 'Rights of Conscience in Health Care' (2001) 27(1) *Social Theory and Practice* 111.

⁴⁴² *Op cit* n.318, 63.

⁴⁴³ *Op cit* n.441, 115.

⁴⁴⁴ Horner, J.S. *Op cit* n.438, 414.

treatments on medical grounds and to advise patients accordingly. However, where treatments are “medically indicated” then the HCP may not refuse to provide them simply because they are not “medically optimal”.⁴⁴⁵ An alternative approach that may avoid conflict is to negotiate with the patient to see if a compromise can be reached.⁴⁴⁶ This may need persuasion, but also requires the professional, in turn, to be open to persuasion.⁴⁴⁷ This mutual openness to persuasion means that if patients choose not to accept the professional’s recommended treatment then it is reasonable to expect them at least to explain why.⁴⁴⁸

This openness to mutual persuasion, which is essential to truly shared decision-making,⁴⁴⁹ is reflected in Meyer’s more specific ‘minimal’ duties, which are: a duty to communicate openly with the professional; to ‘make responsible decisions about his own self-care’; ‘to cooperate on mutually agreed-upon goals (or to negotiate an adjustment of those goals)’; ‘to avoid regarding the health care professional as infallible’; ‘to avoid being a patient’, which means not ‘adopting a sick role solely as a way to shirk the difficult responsibilities of his life’; and to actively participate in the professional-patient relationship and their own care.⁴⁵⁰ Draper and Sorell argued for more general duties of being responsible for one’s own health and behaving as a reasonable citizen in taking sensible precautions to avoid harming one’s health and not abusing the health services.⁴⁵¹ Beyond that, they suggest that the voluntary and beneficial nature of the professional-patient relationship requires patients to ‘listen seriously’ to the professional’s advice and, if they agree with the advice, to follow it.⁴⁵²

⁴⁴⁵ *Op cit* n.441, 118-119. Although the doctor’s personal or clinical autonomy may not justify refusing treatment, the profession or the community may restrict some options on, for example, economic grounds.

⁴⁴⁶ Lelie, A. Verweij, M. ‘Futility Without a Dichotomy: Towards an Ideal Physician-Patient Relationship’ (2003) 17(1) *Bioethics* 21, 27.

⁴⁴⁷ *Op cit* n.368, 21-22.

⁴⁴⁸ *Op cit* n.446, 27.

⁴⁴⁹ *Op cit* n.389.

⁴⁵⁰ Meyer, M.J. *Op cit* n.425, 550-553.

⁴⁵¹ *Op cit* n.430, 341-345.

⁴⁵² *Ibid.*, 346.

Beyond this, the very point of seeking medical assistance perhaps justifies an obligation on patients to allow the professional to confront apparently irrational decisions. If someone is asked for assistance it seems reasonable for that person to require the other to explain why an apparently irrational course of action deserves assistance. Even though acceding to the patient's request that turns out badly may not directly harm them, professionals may still have feelings of guilt and regret as a consequence because, unless HCPs are to act purely as technicians (without independent agency), then they share responsibility for a bad outcome. The duty to allow apparently irrational decisions to be challenged may also follow from the argument that each of us owes other members of the community a duty to behave in a morally responsible way, which includes considering the impact of one's decisions on others.⁴⁵³

A respect for professionals as beneficent and caring experts may require patients to explain their decisions and provide the motivating reasons allowing the HCP to understand the decision or to spot any factual or logical errors. Although consent is primarily predicated on respect for the patient it would be an unjustly one-sided relationship if professionals could not also claim some respect for their role from patients who have requested their assistance. However, if professionals are to justify such respect, they should be sensitive to the different narratives that professionals and patients bring to the encounter. This is particularly important where the decision is intimately connected to the patient's conception of self, life-plan or future goals.⁴⁵⁴ This means that where patients' decisions seem unintelligible, while it is appropriate for professionals to question them, they should try to understand the decision from within the patient's

⁴⁵³ *Op cit* n.434, 161.

⁴⁵⁴ Hallenbeck, J.L. 'What's the Story – How Patients Make Medical Decisions' (2002) 113 *The American Journal of Medicine* 73, 73-74.

narrative. As Hallenbeck cautioned: ‘what doesn’t make sense from the outside may make sense from the inside’.⁴⁵⁵

An important feature of the professional-patient relationship, as far as patients are concerned, is the professional’s trust.⁴⁵⁶ This is important because professionals cannot be certain:⁴⁵⁷ that patients have been open and honest; that patients will behave responsibly in using the information they have disclosed; and, that the apparently cooperative patient will follow their advice. Since HCPs lack complete control over their patients they have little choice but to trust their patients to some extent. However, they do have scope to act in a way that minimises their need to trust their patients. For example, they could deliberately withhold information or emphasise certain risks to manipulate their patients because they do not trust them to make the “right” decision. These consequences of distrust undermine patient autonomy and threaten the mutuality of the relationship and thus, it is arguable that professionals *ought to* trust their patients beyond the minimum level of unavoidable trust.⁴⁵⁸ Although the law could regulate professional conduct to limit these undesirable consequences it seems reasonable to suggest that, because patients potentially benefit from the professional’s trust,⁴⁵⁹ patients should also support that trust by acting in a trustworthy manner,⁴⁶⁰ which at least requires open and honest communication.⁴⁶¹

It is sometimes argued patients have an obligation to be autonomous. Schneider considered, and dismissed, four arguments in favour of mandatory autonomy:⁴⁶²

- The prophylaxis argument

⁴⁵⁵ *Ibid.*, 74.

⁴⁵⁶ *Op cit* n.362, 2-3.

⁴⁵⁷ *Op cit* n.32, 13.

⁴⁵⁸ *Op cit* n.332.

⁴⁵⁹ White, S.M. ‘Consent for anaesthesia’ (2003) 30 *Journal of Medical Ethics* 286, 289.

⁴⁶⁰ *Op cit* n.32, 97.

⁴⁶¹ English, D.A. *Op cit* n.425, 147.

⁴⁶² *Op cit* n.412, 137-179.

- The therapeutic argument
- The “false-consciousness” argument
- The moral argument.

The prophylaxis argument ‘reasons that patients need to be encouraged to make their own decisions to prevent physicians from abusing their power’.⁴⁶³ While professionals do indeed possess power they will not all seek to abuse their position and patients are not completely powerless and unsupported.⁴⁶⁴ The very idea that patients are autonomous suggests they ought to be capable of dealing effectively with professionals.⁴⁶⁵ However, this implies an all or nothing approach to autonomy while, as a capacity, it is a variable ability that may be modulated by the more powerful partner in a relationship. Although the professional is in a position to exploit the patient, this risk may be managed without needing to mandate autonomy. The organisation of the institution of healthcare, or - more locally - the hospital or surgery, may include checks and balances to minimise the risk of abuse. These arrangements can be supported by legal rules and by regulation that is sensitive to the possibility. It is perhaps telling that Schneider used the word ‘encourage’ in his initial description of the problem, as it is one thing to *encourage* autonomy and something else to *require* it.

The therapeutic argument ‘holds that patients should make their own ... decisions because they will benefit medically from doing so’.⁴⁶⁶ Schneider criticised the view that greater control maximises health outcome because of the problems patients have in assimilating information and using it rationally.⁴⁶⁷ However there is evidence to suggest that, if given appropriate information and decisional support, reasonably rational

⁴⁶³ *Ibid.*, 139.

⁴⁶⁴ *Ibid.*, 139-142; Nessa, J. ‘Autonomy and Dialogue: About the Patient-Doctor Relationship’ in Thomasma, D.C. Weisstub, D.N. Herve, C. (eds.) *Personhood and Health Care* (2001) Dordrecht: Kluwer Academic Publishers 355, 360.

⁴⁶⁵ *Op cit* n.412, 140.

⁴⁶⁶ *Ibid.*, 143.

⁴⁶⁷ *Ibid.*, 144-151.

decision-making is possible.⁴⁶⁸ Furthermore, there is also empirical evidence demonstrating the beneficial effect of informing the patient and involving them in their care.⁴⁶⁹ It is also true that too much information, especially in an unsupportive environment or in situations where the patient does not have the time to process it, may be at least as detrimental as too little information.⁴⁷⁰ However, given the different psychology of patients even if information and control may be beneficial for some it will not be for all. Again, it may be better to encourage the patient to be autonomous rather than require it.

The “false consciousness” arguments hold that patients who are reluctant to make their own treatment decisions would lose their reticence if they could be ‘freed from some enslaving delusion’:⁴⁷¹ if they had not been conditioned into this way of thinking they would want to be autonomous. However, as Schneider noted, some of the reasons patients have for ceding the decision are ‘deep-seated’, and may be difficult to shift without adopting coercive strategies that may cause more distress and harm than good. Some patients may be so profoundly conditioned that, in the limited time available in the healthcare setting, it may be impossible to ensure that a decision is autonomous. And, what could be done with the obstinate patient who steadfastly refuses to autonomously engage with the decision? Furthermore, it is paradoxical to suggest that someone should be coerced or forced to be autonomous. This problem is best tackled in the wider community by encouraging autonomy through education. In the healthcare context, patients might be encouraged to be autonomous and supported in their efforts but mandating autonomy is neither likely to be effective nor just.

⁴⁶⁸ Hembroff, L.A. Holmes-Rovner, M. Wills, C.E. ‘Treatment decision-making and the form of risk communication: results of a factorial survey’ (2004) 4 *BMC Medical Informatics and Decision Making* 20; *Op cit* n.348, 309.

⁴⁶⁹ See, e.g. Valimaki, M. *et al.* *Op cit* n.348; Williams, G.C. Rodin, G.C. Ryan, R.M. Grolnick, W.S. Deci, E.L. ‘Autonomous regulation and long-term medication adherence in adult outpatients’ (1998) 17 *Health Psychology* 269.

⁴⁷⁰ *Op cit* n.94, 262.

⁴⁷¹ *Op cit* n.412, 151.

The moral argument is that the essential connection between autonomy and identity creates a non-delegable duty to be self-determining.⁴⁷² Thus, all ‘life-defining’ decisions, including medical ones, should be made autonomously.⁴⁷³ However, as I argue below, it is possible to act autonomously but still cede certain decisions to those who, by virtue of their authority or expertise, are better placed to make a wise decision. This autonomously chosen dependence may be a necessary response to debilitating sickness and it may allow individuals to avoid decisions that would permanently damage their future autonomy. Furthermore, provided the decision to delegate is procedurally autonomous, responsibility is not transferred with the decision and individuals remain instrumental in constructing their identity. Finally, given the nature of our social existence and our relational interdependence, it is unlikely that we can completely avoid some form of dependency. The question then becomes *whom* we should depend on and not *whether* we should depend on anyone at all and avoiding dependence on the healthcare professional may unduly burden friends and relatives.⁴⁷⁴

The final argument might be termed the ‘logical’ argument: mandatory autonomy requires patients to make their own decisions, which means they must listen to the rationally necessary information. Under the most extreme view, this must be communicated without recommendation or attempt to direct the patient, such as the non-directive counselling practised by some geneticists.⁴⁷⁵

I suggested, in chapter one, that there is a distinction between the right to waive information and the right to waive consent and that it might be rational, and hence

⁴⁷² *Op cit* n.341, 459.

⁴⁷³ *Op cit* n.412, 151.

⁴⁷⁴ Schneider recounts salutary tale of Ellen MacFarlane who, in seeking to be independent and in control heaped costly, emotional and time-consuming burdens on her family while refusing to allow them to make any suggestions about her treatment plan: *Ibid.*, 178-179.

⁴⁷⁵ Dworkin, R.B. ‘Getting What we should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship’ (2003) 13 *Health Matrix* 235, 265.

reasonable, for patients to trust their HCP – as an expert – to make medical decisions for them. This means that there is no need for those patients to be provided with the background information required to make that decision. However, they cannot, in effect, waive their right to consent: because consent itself is a waiver, in order to waive their right to consent they must consent to not consenting. Because this is a recursive argument, the nature of consent means that it is inalienable, but only in the sense that the patient must make a decision – even if that decision is simply to allow someone else to make the actual treatment decision. Thus, an attempt to avoid any decision at all is impossible and that very limited aspect of autonomy is an obligation. However, it is a minimal obligation and does not require any medical information. It is enough that patients are aware that while they are not obliged to make the treatment decision they must make the decision not to decide, which carries the same legal and ethical responsibility as if they had made the treatment decision.

The distinction between the two decisions reflects that between procedural and substantive dependence. For individuals to be autonomous, it is only necessary that they are procedurally independent. On this view, if the reasons for being substantively dependent are one's own then an individual may autonomously choose to be dependent.⁴⁷⁶ A classic example of this is when Odysseus asks his sailors to tie him to his mast in order to avoid succumbing to the sirens' song and making the (non-autonomous) decision to sail towards them.⁴⁷⁷ In the same way, patients may recognise their decision-making limitations and allow the professional to make the treatment decision for them. By ensuring that patients understand the ethico-legal implications of their decision, the professional ensures that they have sufficient knowledge to make an autonomous waiver and thus the idea of mandatory autonomy is severely constrained: patients are allowed to cede the treatment decision and professionals are permitted to recommend a treatment

⁴⁷⁶ Haworth, L. *Autonomy: An Essay in Philosophical Psychology and Ethics* (1986) New Haven: Yale University Press, 20.

⁴⁷⁷ *Op cit* n.35, 14-15.

choice, directly advise patients or try to persuade them to adopt the professional's preferred choice.

Although the focus is usually on the professional's duties, I have argued that patients also have obligations to the professional. These obligations are justified on the basis of the patient's autonomy, the mutuality of the professional-patient relationship and the need to support the professional's trust. In the present context, perhaps the most relevant of these duties are, the duty to communicate openly, the duty to actively participate in the relationship, the duty to 'listen seriously' to the professional's advice and the duty to make responsible decisions. These serve to facilitate autonomous decision-making and, if patients expect HCPs to respect and foster their autonomy, then it follows that they *ought to* act in a way that allows HCPs to fulfil their obligation. In moral terms these duties seem reasonable to expect of patients, especially as they themselves will usually benefit by fulfilling them.⁴⁷⁸ However, there is no obligation on the patient to actually make all self-regarding decisions themselves and it is reasonable to rely on the professional's advice. All that autonomy requires of patients is that they decide whether to cede the treatment decision-making, share it or retain it.

The Virtuous Patient

In the subsequent section I will argue that the professionals should be encouraged to be virtuous. This also applies to patients. Virtues, such as wisdom, judgment, and autonomy increase the likelihood of acting autonomously. Other-regarding virtues, such as charity, justice, beneficence and 'moral responsibility in the exercise of self-determination' favour a more relational or socially sensitive autonomy. This last virtue includes such dispositions as honesty, a willingness to actively engage in self-regarding decisions and a disposition to consider the impact of one's decisions on others.⁴⁷⁹

⁴⁷⁸ Meyer, M.J. *Op cit* n.425, 542.

⁴⁷⁹ *Op cit* n.179, at 278.

While the law is not well placed to affect these character traits it may facilitate the expression of virtuous dispositions and hinder the expression of vices. One approach would be to construct an ideal ‘virtuous patient’ and then design the regulation of consent in a way that would encourage or require real patients to act similarly. By attending to the patient’s character in this way, the principles and rules of law (and morality) could be supplemented.⁴⁸⁰ Such a law would need to be drafted carefully as it would be easy to forget that the model is an ideal and requiring too much of real patients may significantly constrain their liberty. If, however, it is autonomy, rather than bare liberty, that is intrinsically valuable this concern need not be prohibitive.⁴⁸¹ Because of the unbridgeable gap between the real and ideal patient the law should focus on facilitating – rather than requiring - expression of the relevant virtues. Similarly, it may be better to discourage rather than wholly prohibit expression of the vices. Nevertheless, the law may justifiably prohibit particular instances that express a vice.

The Virtue of Professionalism and the Professional Virtues⁴⁸²

MacDonald noted that: ‘The ability to do the things that physicians do depends crucially on a whole range of social relations and social institutions’.⁴⁸³ In other words, professional autonomy is mandated by the society that supports it.⁴⁸⁴ This means that professional autonomy is a privilege carrying with it certain obligations that require professionals to behave in concordance with the privilege.⁴⁸⁵ Thus, it is just for society to expect the profession to encourage its members to develop what might be called the virtue of professionalism. Furthermore, there is something more distinctly human, and

⁴⁸⁰ *Op cit* n.201, 194.

⁴⁸¹ *Op cit* n.476, 131.

⁴⁸² This discussion is not intended to be comprehensive. Space only permits the briefest of sketches.

⁴⁸³ MacDonald, C. *Op cit* n.438, 285.

⁴⁸⁴ MacDonald, C. ‘Clinical Standards and the Structure of Professional Obligation’ (1999) 8(1) *Professional Ethics* 7.

⁴⁸⁵ Cruess, S.R. Johnston, S. Cruess, R.L. ‘Professionalism for medicine: opportunities and obligations’ (2002) 177 *Medical Journal of Australia* 208.

hence more appealing, about someone who is disposed to act well as a matter of character rather than someone who simply follows rules.⁴⁸⁶

The virtue of professionalism requires the professional to be inclined to develop the ideal characteristics of the virtuous professional, which may be derived from the professional's duties of care as determined by healthcare's goal or telos ('to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability')⁴⁸⁷ and from the recognition that the patient is a vulnerable moral agent.⁴⁸⁸ This latter concern means that medicine must be about more than just the technical mastery of pathology. Furthermore, the inevitable necessity for the patient to trust the professional adds weight to the need for the professional to be disposed to act in a way that fulfils the spirit of the professional's obligations.⁴⁸⁹ The virtuous professional is more likely to act in a way that preserves rather than destroys the patient's trust, both in the individual professional and the institution of healthcare as a whole.

Doyal suggested that HCPs have three broad duties: 'protect the life and health of their patients'; 'respect the autonomy of their patients'; and 'do both of these things in a fair and just way'.⁴⁹⁰ The first duty points to the virtues of caring, compassion, conscientiousness, and benevolence. As a virtue, caring for someone is to be concerned with helping another to 'achieve authenticity' by supporting or restoring that person's autonomy.⁴⁹¹ Thus, the virtue of caring disposes the professional to pay due heed to the patient's autonomy. The danger is that care may become oppressive and controlling where the subject of care is dominated by the carer.⁴⁹² But a similar danger threatens

⁴⁸⁶ Griffin, J. 'Virtue Ethics and Environs' in: Paul, E.F. Miller, F.D. Paul, J. (eds) *Virtue and Vice* (1998) Cambridge: Cambridge University Press 56, 58.

⁴⁸⁷ *Op cit* n.201, 52-53.

⁴⁸⁸ This thesis is only concerned with the competent patient.

⁴⁸⁹ *Op cit* n.201, 72, 77; Black, C. 'Still striving for utopia' (2006) 332 *British Medical Journal* 47.

⁴⁹⁰ *Op cit* n.397, 530.

⁴⁹¹ Kultgen, J. *Autonomy and Intervention: Parentalism in the Caring Life* (1995) New York: Oxford University Press, 8.

⁴⁹² *Ibid.*, 8.

many other virtues unless moderated by prudence. For Pellegrino and Thomasma compassion ‘is an essential virtue of medicine’,⁴⁹³ and requires professionals to identify with the patient’s suffering so as to assist ‘the patient to balance her assessment of what is good with the good that medicine can offer’.⁴⁹⁴ Benevolence is the virtue that predisposes professionals to place the ‘good of the patient above the preferences the professional espouses’.⁴⁹⁵

The second duty requires virtuous professionals to be open, honest, empathetic, and to have integrity. Integrity as a virtue refers to the idea of ‘moral wholeness’ or the willingness and sensitivity necessary to respect others as moral agents.⁴⁹⁶ It disposes virtuous persons to act in a morally sensitive and consistent way. Temperance and humility may also have a role to play in countering any tendency in professionals to overconfidence in their competence and knowledge, and their ability to know what is best for their patients.⁴⁹⁷ Tolerance may also be a relevant virtue. Ulrich suggested that the tolerant person will be predisposed to negotiate rather than ride roughshod over people whose values appear to conflict with their own.⁴⁹⁸ This is clearly relevant if the professional-patient relationship is to be co-operative and caring.

The third duty can only be fulfilled if HCPs have the virtues of justice and prudence (or practical wisdom).⁴⁹⁹ Justice is concerned with ensuring each person is given their due, including due respect,⁵⁰⁰ and is engaged in knowing how to act fairly when patient autonomy threatens harm to other parties.⁵⁰¹ The virtue of justice also concerns the disposition to treat each patient equitably and, given that healthcare is essentially

⁴⁹³ *Op cit* n.201, 79.

⁴⁹⁴ *Op cit* n.201, 81.

⁴⁹⁵ *Op cit* n.231, 110.

⁴⁹⁶ *Op cit* n.201, 132.

⁴⁹⁷ *Ibid.*, 118-124.

⁴⁹⁸ *Op cit* n.231, 100.

⁴⁹⁹ Putman, D. ‘Virtue and the Practice of Modern Medicine’ (1988) 13 *Journal of Medicine and Philosophy* 433, 440.

⁵⁰⁰ *Op cit* n.486, 63.

⁵⁰¹ *Op cit* n.201, 96.

beneficent, it is arguable that equity should be determined by reference to need and capacity to benefit. Furthermore, given the beneficent telos of medicine, and the altruism inherent in any profession, the virtue of justice, along with the virtue of self-effacement, would also dispose professionals to act in their patient's interest rather than in self-interest.⁵⁰² Prudence is an essential virtue because it disposes virtuous professionals to grasp the goal of any interaction and to make appropriate use of reason to guide their actions towards that end.⁵⁰³ In doing this prudence moderates the expression of the person's other virtues.⁵⁰⁴

In addition to these three duties, Pellegrino and Thomasma argued that because trust is crucial to the professional-patient relationship, professionals have an obligation of 'fidelity to trust', which has a corresponding virtue and is necessary for them to be trustworthy.⁵⁰⁵ This 'fidelity to trust' requires HCPs to try to understand the patient as a person, to avoid manipulation and deception, and to be sensitive to the patient's vulnerabilities. It both supports and provides a backdrop for the professional's substantive obligations and thus it 'intersects' with other virtues.⁵⁰⁶ In this it is supported by the virtue of fortitude,⁵⁰⁷ which counters any temptation to take the path of least resistance in the face of a moral challenge and so encourages consistency and reliability, both of which are important to trust.

External Factors

Although the professional-patient relationship provides the contextual setting for the regulation of consent the relationship cannot be considered in isolation from the external factors that affect it. These include the interaction between the patient and important

⁵⁰² *Ibid.*, 105, 144.

⁵⁰³ *Op cit* n.231, 107.

⁵⁰⁴ *Op cit* n.201, 85.

⁵⁰⁵ *Ibid.*, 75. See also: Gardiner, P. 'A virtue ethics approach to moral dilemmas in medicine' (2003) 29 *Journal of Medical Ethics* 297, 299.

⁵⁰⁶ *Op cit* n.201, 76.

⁵⁰⁷ *Ibid.*, 114.

others; the relevance of a team approach to healthcare; the organisation and behaviour of the institution; the politics of healthcare and the regulation of consent. Other important constraints are the impact of social conditioning and education, the effects of which may explain why older patients and those from a lower social class are more likely to prefer their interactions to be directed by the healthcare professional.⁵⁰⁸ Since the whole thesis deals with regulating consent my focus here is on the other factors.

It is important for the law to take into account the relevance of third parties to the relationship. Patients may be empowered by the support of relevant others who can help them understand the information, facilitate decision-making and provide emotional support.⁵⁰⁹ However, just as third parties can be supportive they can also undermine the patient's autonomy by placing unfair emotional pressure on the patient or trying to manipulate the patient's decision to suit their own ends.⁵¹⁰

The healthcare institution may influence patient autonomy in two ways. The first is its attitude towards patient autonomy and consent. If little value is given to consent then that approach will filter down and it may become a low priority for the healthcare professionals working directly with the patient.⁵¹¹ While this may have been the usual attitude 20-30 years ago the increasing burden of litigation⁵¹² and the recent high profile incidents, such as the Shipman case, and the Bristol heart surgery and organ retention scandals, have perhaps made healthcare providers place more value on consent. However,

⁵⁰⁸ *Op cit* n.349, 868.

⁵⁰⁹ Kaufert, J.M. O'Neil, J.D. *Op cit* n.297, 59.

⁵¹⁰ See *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, discussed in chapter five.

⁵¹¹ See: Meyers, C. *Op cit* n.350.

⁵¹² Harpwood, V. 'The Manipulation of Medical Practice', in: Freeman, M. Lewis, A. (eds.), *Law and Medicine: Current Legal Issues Volume 3* (Oxford 2000), 47, 48; Mulcahy, L. 'Threatening Behaviour? The Challenge Posed by Medical Negligence Claims', in: Freeman, M. Lewis, A. (eds.), *Law and Medicine: Current Legal Issues Volume 3* (Oxford 2000), 81, 83. While Mulcahy argued that her research suggests the threat was exaggerated, in 2001, the NAO reported a seven-fold increase in costs since 1995-1996: NAO, *Op cit* n.3, 1. In 1998, the Health Secretary, Frank Dobson commented on the cost to the NHS of negligence litigation, suggesting that: 'the best place for a lawyer is on the operating table': Department of Health Press Release, 29th April 1998. See also: Lord Irvine of Lairg 'The patient, their doctor, their lawyers and the judge: rights and duties' The Long Fox Lecture 1998.

this value has become defensive as evidenced by the rise of risk management, which makes the avoidance of litigation a prominent – if not the primary - value of consent.⁵¹³ Recent guidance from the Medical Defence Union, the Association of Anaesthetists and the Department of Health reflects this defensive approach to consent by focusing primarily on the minimal requirements of the law and the legal and professional consequences of failing to gain an adequate consent.⁵¹⁴ While this bias is understandable it encourages an undesirable adversarial tone.

The second way in which the healthcare provider may influence patient autonomy is in the actual delivery of care. This includes a restriction of choices available to the patient and the practical organisation of healthcare delivery. Consider, for example, the provision of day surgery. Unless anaesthetists are given sufficient opportunity to see patients before the operation they may be unable to adequately counsel them, make them aware of the available choices and obtain an adequate consent. While this could be amalgamated with the consent for the surgical procedure, the surgeon is unlikely to be able to properly discuss the options available, which may be restricted either because of the patient's health or the experience of the anaesthetist. In the absence of a pre-admission clinic, the anaesthetist's only contact with the patient may be on the day of the operation. This may only allow a hurried chat in the anaesthetic room while the operating department practitioner is applying the monitoring equipment, which is hardly conducive to an autonomous decision. While it would be both impractical and presumptuous for the law to dictate such practical arrangements, it might, through the use of a code of practice, and a regulatory/advisory body encourage the development of systems that are more sensitive to and facilitative of patient autonomy and consent.

⁵¹³ *Op cit* n.459, 289; Peters, E. Challis, M. 'Most doctors see consent from functionalist perspective' (1999) 318 BMJ 735.

⁵¹⁴ Gilberthorpe, J. *Consent to Treatment* (1999) The Medical Defence Union: London; The Association of Anaesthetists. *Consent for Anaesthesia* (2006) available at: <http://www.aagbi.org/pdf/Consent.pdf>. Last accessed 17th July 2006; DH. *Reference Guide to Consent for Examination or Treatment* (2001), available at: www.dh.gov.uk.

This example also highlights the relevance of a team approach to healthcare,⁵¹⁵ which adds a level of complexity to the preceding discussion for two reasons. First, it may mean that many of the relationships are short lived, which perhaps makes a relationship of trust more difficult to establish unless the trust predates the relationship. Second, if different professionals, each of whom is independently responsible, carry out different elements of the patient's care then this raises questions about their responsibilities for seeking the patient's consent.

Individual HCPs may not be sufficiently conversant with the different interventions to inform and advise the patient. For example, should surgeons with little formal training in anaesthetics counsel the patient about the pros and cons of different options, assuming that they are even aware that those options exist? But, if anaesthetists are to take that responsibility then there needs to be appropriate practical arrangements that allow patients sufficient time to reflect on the available choices. Furthermore, consideration needs to be given to whether these elements of care require separate consents or are subsumed by a more general consent to the care plan as a whole.

Finally, patients may see their care holistically and raise questions about an aspect of care that the professional currently counselling them will not be providing. By answering the question HCPs may step on their colleagues' toes and may not give the same answer that their colleague would have given. This could cause misunderstanding and confusion. Furthermore, it is important for patients to know who is responsible for each aspect of their care so that they know who to approach for advice and who to contact if there is a problem. Essentially, all of these issues create problems of coordination and communication, which means that it is not enough for the individual professional to

⁵¹⁵ Black, C. Craft, A. 'The competent doctor: a paper for discussion' (2004) 4 *Clinical Medicine* 527, 530.

behave well. It is equally important to ensure that an appropriate system is in place and that someone is responsible for that system.⁵¹⁶

Finally, it is important to recognise the necessary relationship between politics and consent.⁵¹⁷ For example, if healthcare is provided within a true market system, patients may be treated as consumers and their legal protection based on the libertarian conception of autonomy with greater demands for independent patient choice and decision-making. In such a system, responsibility for outcome might be more tightly linked to consent but the principle of *caveat emptor* may be more relevant, tilting the balance from the professional's duty to disclose to the patient's responsibility to ask questions. Furthermore, the emphasis would more likely focus on rights rather than obligations and this may increase the possibility of litigation and introduce an adversarial element into what perhaps ought to be a cooperative encounter. Exacerbating this, a market approach will encourage a commodification of healthcare with practice driven by financial concerns rather than the community's health needs. In the market environment there is a risk that a 'factory model of care' will pay more attention to a high throughput of patients than to the psychosocial or ethical interests.⁵¹⁸

On the other hand, if the healthcare system is provided by the state and based on a social ethic then autonomy may be seen in a more relational sense, with the focus on obligations rather than rights. Responsibility for outcome may be more readily divorced from the patient's consent. Taking this to a more extreme communitarian system, utility becomes more important, the issue of individual consent becomes less relevant and responsibility for outcome is borne by the community as whole rather than any single patient. It is, of course, possible for the state to pragmatically adopt a mixed approach rather than commit to a purer political vision. However, this can still only be achieved if it is clear what is

⁵¹⁶ *Ibid.*, 530.

⁵¹⁷ Maclean, A.R. 'Consent and Sensibility' (2005) 4 *International Journal of Ethics* 31.

⁵¹⁸ *Op cit* n.441.

wanted from the healthcare system. For example, is it more important to maximise patient throughput or should the emphasis be on how those patients are treated as persons? Is choice more important than quality or equity?⁵¹⁹ How much money are we willing to spend on health and do external financial constraints justify withholding treatment that the patient wants?⁵²⁰ What the community, wants from its healthcare system – and what it is prepared to pay for – inevitably affects the approach to consent as much as it affects the provision of any of the more tangible resources.⁵²¹

Conclusion

In this chapter I examined the professional-patient relationship as a context for regulating consent. I argued that a good relationship requires mutual trust and mutual respect. Both parties come to the relationship as autonomous persons. However, the professionals' autonomy is constrained by the ethics of their profession. Perhaps the most important consequence of the relationship is that it generates obligations for both parties. While HCPs should respect and support their patients' autonomy they should not abandon them to unwise and harmful decisions. Although they do not have the authority to override a competent patient's decision, HCPs have a duty to use rational persuasion to guide the patient towards a mutually acceptable outcome. In order to facilitate this process, patients should also be open and honest with their HCPs, they should be prepared to explain their decisions and be willing to listen to their HCPs' advice. The mutual trust and respect needed for this process means that both HCPs and their patients should behave in a trustworthy way. However, because of the difficulties of encapsulating these obligations in rules, attention must be directed to the HCP's character. In order to apply the rules of consent in practice, HCPs should be encouraged to develop the virtue of professionalism.

⁵¹⁹ Appleby, J. Harrison, A. Devlin, N. *What is the Real Cost of More Patient Choice?* (2003) London: King's Fund, 1-4, 32-35.

⁵²⁰ Pollock argues that the present Government's policies are already driving the NHS towards this approach: Pollock, A.M. *NHS plc: The Privatisation of Our Health Care* (2004) London: Verso. The reference to the 'factory model' is on p.201.

⁵²¹ See the discussion in: White, S.M. *Op cit* n.459, 289-290.

The institution of healthcare must be organised to facilitate the practice of these obligations. However, as a final caveat, it is acknowledged that the conception of consent and its implementation are ultimately political and depend on what the community wants from its healthcare system and how much it is prepared to pay.

Chapter Four: The Concept of Consent – what it is and what it isn't

In the first three chapters of the thesis I discussed the ethical basis and practical context of consent to medical treatment. I argued that the primary justification for consent is the patient's autonomy but that the context of the professional-patient relationship constrains the implications of that autonomy. On entering the relationship both the professional and the patient acquire certain obligations towards the other party that shape how the patient's autonomy is given effect. In this chapter I will explore the concept of consent itself bearing in mind the arguments and conclusions of the earlier chapters.

This chapter is a necessary part of the thesis because, as Larry Alexander noted: 'consent is woefully underanalyzed in the legal and philosophical literature'.⁵²² It is essential to understand consent for four reasons. First, without an insight into consent any attempt to determine the regulation of consent will be flawed. Second, arguments advanced about consent may in fact be about a primary underlying claim right rather than about consent *per se*. This type of argument will remain hidden and inadequately dealt with unless it is exposed and to do this requires recognition of both the meaning and extent of consent. Third, an understanding of consent and its requirements is necessary to predict the interaction between consent and the provision of healthcare. Fourth, elucidation of consent will then allow a critique of the current law.

A preliminary definition

The Oxford English Dictionary lists consent as both a verb and a noun. As a verb, it has two senses. The first sense is 'to agree together ... to come to agreement upon a matter or as to a course of action'. The second sense is 'to agree to a proposal, request etc ... voluntarily to accede to or acquiesce in what another proposes or desires'. Etymologically

⁵²² Alexander, L. 'Introduction to Issues 2 and 3: Symposium on Consent in Sexual Relations' (1996) 2 *Legal Theory* 87.

the word derives from the Latin conjunction of *con*, meaning ‘together’ with *sentire*, meaning ‘to feel, think or judge’. Thus, it is the first sense of the word that is closest to the original meaning of the term. As a noun, the only current use is as: ‘voluntary agreement to or acquiescence in what another proposes or desires; compliance, concurrence, permission’, which is closest in meaning to the second sense of the verb consent.

It is interesting that the earliest use of the word refers to shared decision-making while the later use refers to a proposal and voluntary acceptance of that proposal. In its role as a check on physician autonomy this etymological development is reversed. Thus, the traditional use of the word is to refer to the patient voluntarily agreeing to undergo the treatment proposed by the doctor. With the early attacks on paternalism this meaning of consent was championed as a shield for patient rights. When this shield was swapped for a sword and the requirements of individual autonomy taken to an extreme some commentators felt that both doctors and patients suffered, which led to a move away from perceiving consent as two parties negotiating a ‘contract’ at arms length. Instead, these writers championed the cause of shared decision-making and called for a ‘therapeutic alliance’.⁵²³

In the previous chapters I argued that the patient’s autonomy grounds the right to give or withhold consent but that this right must be framed by the mutual obligations arising from the professional-patient relationship. A reasonable conception of consent ought to take both of these factors into account. Thus, it is arguable that both senses of consent are relevant: while the patient must give or withhold consent this decision is not free-floating but is made as part of an ongoing relationship.

⁵²³ Teff, H. ‘Consent to Medical Procedures: Paternalism, Self-determination or Therapeutic Alliance’ (1985) 101 *The Law Quarterly Review* 432.

In both senses of the word it initially appears that an agreement lies at the very heart of the concept of consent. Gillon noted that the simple idea of an agreement is only one of two possible meanings of consent. However, consent as a simple agreement 'is not relevant to medical interventions'.⁵²⁴ For him:

consent means a voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her.⁵²⁵

Meisel and Kuczewiski, however, preferred to see consent as a '*shared process of decision making*'.⁵²⁶ For them, this was important because: 'conceived as a process of shared decision making, informed consent can accommodate both patient autonomy and the physician's responsibility for the well-being of the patient'.⁵²⁷ In the context of consent to research, Horton noted the danger of consent being seen as an adversarial procedure. He suggested, that the patient's consent should be seen as the 'outcome' of 'an extended consent process [that] would bind both patient and doctor closer together'.⁵²⁸ This perhaps combines both senses of consent into an open ended and iterative process.

At this stage, I will propose two primitive definitions of consent:

Consent 1: An agreement, by the patient, to undergo an intervention offered by the HCP.

Consent 2: A mutually arrived at agreement to an intervention that the patient will undergo.

⁵²⁴ *Op cit* n.40, 113.

⁵²⁵ *Ibid.*, 113.

⁵²⁶ Meisel, A. Kuczewiski, M. 'Legal and Ethical Myths About Informed Consent' (1996) 156 *Archives of Internal Medicine* 2521, 2522.

⁵²⁷ *Ibid.*, 2522.

⁵²⁸ Horton, R. 'The context of consent' (1994) 344 *Lancet* 211, 212.

There is a problem with both of these primitive definitions since, as Gilbert argued: ‘an agreement is, in effect, a joint decision’. Such a joint decision entails ‘joint acceptance’ of the agreed action(s), which, in turn, ‘requires ... a “joint commitment”’.⁵²⁹ For Gilbert both parties possess a mutual obligation to honour the agreement, which means that neither party may withdraw unilaterally.⁵³⁰ The difficulty here is that it is accepted that persons giving a consent to a breach of bodily integrity may withdraw their consent and with it the permission that justifies action. If Gilbert is correct about an agreement then this may make unacceptable a unilateral withdrawal of consent.

In one sense, consent operates to create mutual obligations and properly constitutes ‘agreement’. This is the situation when contracts are created, and is also the sense of consent when the HCP agrees to provide treatment. In the current context, however, because our bodies are so fundamentally important to our self-identity and autonomy, it seems inequitable to hold a patient to his consent. This means that consent to medical treatment is either not an agreement or it is a particular kind of agreement that does not impose a binding obligation on the consenter. The difficulty with this latter position is that it threatens to undermine fatally the social and normative meaning of ‘agreement’. This suggests that perhaps it is better to conceptualise consent in this context as something other than, or in addition to, an agreement.

As noted earlier, consent has two senses and both seem relevant to an exercise of the patient’s autonomy within the context of the professional-patient relationship. The mutuality of the relationship suggests the relevance of both parties’ involvement and agreement, while respect for the patient’s autonomy is reflected through the control allowed by consent as permission. Thus, it may be appropriate to acknowledge that

⁵²⁹ Gilbert, M. ‘Agreements, Coercion, and Obligation’ (1993) 103 (4) *Ethics* 679, 691.

⁵³⁰ *Ibid.*, 693.

patient decision-making involves both consent as an agreement (consent_A) and consent as permission (consent_P). The agreements between professionals and their patients arise at an earlier stage of the encounters and are precursors to consent_P. While consent_A creates obligations, consent_P acts by waiving the obligation of non-interference with the patient's body.

One potential problem with 'permission' is its connection with 'permit'. Where someone permits an act this may imply an active grant of a power to act that, like consent_P, removes the moral and legal prohibition on acting, assuming the person giving permission has the right to do so. Alternatively, permit may mean a passive submission or failure to resist. Although submission may follow – and, in certain circumstances, imply - consent_P there are other reasons for failing to resist including violence, force and coercion. Such a submission would not affect the moral or legal status of the act and would not, therefore amount to consent_P.⁵³¹ As Coleridge J stated: 'Every consent to an act involves a submission; but it by no means follows that a mere submission involves consent'.⁵³² Thus, a distinction must be made between passively 'permitting something' and actively 'giving permission'.

The primitive definitions might be revised as follows:

Consent 1: Permission given by the patient for the HCP to undertake the intervention on offer.

Consent 2: Permission given by the patient for the HCP to undertake the intervention previously determined by a mutually arrived at agreement.

⁵³¹ See, e.g. *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936, 949.

⁵³² *R v Day* (1841) 173 ER 1026.

Attribute A: Effect:

Value: Removes the HCP's obligation of non-interference

The Nature and Function of Consent to Medical Treatment

There appear to be three broad views of the nature of consent.⁵³³ First, it may be a mental state. For Hurd, 'consent must essentially constitute an act of will – a subjective ... [and] purposive mental state possessed of propositional content'.⁵³⁴ Similarly, Alexander stated that: 'consent ... must be the exercise of the will and, thus, a subjective mental state ... [and] ... that it is an "intentional" mental state ... not equivalent to states of belief or desire'.⁵³⁵ And for O'Neill, 'consent is a *propositional attitude*'.⁵³⁶ Second, consent may be seen as an intentional act. Wertheimer, for example, suggested that 'consent is performative rather than attitudinal'.⁵³⁷ Others, for pragmatic reasons, have suggested that consent is both a state of mind and a signifying act.⁵³⁸ Thus, Sherwin argued that consent is a 'social act', but one whose 'object is to express a particular mental act'.⁵³⁹

The categorisation of consent as a mental state or as an intentional act perhaps reflects the distinction between law and morality. As McGregor noted: 'consent would not make legal sense as a demarcation if it was merely a function of a person's mental attitudes, with no epistemological access necessary, or even possible, for its presence'.⁵⁴⁰ If consent were simply a mental state and was not communicated, it would be impossible for an actor to know whether or not the other party was consenting to the act. In the absence of such knowledge it would be wrong to act and the actor may be considered legally

⁵³³ *Op cit* n.522; Wertheimer, A. 'What is Consent? And Is It Important?' (2000) 3 *Buffalo Criminal Law Review* 557, 566.

⁵³⁴ Hurd, H.M. 'The Moral Magic of Consent' (1996) 2 *Legal Theory* 121.

⁵³⁵ Alexander, L 'The Moral Magic of Consent (II)' (1996) 2 *Legal Theory* 165.

⁵³⁶ *Op cit* n.32, 43.

⁵³⁷ Wertheimer, A. 'Consent and Sexual Relations' (1996) 2 *Legal Theory* 89, 94.

⁵³⁸ Malm, H.H. 'The Ontological Status of Consent and its Implications for the Law on Rape' (1996) 2 *Legal Theory* 147.

⁵³⁹ Sherwin, E. 'Infelicitous Sex' (1996) 2 *Legal Theory* 209, 209, 217.

⁵⁴⁰ McGregor, J. 'Why When She Says No She Doesn't Mean Maybe and Doesn't Mean Yes: A Critical Reconstruction of Consent, Sex, and the Law' (1996) 2 *Legal Theory* 175, 193.

culpable. A consideration of the act, which would only make sense from a moral perspective, would find that it was not morally wrong. From the legal perspective, however, the actor must have some reason for believing that the other party is consenting. This is true whether the actor's belief is tested objectively or subjectively.

An examination of the work expected of consent may indicate whether it is best seen as a mental state, intentional act or a combination. Traditionally, consent either legitimates an otherwise forbidden act and/or it creates new obligations. As a creator of obligations, consent is crucial to an agreement (or contract).⁵⁴¹ Consent's other role is to provide a rights-bearer with control of that right, which it does by transforming an illegitimate act into a permitted one. As Alexander stated: 'consent functions as a "moral transformative" by altering the obligations and permissions that determine the rightness of others' actions'.⁵⁴² Hurd went further than this and argued that: 'when we give consent, we create rights for others'.⁵⁴³ This claim, while it may be true for consent_A, is over inclusive. For consent_P, it is perhaps more accurate to view consent as generating permissions rather than rights per se.⁵⁴⁴ Although some of those permissions may also grant rights this will not be universally so. For example, consider the consent_P given to a surgeon to perform an operation. This does not give the surgeon a right to operate since the patient still retains sufficient control of his or her right to bodily integrity to withdraw permission. In this context consent_P operates as a form of waiver rather than as a transfer of a right.⁵⁴⁵

In her discussion of consent_P in the context of rape law, Hurd suggested that it alters the morality of another's actions in two ways. First, she posited that 'consent can function to transform the morality of another's conduct – to make an action right when it would

⁵⁴¹ Young, P.W. *The Law of Consent* (1986) The Law Book Co Ltd: North Ryde (NSW), 3.

⁵⁴² *Op cit* n.535.

⁵⁴³ *Op cit* n.534.

⁵⁴⁴ McConnell, T. *Inalienable Rights: The Limits of Consent in Medicine and the Law* (2000) New York: Oxford University Press, 8.

⁵⁴⁵ *Ibid.* See also: Sherwin, E. *Op cit* n.539, 217.

otherwise be wrong'. Second, she claimed that: 'consent can generate a permission that allows another to do a wrong act ... [This] does not morally transform a wrong act into a right act, but it grants another a right to do a wrong'.⁵⁴⁶ Both claims are problematic.

Hurd's first suggestion is flawed because she assumes that since doing a non-permitted act would be wrong it must be right to perform a permitted act. This is wrong because it places the whole normative judgment at consent's door. This ascribes consent too much power. Consent simply prevents an act being a wrong against the consenter. This does not affect the rightness or wrongness of the act more generally. Thus, if it is wrong to kill for reasons other than simply infringing bodily integrity, the 'victim's' consent does not alter the wrongness of the act. For a couple not wanting children, consent to unprotected sex does not make it 'right'. It arguably remains morally wrong for being an irresponsible act.

If the act is not inherently wrong but is only forbidden because it affects something over which I have the right of control, then consent makes the act morally permissible. Even here, however, consent is unable to alter the inherent value of an act. Giving consent does not make an inherently bad act - nor even a morally neutral act - good. All it does is give permission for the act. The same is true in relation to the legal function of consent. As West notes: '[consent] converts the illegal act into a legal one, but doesn't convert the illegal one into something of value'.⁵⁴⁷

Hurd's second mechanism is similarly flawed. As an example, Hurd utilised the 'wrong' of abortion as a form of contraception.⁵⁴⁸ While the woman's consent permits the doctor to perform an abortion it is only by virtue of the fact the woman herself is permitted to act 'wrongly' that she may give another permission to assist her in that act. However, where

⁵⁴⁶ *Op cit* n.534, 123.

⁵⁴⁷ West, R. 'A Comment on Consent, Sex, and Rape' (1996) 2 *Legal Theory* 233, 250. This statement is equally valid if 'illegal' and 'legal' are replaced by immoral and moral.

⁵⁴⁸ *Op cit* n.534, 123-124.

the consentor has no right to do something then his or her consent is ineffective in granting the actor permission. For example, if my car has no road tax my consent cannot give you permission to drive it on a public road.⁵⁴⁹ Furthermore, even when persons are permitted to do a particular act, it is not always the case that they can transfer that permission to another. I may be permitted to cut off my own leg. However, without external justification (such as the leg is gangrenous and you are a surgeon) I cannot give you a legally effective permission to perform the amputation.⁵⁵⁰

Hurd's explanation of how consent works is too broad because it ignores the fact that consent is insufficient as a normative tool to justify all acts. Some acts are justified irrespective of the person's consent, such as treatment for infectious diseases that are a public health hazard; 'sectioning' the dangerously mentally ill; and incarcerating convicted criminals. Other acts - such as routine therapeutic medical procedures - will be justified only if consensual.⁵⁵¹ Finally, there are acts that consent cannot justify. From a legal perspective, these include consent to be killed or maimed. While this third group may be larger from a legal rather than a moral perspective, it is also arguable that there are morally wrong acts that cannot be justified or excused by the 'victim's' consent. Consider someone who consents to be killed. If that person is healthy, with obligations towards a partner and young children, then it is wrong to kill him or herself. Even if that person consents to being killed by another, it would be wrong of that other to kill him or her. While consent may give actors permission it cannot relieve them of their duty to make - and take responsibility for - an independent moral judgment. A valid consent does mean that the consentors have no right to complain if they are harmed by the act: consent affects the wrongness of an act within the context of the relationship between actor and

⁵⁴⁹ Although this is a legal argument the same example would support a moral argument since, if you have never driven before you will place yourself, and perhaps others, at risk. My consent cannot make it right for you to risk anyone's health. This is especially true where third parties are placed at risk.

⁵⁵⁰ Consider, for example, the moral dilemma, irrespective of their ability to give a competent consent, raised by patients with body dysmorphic syndrome who request such an amputation.

⁵⁵¹ I am only discussing the competent adult here.

consenter. It does not, however, affect the wrongness of an act if that wrongness is external to the relationship.

It is apparent then, that consent acts to transform the status of an act between the actor and the consenter. It removes the consenter's right to complain about the act. For some acts consent provides the necessary justification and where those acts are beneficial in nature consent transforms the act into a morally good one. Consent, however, is neither necessary nor sufficient to make an act 'good'.⁵⁵² Where a person is unable to consent the act is still justified if it is in the person's 'best interests'.⁵⁵³ Where an act is 'wrong' then consent is unable to make it right or even justify the act. Where the act is seen as a serious wrong, such as killing a person for whom life is not seen as harmful, then consent is wholly ineffective and both the act and the actor are condemned. Where an act is seen as a less serious harm the act remains wrong but the person's consent may excuse the actor from moral blame. Thus, while consent may be sufficient to alter the rights and obligations between the actor and the consenter, it is insufficient to make a wrong act right.

Too much may be demanded of consent if it is treated as a primary right, equivalent in nature to the right to life or the right to bodily integrity. To discuss consent in this way is mistaken.⁵⁵⁴ Consent is not a right in the same sense as these other rights. It is not something possessed equally by all persons within the rights-holding community. Persons who are incapable of giving or withholding consent still possess the right to bodily integrity but it is not necessary to gain their consent before, for example, subjecting them to an operation. Allowing others to provide proxy consent goes some way to creating the

⁵⁵² *Op cit* n.537, 90.

⁵⁵³ The 'best interests' test is not without its problems but this is not the place to discuss those problems. Sometimes an act may also be justified on utilitarian grounds e.g. the treatment and isolation of a person suffering from a highly contagious disease.

⁵⁵⁴ Brownsword, R. 'The Cult of Consent: Fixation and Fallacy' (2004) 15 *King's College Law Journal* 223, 225.

impression that the right may be more similar to the primary right than it actually is.⁵⁵⁵ Consent, however, is a derivative or secondary right. In the absence of a right to bodily integrity, consent would not be required to give someone permission to interfere with our bodies. Thus, unlike these other rights, consent is contingent. Furthermore, unlike the other rights it is dependent on the person's ability or their status. In this way, consent is perhaps best seen as an aspect of all other rights that arises because it is inherent to the concept of a right that someone, usually the right-holder, has control over it. This is important because it means that no one can consent to something unless they have a right that may be waived or alienated. In this context, consent reflects the negative aspect of liberty.

Apart from operating either to legitimate an action or to create an obligation, consent may also affect responsibility for the outcome of the action.⁵⁵⁶ It might be thought that responsibility necessarily travels with consent,⁵⁵⁷ but there is no reason why this should be the case. If I give you consent to use my bicycle, there is no prima facie reason why I should be responsible for any damage you might cause to my bicycle. However, it is certainly arguable that I should be responsible for the 'wear and tear' that is the natural and foreseeable consequence of use.⁵⁵⁸ For consequences that do not necessarily follow from the act consented to it is arguable that the actor should bear responsibility where he is morally or legally culpable. If you damage my bike because you ride at night without lights then you should be responsible for the damage that results. This is because, whether or not you act negligently is - at least partly - a consequence of your agency and not a

⁵⁵⁵ It is arguable that, because consent is derivative on a right, that proxy consent is a misnomer that is more akin to authorisation than consent. See: *Final Report of the Independent Review Group on Retention of Organs at Post-Mortem* (2001) Edinburgh: Scottish Executive Health Department, 16.

⁵⁵⁶ See for example: Schuck, P.H. 'Informed Consent in the U.S.: Perspectives from Tort Law', in: Westerhall, L. Phillips, C. (eds.) *Patient's Rights – Informed consent, access and equality* (1994) Stockholm: Nerenius & Santerus Publishers 383, 391, where it is argued that the person giving consent assumes responsibility for risk.

⁵⁵⁷ Epstein, M. 'Why effective consent presupposes autonomous authorisation: a counterorthodox argument' (2006) 32 *Journal of Medical Ethics* 342, 344.

⁵⁵⁸ It is open to the parties to negotiate other arrangements should they wish.

necessary consequence of my own agency, in the shape of my consent. The ‘wear and tear’ damage is different since it is entailed by your exercise of the permission I have granted.

A third type of consequence results from luck.⁵⁵⁹ Certain things that happen do so outside of anyone’s control or influence and may be put down to good or bad luck.⁵⁶⁰ If it happens that you ride over a nail, puncturing one of the tyres on my bicycle, who should be responsible for repairing the damage? Certainly, if you have taken my bike without consent, it would be your responsibility. However, does my consent cause that responsibility to shift to me? The answer to this is that it perhaps depends more on convention and political stance than on any underlying moral argument. Both parties have exercised agency and the damage is nobody’s fault. It might seem unfair that either party should be held responsible but, by default, if responsibility is allowed to lie where it falls it will be me, the bicycle owner, who will be shouldered with the cost of the repair. One option is to argue that it might depend on who benefits most from the act, or alternatively, who would gain from good luck.⁵⁶¹

Consider a person who consents to a non-therapeutic research intervention. In this case, the person giving consent does not stand to gain from the act in any direct sense.⁵⁶² It is both society and the researcher who gain. Society gains by the advancement in medical science while the researcher gains prestige and improves his potential for career advancement. Under these circumstances, it might be thought unfair to allow the research subject to bear the responsibility for injury caused by bad luck. Instead, he should be compensated either by society or the researcher, since it is those parties that stand to gain most from the research. It is perhaps for this reason that the Declaration of Helsinki

⁵⁵⁹ Honoré, T. ‘Responsibility and Luck’ (1988) 104 LQR 530.

⁵⁶⁰ *Op cit.* n.270.

⁵⁶¹ Nagel, T. ‘Moral Luck’, in: *Mortal Questions* (1979) Cambridge: Cambridge University Press, 24; *Op cit* n.559; Cane, P. *Responsibility in Law and Morality* (2002) Oxford: Hart Publishing, 76.

⁵⁶² Ignoring the speculative psychological benefits accruing from an altruistic act.

states: 'the responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given consent'.⁵⁶³ However, where consent is to conventional medical treatment, it is the patient who stands to benefit and thus it is the patient who accepts responsibility for the outcome caused by bad luck.⁵⁶⁴

Although consent is neither necessary nor sufficient to shift responsibility for outcome from the actors, where they require the other party's consent to legitimise their action then consent is necessary to allow that party to be included in the apportionment of responsibility. Once a valid consent is given, responsibility for outcome is determined by principles of justice. This, of course, is not to say that pragmatic arguments could not affect legal responsibility for the outcome. For example, it might be argued that, in order to reduce the costs and inefficiencies of the legal system, a no-fault compensation system should be established. Whatever approach is taken to outcome responsibility, it is important to recognise that any harm consequential to the intervention is distinct from the harm to the patient's autonomy caused by an infringement of the right to consent. This separation will become relevant when I consider the way the law has developed to regulate risk disclosure through the tort of negligence.

I now return to the fundamental nature of consent. As noted earlier, there are three competing views of consent: that it is a state of mind, a signifying act or a state of mind evidenced by an appropriate act. It may be thought that since consent is predicated on autonomy,⁵⁶⁵ which in turn requires free will, it must at least be a state of mind.⁵⁶⁶ Where

⁵⁶³ Principle 15, Declaration of Helsinki 1964 (as amended, Edinburgh 2000).

⁵⁶⁴ Dickenson, D. *Moral Luck in Medical Ethics and Practical Politics* (1991) Avebury: Aldershot, 99. This may be dependent on awareness of risk. See: Agell, A. 'The Conceptual Relationship between Medical Malpractice and the Lack of Informed Consent', in: Westerhall, L. Phillips, C. (eds.) *Patients' Rights – Informed consent, access and equality* (1994) Stockholm: Nerenius & Santerus Publishers 85, 94.

⁵⁶⁵ See: Bogart, J.H. 'Commodification and Phenomenology: Evading Consent in Theory Regarding Rape' (1996) 2 *Legal Theory* 253, 262.

⁵⁶⁶ *Op cit* n.534, 125.

the actor is not to be held responsible, and the post-act beliefs and evidence of the person accurately reflect his or her state of mind at the time of the act, then that person's state of mind would be sufficient to constitute a valid consent (or refusal). However, where the actor is held responsible for the act unless legitimised by consent, given the problems of hindsight, then some tangible evidence of consent is required. At the very least, this would require some communication from the person to the actor that the person is consenting. It might even be argued that until communication of consent has occurred the act remains illegitimate. An uncommunicated consent, while still consent, may be ineffective as far as granting the actor permission to act.

From a moral perspective, it is arguable that providing the person has formed the relevant state of mind, communication to the actor is irrelevant and the act is morally legitimate.⁵⁶⁷ Whatever the actor believes, the act has been permitted and the act is therefore not wrong for lack of consent. On the other hand, if 'respect for others and their rights lie at the heart of the issue of consent',⁵⁶⁸ it is arguable that the actor's state of mind is of equal importance.⁵⁶⁹ Without any form of communication of the person's state of mind, the actor will be unable to form any rational belief about the existence of consent. Any act would then be performed without believing it was permitted and this would fail to respect the person irrespective of whether he or she had the requisite state of mind. As such, the act would be morally wrong.

In the previous chapter I suggested that consent must be placed in the context of the professional-patient relationship and that the approach to consent helps to define that relationship. A good relationship requires mutual trust and respect, which includes an obligation to respect the other's autonomy. This mutual respect requires open and honest communication allowing both parties to play their role within the relationship. If HCPs

⁵⁶⁷ *Op cit* n.535.

⁵⁶⁸ *Op cit* n.190, 7.

⁵⁶⁹ *Op cit* n.540, 191.

are to respect their patients' autonomy, they must believe that the patient is consenting before they act. This belief can only be reliably achieved by communication of the consent.

Pragmatically, communication of consent is necessary to allow the law to apportion responsibility for outcome or to hold the actor legally culpable in the absence of consent. In a very real sense, it is impossible to avoid the issue since the two parties will draw inferences from both verbal and non-verbal signals. Irrespective of whether the person has formed the relevant state of mind, if he or she behaves in such a way as to cause the actor reasonably to believe that he or she is consenting, it would be unjust to hold that the act was unlawful.

Given the arguments above, and the fact that it would be impossible for two persons to interact without some degree of communication, it seems reasonable to suggest that consent exists but is ineffective in the absence of communication,⁵⁷⁰ which means that communication of consent is not part of the core theory but is an attribute of consent, albeit one that is necessary in the context of this enquiry. Consent as a state of mind, however, seems to be essential to the core theory.

At this point it is worthwhile modifying the primitive definitions of consent.

Consent 1a: A state of mind of the patient formed with the intention of permitting an intervention offered by the HCP.

Consent 2a: A state of mind of the patient with the intention of permitting an intervention formed as the result of a mutually arrived at agreement.

⁵⁷⁰ The issue then becomes: what is the appropriate test for communication that would allow the law to determine culpability and apportion outcome responsibility.

Attribute A: The communication of the patient's state of mind to the HCP.

Attribute B: Effect:

Values:

1. Alters obligations for:
 - a) The HCP, by removing the obligation of non-interference
 - b) Both the patient and HCP by negotiation to establish new obligations of cooperation and treatment;
2. Justifies intervention through moral/legal transformation;
3. Permits apportionment of outcome responsibility

As discussed earlier, as a derivative right, consent would be meaningless in the absence of the relevant substantive right. If there were no right to bodily integrity then we would be unable to use consent to waive that right. It might be argued, however, that a pre-existing right is unnecessary to the individual's agreement to an intervention, which may be given irrespective of whether he or she has control over the variable affected by the act. But, without the necessary control the agreement would be unable to legitimise the act. The law would have to look elsewhere to determine if the act was permissible. Furthermore, should the actor intervene without the individual's agreement, the law would not treat this any differently from the case where the individual has agreed.

It might then be argued that acting without the individual's consent is in itself a breach of a right and so the existence of an underlying right is unnecessary. This, however, raises the question of: consent to what? The answer cannot be to everything since the world would grind to a complete halt if that were the case. It would be a practical impossibility to seek, let alone obtain, everyone's agreement before acting. In order to allow society to

function the limits of consent must be defined and as soon as this happens the things over which we have the power of consent become our 'right'. If society allows that you may only legitimately disclose my medical information with my consent then it becomes a 'wrong' for you to disclose it in the absence of consent. *Ipsa facto*, I have a 'right' to confidentiality. If consent is to have any moral or legal force, it must be derivative on an underlying right. This underlying right is one of the necessary attributes of consent and, in the present context, the right is that right to bodily integrity.⁵⁷¹ Thus, consent must have a third attribute, *Attribute C*, is the primary right and for consent_P this has the *value*: bodily integrity.⁵⁷² For consent_A, the primary right is autonomy itself.

Consent as a Process

Some commentators suggest that consent should be seen as a process.⁵⁷³ Meisel and Kuczewski, for example, argued that a rights-based approach to consent is too restrictive and often inapplicable to the clinical realities. Instead of a model characterising physicians as technical experts advising their patients who then make decisions based on their own beliefs and values, they see consent as a 'shared process of decision-making'.⁵⁷⁴ The problem with this is that it conflates consent with the process of enabling patients to give a valid consent to the intervention on offer. If consent is a state of mind then it only serves to confuse matters to argue that it is also a process. Rather, consent should be preceded by a process of information disclosure, expert advice from the physician and

⁵⁷¹ More expansively, it might be argued that the relevant right is privacy.

⁵⁷² For this to be comprehensive, bodily integrity would have to be interpreted broadly to include those interventions that do not involve contact.

⁵⁷³ Usher, K. J. Arthur, D. 'Process consent: a model for enhancing informed consent in mental health nursing' (1998) 27 *Journal of Advanced Nursing* 692; Dyer, A.R. Bloch, S. 'Informed consent and the psychiatric patient' (1987) 13 *Journal of Medical Ethics* 12; Kay, R. Siriwardena, A.K. 'The process of informed consent for urgent abdominal surgery' (2001) 27 *Journal of Medical Ethics* 157; *Op cit* n.526, 2522; Aveyard, H. 'The requirement for informed consent prior to nursing care procedures' (2002) 37(3) *Journal of Advanced Nursing* 243, 248; *Op cit* n.398, 354.

⁵⁷⁴ *Op cit* n.526, 2522.

negotiation,⁵⁷⁵ which means that the idea of a process does not form part of the central theory of consent. However, because negotiation/shared decision making (see below) recognises the professional-patient relationship and allows patients greater involvement and control without abandoning them to their own devices, it is important to include the process of consent as an attribute with two values: negotiation and patient's decision. This is modelled below.

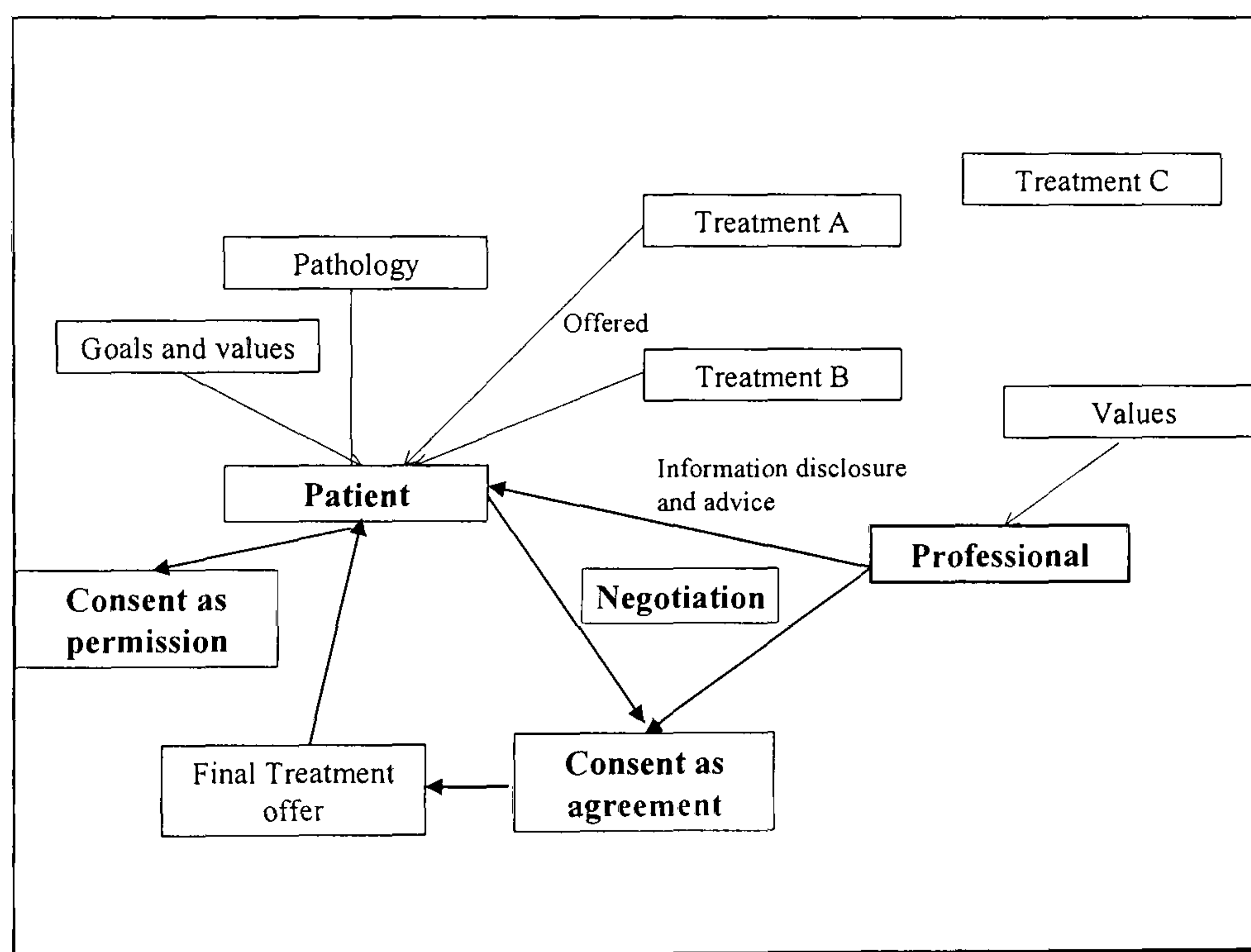


Figure 1: The Process Leading to Consent

The professional, who controls the treatments available, has offered the patient a choice of two treatments (A and B). In other cases, the professional may only offer one treatment to the patient. Whether or not this is legitimate is independent of the patient's right to bodily integrity and hence is independent of consent as permission. Consent_p is a device for controlling negative liberty rights. The exercise of positive liberty rights comes in the form of a demand or request rather than a waiver and may be served to some extent by

⁵⁷⁵ McLean, S.A.M. 'Talking to Patients – Information Disclosure as “Good” Medical Practice', in: Westerhall, L. Phillips, C. (eds.) *Patients' Rights – Informed consent, access and equality* (1994) Stockholm: Nerenius & Santerus Publishers 171, 174.

the requirement of consent_A. This re-connects with the first sense of consent to engage both parties in negotiation to determine the final management decision.

At this point of the process patient autonomy meets clinical autonomy. Patients may choose to waive their right to be involved in the decisional process, leaving the treatment choice at the professionals' discretion. However, insofar as professionals are legally obliged to offer a choice of effective treatments, patients' positive claim rights may impinge on the professionals' clinical autonomy. Patients' claim right to treatment, while it may engage their autonomy, is determined prior to their consent and is a matter of distributive justice,⁵⁷⁶ which is beyond the scope of this thesis and will not be further considered.

This model of consent is rights-based, but does not reduce the professional's role to one of technician. All it does is recognise that professionals may not legitimately treat competent adult patients without their consent. They must still act as advisors and the treatment options open to the patient remain under their control. Finally, it should be remembered that consent is a state of mind, which may change over time. As such, even when patients have communicated their consent, professionals have a duty to ensure that their patient is still consenting at the time of the intervention.

Time Course of Consent

The time course (duration) of consent constitutes an additional attribute and depends on whether consent is purely a state of mind or whether communication is an integral component. As a state of mind, consent persists for as long as the individual maintains that particular state of mind. This is problematic where the patient is to be anaesthetised since the requisite state of mind will be lost while unconscious, which again emphasises the importance of communication. When communication is taken into account, consent

⁵⁷⁶ *R (Burke) v GMC* [2005] EWCA 1003, [31].

may be seen as having a continuing effect until a withdrawal is communicated. Given the professionals' role within the professional-patient relationship, this need for consent to be terminated by withdrawal underscores the professionals' duty to determine whether the patient is still consenting at the relevant time.

Consent as a Choice

In a limited sense consent is always associated with the choice of whether to give or withhold consent. In the present context, this equates to accepting or rejecting the proffered treatment. Some commentators go further and argue that consent also requires, where available, a range of treatment options.⁵⁷⁷ Austoker, for example, explicitly discussed consent as 'choice' and noted that: 'tension may exist between the aims of promoting effective forms of healthcare and promoting patient choice'.⁵⁷⁸ Caplan, while recognising the need to gain consent for specific procedures,⁵⁷⁹ argued that: 'competent patients must be given the opportunity to control the provision of medical care even if death or disability may result'.⁵⁸⁰

The push to extend the role of consent to protect positive autonomy is reflected in the development of 'informed consent' and arguments for 'shared decision-making'. Thus, the Emanuels noted the 'call for greater patient autonomy ... conceived as patient *choice* and *control* over medical decisions'.⁵⁸¹ In *Canterbury v Spence*, a leading US case on informed consent, Robinson CJ stated: 'True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably

⁵⁷⁷ *Op cit* n.412, 7-9.

⁵⁷⁸ Austoker, J. 'Gaining informed consent for screening' (1999) 319 *BMJ* 722. See also: Worthington, R. 'Clinical issues on consent: some philosophical concerns' (2002) 28 *Journal of Medical Ethics* 377, 378.

⁵⁷⁹ Caplan, A.L. 'Informed Consent and Provider-patient Relationships in Rehabilitation Medicine' (1988) 69 *Arch. Phys. Med. Rehabil.* 312, 316.

⁵⁸⁰ *Ibid.*

⁵⁸¹ Emanuel, E.J. Emanuel, L.L. 'Four Models of the Physician-Patient Relationship' (1992) 267 *JAMA* 2221, 2223.

the options available'.⁵⁸² And Stirrat and Gill suggested that: 'The term "informed choice" is often to be preferred over "informed consent"'.⁵⁸³ Although the move to enhancing patient choice recognises that the patient must still consent to the intervention agreed upon, by viewing consent as a process and arguing for shared decision-making, this 'consumer rights' approach seeks to make consent a weapon for positive autonomy.⁵⁸⁴ Thus, Charles *et al* noted that 'the principle of "informed choice" i.e. disclosure of treatment alternatives rather than merely informed consent has been endorsed at several government levels in Canada and the United States'.⁵⁸⁵ For Capron: 'An analysis of informed consent that goes beyond the legal formulae themselves must inquire into the functions served by the doctrine, not in bringing about "better" results but in promoting choices made by persons for themselves and for which they can take responsibility'.⁵⁸⁶ Thus, 'The thrust of informed consent ... is to make the patient ... an active and informed participant in the decisions which must be made'.⁵⁸⁷

It might be argued that consent merely requires information about alternative options rather than that those options are made available. However, if an option is not available then knowledge about it is irrelevant to consent. In order to give valid consent patients must appreciate the implications of their decision. This includes understanding that by consenting to treatment A they will be excluding non-treatment and alternative treatment options. However, if treatment C is unavailable they will not be excluding the implications of C by consenting to A. Thus, it would be nonsensical to require they be informed about treatment C. It is not consent, at least as a waiver, but the professional's

⁵⁸² *Canterbury v Spence* 464 F2d 772, 780 (1972).

⁵⁸³ *Op cit* n.301, 129.

⁵⁸⁴ Charles, C. Gafni, A. Whelan, T. 'Shared Decision-Making in the Medical Encounter: What Does it Mean? (Or it Takes at Least Two to Tango)' (1997) 44 *Social Science and Medicine* 681, 681-682. The more recent push for shared decision-making aims to make the patient a 'responsible partner', and so blunt the earlier consumerist approach (see above).

⁵⁸⁵ *Ibid.*

⁵⁸⁶ Capron, A.M. 'Informed Consent in Catastrophic Disease Research and Treatment' (1974) 123 *University of Pennsylvania Law Review* 340, 349.

⁵⁸⁷ *Ibid.*, 353.

duty of care that drives the treatment options on offer.⁵⁸⁸ The power to determine the treatments that should be offered, while constrained by the patient's consent, lies with the professional.⁵⁸⁹

It appears that consent is unable, without a significant reconceptualisation, to require options other than the right to say "yes" or "no" to an intervention on offer. Consent in this context is permissive and the patient's consent carries no power to oblige professionals in any way.⁵⁹⁰ However, there are two arguments that suggest this view of consent is too narrow. First, if patients' right to withhold consent acts as a veto then treatments refused cease to be options. Professionals still owe a duty to act in their patients' best interests and if a treatment exists that would be better than none at all then they must either offer that alternative or refer the patient to a colleague. In this way, even if HCPs are unwilling to offer a treatment option, their patients' right to withhold consent may oblige them to offer it.⁵⁹¹ As such, it is perhaps preferable, at least from an autonomy perspective, to make patients aware of the options even before any refusal. While professionals arguably should advise their patients as to their preferred choice the patients would then be in a position to weigh up the pros and cons of all beneficial treatment options.

The second argument arises from the sense of consent as an agreement. While an agreement *per se* cannot force either party to do something they are unwilling to offer up for agreement, it is also arguable that any reasonable conception of a negotiation requires more than simply a 'take it or leave it choice'. If consent is to operate in this way then professionals' obligations and their own right of consent (in the sense of creating

⁵⁸⁸ *Op cit* n.576, [32].

⁵⁸⁹ Habiba, M.W. 'Examining consent within the patient-doctor relationship' (2000) 26 *Journal of Medical Ethics* 183, 185.

⁵⁹⁰ Doyal, L. 'Good clinical practice and informed consent are inseparable' (2002) 87(2) *Heart*, 103.

⁵⁹¹ It should be noted that this is driven by the patient's right to sue in negligence rather than any claim right to a particular treatment (see below).

obligations rather than in the sense of a waiver) must be considered.⁵⁹² However, the concept of negotiation still requires that there are options to negotiate. Thus, it is arguable that consent requires more choice than a simple acceptance or refusal of a single treatment option.

Although consent as a waiver can, if the offered treatment is refused, require alternative treatments to be offered, the case for disclosure of alternatives is strengthened if consent is also approached in the sense of an agreement. The argument for consent as choice is suggestive of the type of negotiated consent seen in contractual negotiations where the consent is mutual and establishes bilateral obligations. Since consent as a waiver is necessary to justify medical treatment, consent as a choice appears to be a hybrid of its two senses; agreement and permission.

Consent and Non-treatment

Following from this is the suggestion that consent should also be necessary for non-treatment decisions. Biegler, for example, argued that, if consent is predicated on respect for autonomy and autonomy has positive as well as negative aspects then patients would 'be justified in requesting treatments that are in their best interests'.⁵⁹³ He discussed this in the context of 'do not resuscitate' orders and concluded that 'consent ought to be required to withhold treatment that is in a patient's best interests to receive'.⁵⁹⁴ It appears that he was arguing for a claim right to those treatments that are in the patient's best interests and that the patient's consent is necessary to waive that right and permit the professional to withhold it. The difficulty with this is that it has implications for resource allocation and for professional autonomy. Furthermore, it should be noted that consent does not do the initial work here: to make consent relevant an initial right must exist that

⁵⁹² This is exactly what negligence law does in requiring disclosure of alternatives (see chapter five).

⁵⁹³ Biegler, P. 'Should patient consent be required to write a do not resuscitate order?' (2003) 29 *Journal of Medical Ethics* 359, 360.

⁵⁹⁴ *Ibid.*, 363.

may then be waived. Thus, before consent becomes relevant the claim right to particular treatments must be justified on grounds of distributive justice.

A second way in which consent may be relevant here engages the other sense of consent. Where there is no pre-existing right to treatment then, because non-treatment does not breach the patient's bodily integrity, consent_p is irrelevant. The duty to treat is regulated by the law of negligence and, providing HCPs act reasonably, they will fulfil their obligation and avoid liability. The professional's duty in negligence does not create a consequential right to treatment: the associated right is the right to sue for damages. However, Article 8, Schedule 1 of the Human Rights Act 1998 allows the right to a private and family life, which subsumes autonomy and, as far as the family is concerned, has allowed that parents have a right to be involved in decisions about their children even where they have been taken into care.⁵⁹⁵ This suggests, by analogy, that patients should be involved in decisions concerning non-treatment, and consent_A, rather than consent_p, might be an appropriate mechanism for regulating this involvement. At the very least, patients may be able to claim a right to know that such a decision has been made even if they have no claim right to require treatment.⁵⁹⁶ In this context, consent can only be relevant in the sense of an agreement because the primary right of bodily integrity is not engaged by a decision not to treat.

Using consent in the context of non-treatment raises certain issues regarding the consequences of patients refusing to give their consent to the withholding of treatment but this is not the place to discuss those issues. Strictly speaking this thesis is concerned with consent to medical treatment, which - if narrowly interpreted - does not include non-treatment decisions. However, deciding not to provide a particular treatment, or any treatment at all is an important aspect of medical decision-making and arguably involves

⁵⁹⁵ *W v UK* (1988) 10 EHRR 29, 50.

⁵⁹⁶ Feldman, D. *Civil Liberties and Human Rights in England and Wales* (2nd ed., 2002) Oxford: Oxford University Press, 515.

consent_A even if it does not engage consent_P. Because of this relationship between treatment and non-treatment decisions, both of which engage the patient's autonomy, it may be worthwhile considering the legal regulation of non-treatment decisions at the same time as I consider consent to treatment. This would acknowledge the sibling relationship between the two types of consent, which might then be categorised under a more general heading of consent to a medical management plan.

Consent and Shared Decision-Making

Beauchamp and Childress note that: 'Some commentators attempt to reduce the idea of informed consent to shared decision-making between doctor and patient, so that informed consent and mutual decision-making are synonymous'.⁵⁹⁷ Meisel and Kuczewski, for example, argue: 'Conceived as a process of shared decision making, informed consent can accommodate both patient autonomy and the physician's responsibility for the well-being of the patient'.⁵⁹⁸ Beauchamp and Childress dismiss shared decision-making as 'worthy ideal in medicine' but one that 'neither defines nor displaces informed consent'.⁵⁹⁹ This argument is valid but perhaps misleading as to the role of shared decision-making.

For many commentators, shared decision-making is not so much an alternative model but a way of achieving a more meaningful consent.⁶⁰⁰ In this sense, the patient's consent is still necessary but, instead of disclosing the relevant information and abandoning patients

⁵⁹⁷ *Op cit* n.51, 77.

⁵⁹⁸ *Op cit* n.526, 2522; Giesen, D. 'From Paternalism to Self-Determination to Shared Decision Making in the Field of Medical Law and Ethics', in: Westerhall, L. Phillips, C (eds.) *Patient's Rights – Informed consent, access and equality* (1994) Stockholm: Nerenius & Santerus Publishers 19, 37.

⁵⁹⁹ *Op cit* n.51, 78.

⁶⁰⁰ Gutheil, T.G. Bursztajn, H. Brodsky, A. 'Malpractice prevention through the sharing of uncertainty: Informed consent and the therapeutic alliance' (1984) 311 *New England Journal of Medicine* 49, 50; Brody, D.S. 'The Patient's Role in Clinical Decision Making' (1980) 93 *Annals of Internal Medicine* 718; Teff, H. *Reasonable Care* (1994) Oxford: Clarendon Press, particularly chapter 3; *Op cit* n.584; Marta, J. 'Whose Consent is it anyway? A Poststructuralist Framing of the Person in Medical Decision-making' (1998) 19 *Theoretical Medicine and Bioethics* 353, 354; Katz, J. *The Silent World of Doctor and Patient* (1984, 2002) Baltimore: John Hopkins University Press.

to their decisions, professionals work through them with their patients.⁶⁰¹ Once they arrive at a mutually acceptable treatment option the patient's state of mind will be one of consent and the professional should be aware of this. Once the procedural requirements of consent are satisfied, the intervention would be morally and legally justified. This view of shared decision-making reflects the relevance of the professional-patient relationship explored in chapter three.

The U.S. President's Commission saw shared decision-making as an ethical ideal:⁶⁰²

the patient and physician will arrive at a joint decision in which the physician agrees to care for the patient and the patient agrees to be treated ... The resiliency of the relationship will depend importantly on the extent of trust and confidence exchanged between patient and professional.⁶⁰³

This does not, however, mean that this vision was meant to replace the law's doctrine of informed consent. Rather, it was to supplement the physician's legal obligation. The Commission's approach also included the idea of patient choice, although a choice constrained by accepted medical values and others' claims on scarce resources. This reinforces the suggestion above that consent is seen as a hybrid involving both consent_A and consent_P. It is, however, important to recognise that the consent_P is essential while consent_A is desirable but, because it is fundamentally dependent on the political questions of clinical autonomy and distributive justice, it is perhaps better treated as a possible attribute rather than a central part of the theory. This is particularly so since some

⁶⁰¹ See: Bridson, J. Hammond, C. Leach, A. Hester, M.R. 'Making consent patient centred' (2003) 27 *British Medical Journal* 1159.

⁶⁰² President's Commission. *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, volume 1* (1982) Washington (DC), 6.

⁶⁰³ *Ibid.*, 37.

decisions are so clinically certain and of relatively low importance to the patient that there may be little need or desire for negotiation.⁶⁰⁴

Consent and Refusal: Two Sides of the Same Coin?

It is reasonable to suggest that the right to give consent necessarily implies the right to refuse consent. Since 'right' carries with it the idea of 'control' there can be no right where the individual (or lawful proxy) has no control. If one has no option but to exercise the 'right' then that option is not really a right but a duty. This argument explains why consent as a waiver of a primary right even exists. However, the very justification for consent also defines its limitations. Although refusal of consent is the opposite side of the same coin, this does not mean that a refusal of consent is sufficient to prohibit a breach of bodily integrity.

When A gives B consent to perform an intervention A waives his or her right to bodily integrity. This means that the subsequent intervention is not a breach of bodily integrity. If B intervenes without A's consent then B will be breaching A's right to bodily integrity. However, unless a right is absolute, consent will not be the only justification for performing the intervention. For example, imagine that A has a highly contagious disease that threatens the health of other members of the community. Although it would be respectful of the individual to seek consent to intervene to isolate and treat A, it may still be justified – because of the risk of harm to others – to intervene even if A refuses to give consent. In this case the justification comes from the rights of the other members of the community. If the intervention is non-consensual then A's right to bodily integrity has been breached, but it is a justified breach. Some authors would say that his right has been infringed but not violated.⁶⁰⁵

⁶⁰⁴ Whitney, S. 'A New Model of Medical Decisions: Exploring the Limits of Shared Decision Making' (2003) 23 *Medical Decision Making* 275.

⁶⁰⁵ *Op cit* n.51, 358.

What this means is that there will be occasions when, despite a refusal (or lack) of consent, an intervention will be legitimate even though it breaches the primary right of bodily integrity. This argument perhaps provides some insight into Lord Donaldson MR's judgments in *Re R* and *Re W*.⁶⁰⁶ In *Re R*, Lord Donaldson MR adopted the analogy of a key-holder to explain that even where a child is capable of giving consent their refusal may be overridden by someone with parental responsibility. The relevance of my argument here is that, providing the law allows two or more individuals the right of consent, then a refusal of either of those parties will be insufficient to prohibit the intervention. This does not claim that the law is right in allowing two parties the right of consent, merely that unless a right is absolute, the individual's refusal to give consent is insufficient as a veto.⁶⁰⁷

Interestingly, in *Re W*, Lord Donaldson withdrew his key-holder analogy and replaced it with one involving flak jackets.⁶⁰⁸ In one way, this is unfortunate since the key-holder analogy fits better with the concept of consent as a waiver of a right. However, it could be argued that the key-holder analogy tallies with the child's right to consent while the parents' right to consent has a different justification and is better represented by the flak jacket analogy. If the right to bodily integrity truly belongs to the child then the parents cannot legitimately waive that right. While the child is incompetent to consent, some other means of justifying necessary interventions is required. This comes from allowing the parents the power to determine whether or not a particular intervention is a justifiable breach of the child's bodily integrity. Legally, this has two parts. The first is to agree that the intervention is necessary, the second is to waive the right to complain about the intervention and it is only by virtue of this latter part that the permission to intervene is

⁶⁰⁶ *Re R (A minor) (Wardship: Consent to Treatment)* [1992] Fam 11, CA; *Re W (A Minor) (Consent to Medical Treatment)* [1993] 1 FLR 1, CA.

⁶⁰⁷ It could be argued that parental consent merely prevents the intervention from being a violation of the child's right to bodily integrity but, without the child's consent, the intervention remains a breach (or infringement) – albeit justified – of that right.

⁶⁰⁸ *Re W (A Minor) (Consent to Medical Treatment)* [1993] 1 FLR 1, 9.

legitimately called 'consent'. The consent, however, is not a waiver of the right to bodily integrity but a waiver of the right to sue. As such, it may still persist even when the child is competent to consent to the intervention itself. In this way, the child's consent is like a key while the parent's consent is more like the flak jacket.⁶⁰⁹

Some commentators have argued that competence to consent should be assessed on the basis of the risk posed by the intervention.⁶¹⁰ This would allow that someone might be competent to consent to a procedure, but not competent to refuse consent. I have argued elsewhere that competency should be based on the complexity rather than the risk of the decision and that the relevance of risk lies in ensuring that the competency assessment reaches the correct conclusion.⁶¹¹ This is not the place to reiterate the arguments in favour of that conclusion. It is, however, worth noting that if my argument here about the nature of consent is correct then the decision to give or withhold consent is a single decision. Refusal of consent may not be divorced from the giving of consent since the decision not to give consent is equivalent to a refusal of consent.

Some of the difficulties over consent perhaps arise because it is easy to forget that the individual's consent is only one of the possible justifications for performing an intervention. For example, Harris asserted that: 'The idea that a child (or anyone) might competently consent to a treatment but not be competent to refuse it is palpable nonsense'.⁶¹² This statement is only true if he means refusal of consent rather than refusal of treatment. A refusal of consent only means that the individual's right to bodily integrity has not been waived. This does not mean that it may not legitimately be

⁶⁰⁹ This argument is entirely a legal argument and would not preclude criticism of this position on moral grounds.

⁶¹⁰ See e.g. Brock, D.W. 'Decisionmaking, competence and risk' (1991) 5 *Bioethics* 105; Wilks, I. 'Asymmetrical competence' (1999) 13 *Bioethics* 154.

⁶¹¹ Maclean, A. 'Now You See It, Now You Don't: Consent And The legal Protection Of Autonomy' (2000) 17(3) *Journal of Applied Philosophy* 277, 281-287. See also: Wicclair, M.R. 'The continuing debate over risk-related standards of competence' (1999) 13 *Bioethics* 149.

⁶¹² Harris, J. 'Consent and end of life decisions' (2003) 29 *JME* 10.

infringed provided a suitable justification can be found. A justifiable breach is not a violation of the individual's right. However, the breach must be justified if it is to be a legitimate act.

Consent, Power and Control

There can be little doubt that consent is concerned with issues of power and control.⁶¹³

The language used when discussing consent and the factors that invalidate it reflect the tussle between the parties for control of the relationship. Both a lack of knowledge and undue influence – whether coercive or not – are capable of shifting the balance of power. Similarly, the language of rights, the protection that rights afford against exploitation, and the enforcement of those rights by the law all indicate the relevance of power and control.⁶¹⁴ Thus, consent, predicated as it is on the right to self-determination (or autonomy), demands that the decision to give or withhold consent is voluntary. As Strong noted:

The state may have granted doctors a monopoly of practice in certain respects but it has given them almost no legal powers to constrain their patients' behaviour. It may be up to the doctor to decide whether or not patients should receive treatment, but the latter typically reserve the right to decide both whether to seek it in the first place and, if offered it, whether or not to accept.⁶¹⁵

The importance of consent lies in allowing individuals to control particular aspects of their life. It is necessary precisely because without the protection of consent and the underlying right individuals will lack control in all relationships in which they are the

⁶¹³ Montgomery, J. 'The Role of Law in Raising Standards of Consent', in: Alderson, P (ed.) *Consent to Health Treatment and Research: Differing Perspectives* (1994) London: The Social Science Research Unit 35.

⁶¹⁴ Foucault, M. 'Two Lectures', in: Gordon, C. (ed.) *Power/knowledge* (1980) Brighton: The Harvester Press 78, 93.

⁶¹⁵ Strong, P.M. 'Sociological Imperialism and the Profession of Medicine: A Critical Examination of the Thesis of Medical Imperialism' (1979) *13A Social Science and Medicine* 199, 210.

subordinate party. This is particularly important in the healthcare setting. There are a number of reasons why professionals occupy the dominant position; their social position; their superior knowledge; their control over access to healthcare; the patient's illness⁶¹⁶ and the fact that the patient has come to them for help.⁶¹⁷ Apart from the deontological justification for consent, it has been shown that a sense of control has valuable and sustainable benefits for the individual's health.⁶¹⁸ What consent does in this context is not to neutralise the power imbalance but to legitimise it.⁶¹⁹ Ensuring that patients have the ultimate control over their own body, consent prevents the professional's authority from being exercised in an authoritarian fashion.⁶²⁰ It is precisely because the power imbalance is unavoidable that consent is necessary.

Despite the power that consent gives to the patient, it is important to realise that this does not emasculate the professional who remains the dominant 'partner'. This is not, however, a bad thing. Power is not simply repressive and the power professionals possess is what enables them to help their patients.⁶²¹ This power allows professionals to discover things about their patients that they would not otherwise be allowed to know, it allows them to advise their patients and it allows them to heal their patients.⁶²² Without it professionals would become simply a dispenser of tablets or a technician. This power, however, must be exercised fairly and responsibly if it is to remain legitimate.

⁶¹⁶ Seeman, M. Seeman, T.E. 'Health Behavior and Personal Autonomy: A Longitudinal Study of the Sense of Control in Illness' (1983) 24 *Journal of Health and Social Behavior* 144.

⁶¹⁷ *Op cit* n.342, 16-17; Haug, M. R. Lavin, B. 'Practitioner or Patient – Who's in Charge?' (1981) 22 *Journal of Health and Social Behavior* 212.

⁶¹⁸ *Op cit* n.616.

⁶¹⁹ Withholding consent in the absence of any other justification for acting will, however, neutralize the actor's power.

⁶²⁰ For the distinction between authority and authoritarianism see: Haug, M. R. Lavin, B. *Op cit* n.617, 214.

⁶²¹ Foucault, M. 'Body/Power' in: Gordon, C. (ed.) *Power/knowledge* (1980) Brighton: The Harvester Press 55, 59.

⁶²² As Brody argues, 'the physician has the power to improve the patient's health status to the extent that she can alter the meaning that the patient attributes to the illness in a positive way': *Op cit* n.342, 133.

Even within the context of information disclosure, while consent may go some way to reducing its authoritarian potential, it is unable to negate completely the potential for repression inherent in power. This is not to argue that power is itself repressive, but simply to recognise that it may be exercised repressively. For example, the way in which professionals present the information and advice to their patients will affect the 'truth' that the patient accepts. While it may be argued that this manipulation would invalidate consent in a moral sense, it may not be susceptible to legal regulation. In practice, then, professionals may manipulate the timing and presentation of information in such a way as to gain the patient's agreement, which currently the law would deem sufficient for consent. Similarly, exercising power repressively during the consultation may affect the ability of patients truly to engage in the decision-making process and any 'consent' would simply involve an acceptance of the professional's advice. Interrupting patients and ignoring questions, whether or not done consciously, may all reduce patients' ability to exercise their autonomous power.⁶²³ This is important because the realisation that formalised rules of consent may be unable to prevent an unethical exercise of power highlights the need for professionals to be sensitive to an appropriate ethical framework.

This discussion suggests another value to be included under the Effects attribute:
[consent has the effect of] legitimising a beneficent exercise of the professional's power.

The Pre-requisites for Consent

Consent, Information, Knowledge and Risk

It is frequently claimed that for consent to be valid it must be 'informed'.⁶²⁴ The purpose of providing information is to help individuals to gain the knowledge necessary to allow

⁶²³ Ainsworth-Vaughan, N. *Claiming Power in Doctor-Patient Talk*. (1998) New York: Oxford University Press, 51.

⁶²⁴ See e.g. Brock, D.W. *Op cit* n.200, 36; Winick, B.J. 'Competency to Consent to Treatment: The distinction between assent and objection', in: Wexler, D.B. Winick B.J. (eds) *Essays in Therapeutic Jurisprudence* (1991) Durham (NC): Carolina Academic Press, 41; Kennedy, I. 'The Law and Ethics of Informed Consent and Randomized Controlled Trial', in: *Treat Me Right* (1988) Oxford: Clarendon Press, 213; *Op cit* n.40, 113.

them to consent to the proposed intervention.⁶²⁵ It is certainly trite that in order to consent individuals must know something. At the very least they must know that their consent is required. If they must know this, then since consent is a propositional attitude (i.e. consent is not an abstract state of mind but always exists in relation to something),⁶²⁶ they must also know that there is something for which their consent is required. This much is entailed by the knowledge that consent is required. The question is whether consent requires more than that B knows that A wishes to do something requiring B's consent?

The crucial question, and one that may not be answerable definitively, is what must the patient know in order to consent to procedure X rather than to some inadequate conception X*? As a general starting point it is submitted that patients have no need to know about the mechanics of the procedure.⁶²⁷ If knowledge is seen as an ability to utilise the information possessed then knowing about the mechanics is only necessary if one is required to perform the procedure.⁶²⁸ For example, it is completely unnecessary for patients to know that a purse string suture is employed to close the defect left when an appendix is excised. It may even be counter-productive as it might confuse patients or deflect their attention from more important information.⁶²⁹ A second piece of information that could be safely omitted is details of the scientific evidence in support of the procedure. While patients may need to know that research has shown procedure X to be more effective than procedure Y, they would not need to know how the studies showed this to be the case.

⁶²⁵ Although the meaning of knowledge is contested, for the purposes of this thesis I will accept Hyman's definition: 'personal propositional knowledge is the ability to act, to refrain from acting, to believe, desire or doubt for reasons that are facts'; Hyman, J. 'How Knowledge Works' (1999) 49 *The Philosophical Quarterly* 433, 451.

⁶²⁶ *Op cit* n.32, 43.

⁶²⁷ *Op cit* n.362, 76.

⁶²⁸ It would also be required if one was called upon to explain the mechanics of the procedure to someone else, i.e. in an exam.

⁶²⁹ See n.339

At this point it is tentatively suggested that patients need to have sufficient knowledge to *distinguish X from the alternatives in terms of the risks and effects of the procedure*. At the very least this requires patients to be able to distinguish the implications of procedure X from the implications of no treatment at all. However, as I have already discussed,⁶³⁰ for consent - both as a waiver and as an agreement - the professional may be obliged to disclose alternative options and patients should therefore be able to appreciate the implications of accepting treatment X rather than treatment Y.

When discussing the information disclosure aspect of consent, attention is often focused on the risks. This is understandable since, from a legal perspective, issues of consent often arise in relation to the harm caused by an undisclosed risk materialising. While risk is crucial to the consent decision, it is important not to ignore the relevance of other types of information. As suggested above, if patients are to consent to a procedure they must know the implications of their decision, which requires knowledge of the alternatives on offer. The reason for this may be explained as follows:

Premise (P) 1: If I am to consent to X, I must know the implications, P, of consenting to X.

P 2: If I consent to X this may exclude (or at least affect the implications of) the alternatives to X.⁶³¹

⁶³⁰ See earlier discussion, at n.588ff.

⁶³¹ If I consent to X I am excluding *not-X*. For other options, at the very least my decision will make those options unavailable at that time and may have implications for the future use of those options. For example, consider patients with an injured spleen. Assuming – for the sake of argument - they are sufficiently competent to consent then their options may be ‘wrapping’ or ‘removal’ of the spleen. If they choose ‘removal’ then ‘wrapping’ is permanently excluded and the implications include permanent loss of splenic function. If they choose ‘wrapping’ this may fail to halt the bleeding and they may require further surgery and more blood transfusion. Although they retain the option of ‘removal’ this will be at a later time and will require a second operation.

Conclusion 1/P 3: Since consenting to *X* excludes other alternatives, I cannot know *P* unless I know the implications of not consenting to the alternatives.

P 4: The implications of the alternatives to *X* are *not-X* (i.e. no treatment) and *Z*, where *Z* represents the implications of all other available treatments.

Conclusion 2: Therefore, to consent to *X*, I must know *that P*, *that Z* and that *not-X*.

What is perhaps surprising about this argument is that, in order to consent to *X*, I do not need to know *that X*. In other words, I do not need to know the procedure in order to consent to it. If accepted, this conclusion would explain the fallacy of arguing that ‘informed consent’ cannot be achieved by laypersons because they lack medical training and so cannot possibly understand complex procedures. Instead, what is required is knowledge of the implications of the procedure.

A final point is whether patients are obliged to receive the information in order to give a valid consent. In other words, is the professional’s duty predicated on an alienable right possessed by the patient? This waiver of the right to information is distinct from the question of whether patients may waive the right to consent.⁶³² Unfortunately the distinction is not always maintained. For example, Wear stated:

The least troublesome exception [to disclosure] would seem to occur when the patient voluntarily gives up his right to an informed consent.

Various reasons may lie behind such an action, including that the patient does not want to be upset by hearing the gory details, or he

⁶³² I will consider this latter question in more detail later.

feels incapable of making decisions and would prefer that his doctor decide.⁶³³

The problem with this is it concatenates the right to information with the right to consent. The two are distinct, although a valid consent requires that the patient's right to information has not been unjustifiably breached. As with other rights, the right to information may be waived, since, without the power to waive the right becomes an obligation and, as I will explain below, there is no reason why that should be the case in this context.

Providing patients are aware that they have a right to the information, and that by waiving the right they are accepting risks determined by the HCP, then it is reasonable for them to relinquish their right to information. It is reasonable to trust experts where they have a duty to act in one's interests and there is no reason to suspect that they will do otherwise. If autonomy is the basis for consent then, as Faulder stated: 'it is equally a denial of autonomy to force unwanted information on those who have clearly indicated ... that they do not want it'.⁶³⁴ As long as patients are aware of the implications of refusing information and it is reasonable for them to trust the HCP's advice then they are acting autonomously. To argue that autonomy requires that patients actually make the clinical decision itself, on the basis of a 'neutral' disclosure, prioritises that decision and constrains patients' autonomy by preventing them from making the alternative decision to rely on expert advice. Thus, patients may legitimately waive their right to information.

Consent and Voluntariness

The primary purpose of consent is normatively to transform the legitimacy of an act. Following from this transformation, consent also protects the actor against complaint and

⁶³³ Wear, S. *Informed Consent: Patient Autonomy and Clinician Beneficence Within Health Care*, (2nd ed., 1998) Washington D.C.: Georgetown University Press, 23.

⁶³⁴ Faulder, C. *Whose Body Is It? The Troubling Issue of Informed Consent* (1985) London: Virago, 25.

justifies including the consentor in the allocation of outcome responsibility. All of these roles rely on the relationship between autonomy, control and responsibility. Autonomy is concerned with the idea of moral agency; that we should be free to make our own decisions and to take responsibility for the ensuing consequences.⁶³⁵ Thus, if consent is to act as a permission that alters the legitimacy of an act then it must be wilfully and freely given.⁶³⁶ As Hermeren noted: '[being] ... a moral agent, according to this ideal ... means to choose and act freely'.⁶³⁷ Without the freedom to give or withhold consent that consent loses its moral (and legal) force and is reduced to being a normatively meaningless assent that lacks the power to legitimise the act.⁶³⁸

Two possible strategies exist for coping with the interaction between consent and voluntariness. First, voluntariness could be seen simply as essential to the normative force of consent. This would mean that an involuntary consent would still be consent but it would not have the power to legitimise the intervention. This is perhaps the way in which the courts have traditionally handled consent since judges usually talk of consent being 'vitiating' rather than defeated *ab initio*. The second strategy would be to argue that a lack of voluntariness means that the given permission is not, in fact, 'consent'. This second manoeuvre would further develop consent as a 'term of art' and distance it from its everyday use. Which of these strategies is chosen is, to a large extent, a matter of personal preference. In both cases 'consent' loses its normative and legal force and the consequences may be broadly similar. Because the second strategy has the advantage of simplicity and clarity, it is the approach I will adopt.

⁶³⁵ For more discussion of autonomy and agency see chapter two.

⁶³⁶ McGregor, J. 'Force, consent, and the reasonable woman', in: Coleman, J.L. Buchanan, A. (eds.) *In harm's way: Essays in honor of Joel Feinberg* (1994) New York: Cambridge University Press 231, 242.

⁶³⁷ Hermeren, G. *Op cit* n.298, 45.

⁶³⁸ Similarly, if responsibility for outcome travels with consent then a lack of voluntariness will affect the balance of responsibility attributed to the consentor and consentee. See: Kernohan, A. 'Social Power and Human Agency' (1989) 86 *The Journal of Philosophy* 712.

It is, of course, important to determine exactly what is meant by ‘voluntariness’. All of us are subject to both internal and external constraints that affect our choices and none of us makes choices in a vacuum. We live in a network of relationships all of which enmesh us in mutual obligations and expectations. It is arguable that these obligations and expectations ought to be considered when making our decisions and as such should be considered the background conditions of freedom, which emphasises the importance of contextualising consent within the professional-patient relationship (see chapter three). On top of this, our decisions may be subject to more direct and immediate pressures. It is these influences that may affect the voluntariness of our choices. The difficulty lies in distinguishing between legitimate background constraints and the illegitimate pressures that undermine the normative force of consent.

Consent and Competence

Competence is relevant whether consent is conceived of as a mental state or a signatory act of communication. It is relevant because consent always requires an active input. Clearly, persons unable to perform the necessary act – either the formation of a particular mental state or the requisite communicative behaviour (or both) – are also unable to consent. The difficulty comes when individuals have some ability but it is deficient in some way. One problem arises because ability is a continuous variable while competency is biphasic – an individual is either competent or incompetent. One way around this is to adopt the approach taken by the law, which is to make competency task or decision specific.⁶³⁹ Another problem arises where someone is capable of making and communicating a decision but lacks the ability to make a rational autonomous one.

First, and most importantly in this context, overriding the decision of persons lacking the mental capacity for autonomy should be justified. One approach to this would be to argue

⁶³⁹ See, for example, the focus on individual decisions rather than global incompetence in: The Lord Chancellor, *Making Decisions: The Government's proposals for making decisions on behalf of mentally incapacitated adults* (1999) Cm 4465, Chapter 1.6.

that if consent is to act as a morally transformative permission then the consentor must be a moral agent. Moral agency requires the appropriate autonomous ability and where individuals lack that ability their consent cannot be permissive. Legal agency is similarly justified on the basis of when society believes that individuals should be held legally responsible for their actions. This is largely derivative on the idea of moral agency, as indicated by the law's emphasis on autonomy.⁶⁴⁰ Second, there is the problem of deciding the ability necessary to justify respect for that person's decision. I do not need to go into this here because it is sufficient for me to simply establish that competence is a pre-requisite for consent. This is achieved if it is accepted that for consent to be morally or legally transformative, agency is required.

Summary of the Nature, Attributes and Function of Consent

It is now possible to summarise a final definition of consent to medical treatment:⁶⁴¹

Consent Theory: A state of mind of the patient formed with the intention of permitting treatment suggested by the HCP.

Attribute A: Primary right

Value:

1. Bodily Integrity.⁶⁴²

Attribute B: Explicit or implicit communication between patient and HCP

Values:

⁶⁴⁰ See: Maclean, A. *Op cit* n.611. It should be noted that in some circumstances the law deems agency even if moral agency is in fact lacking (and vice versa). The idea of legal responsibility, however, is derivative on the idea of moral agency. It should also be noted that, for adults, agency, and hence competence, are presumed.

⁶⁴¹ I do not here include the sense of consent in the context of non-treatment, where consent is an agreement rather than a permission or waiver.

⁶⁴² Bodily integrity in this context is wider concept than the right protected by trespass as it includes any interference with the person's body whether it is direct or not.

1. The patient's attitude towards the proposed intervention.

Attribute C:

Effect

Values:

1. Alters obligations for:
 - a. The HCP, by removing the obligation of non-interference; and, if Attribute D, value 1 is present,
 - b. Both the patient and HCP by negotiation to establish new obligations of cooperation and treatment.
2. Justifies intervention or non-intervention through moral/legal transformation.
3. Legitimises a virtuous exercise of power.
4. Allows apportionment of outcome responsibility.

Attribute D:

Process

Values:

1. Shared decision-making/negotiation culminating in consent as an agreement.
2. Patient's decision.

Attribute E:

Time Course

Values:

1. Until withdrawn.
2. Until relevant circumstances change.

Prerequisites:

1. Competence.

2. Relevant knowledge
 - a. Disclosure
 - b. Understanding.
3. Voluntariness.

Conclusion

In this chapter I have explored the concept of consent and determined the underlying theory and important attributes. I argued that consent should be seen as a permissive state of mind that waives the right to bodily integrity. Once communicated to the actor the permission takes effect by justifying the intervention and legitimising the virtuous exercise of the doctor's power. I also suggested that consent as agreement, while not an essential part of the theory of consent, should be incorporated as an attribute. This reflects the context of the professional-patient relationship and allows patients the opportunity to negotiate treatment options prior to giving permission. Once the negotiation is complete it is arguable that patients and their professionals have entered into morally binding agreements that create obligations and expectations for both. I further noted the limits of consent in that a refusal of consent, while it may operate as a veto for certain treatment, is not the same as a refusal of treatment and other justifications may exist that normatively transform the act. Furthermore, although consent lacks the power to oblige performance of a particular act, in combination with the professional's duty to the patient it may be valid to utilise the concept of consent, particularly as agreement, when dealing with non-treatment decisions.⁶⁴³ This may be seen as a secondary function of consent, with the primary purpose – in this context – being the justification of an intervention. Finally, some acts remain forbidden, even in the presence of an otherwise valid consent.

⁶⁴³ *Op cit* n.593, 363.

Addendum

To close this first part of the thesis I will pull together the various strands of my argument to present a model of consent (Figure 2) to medical treatment that will form the basis for critiquing the current legal regulation. I have argued that consent should be contextualised within the professional-patient relationship that grounds it. The context of the relationship establishes the mutual obligations that give practical substance to the theory and moral justifications underlying consent.

Consent is the act of communicating the patient's mental attitude towards the HCP's proposal. It is predicated on the patient's personal autonomy but, since it is set in the context of the professional-patient relationship, it must also account for the professional's autonomy and his or her role responsibilities. This is achieved by incorporating consent_A into the model as an attribute (Figure 2). While, through consent_P, patients retain control of what happens to them, consent_A allows the professional to challenge apparently irrational decisions and to attempt to persuade the patient to change his or her mind and accept the professional's advice. The professionals' duties to the patient, of beneficence and respect for autonomy, mean that this power to persuade becomes an obligation. Furthermore, the patient's obligations, which arise from the relationship and are expressed through consent_A, require patients to respect the professional's role within the relationship. They should explain their decisions, listen to the professional and be open to persuasion. Similarly, the professional should also be open to persuasion that the patient's decision is appropriate. The relationship between the HCP and the patient justifies imposing positive obligations on the HCP to engage the patient in a mutual dialogue where each party is open to persuasion. This mutual participation is a crucial part of consent_A.

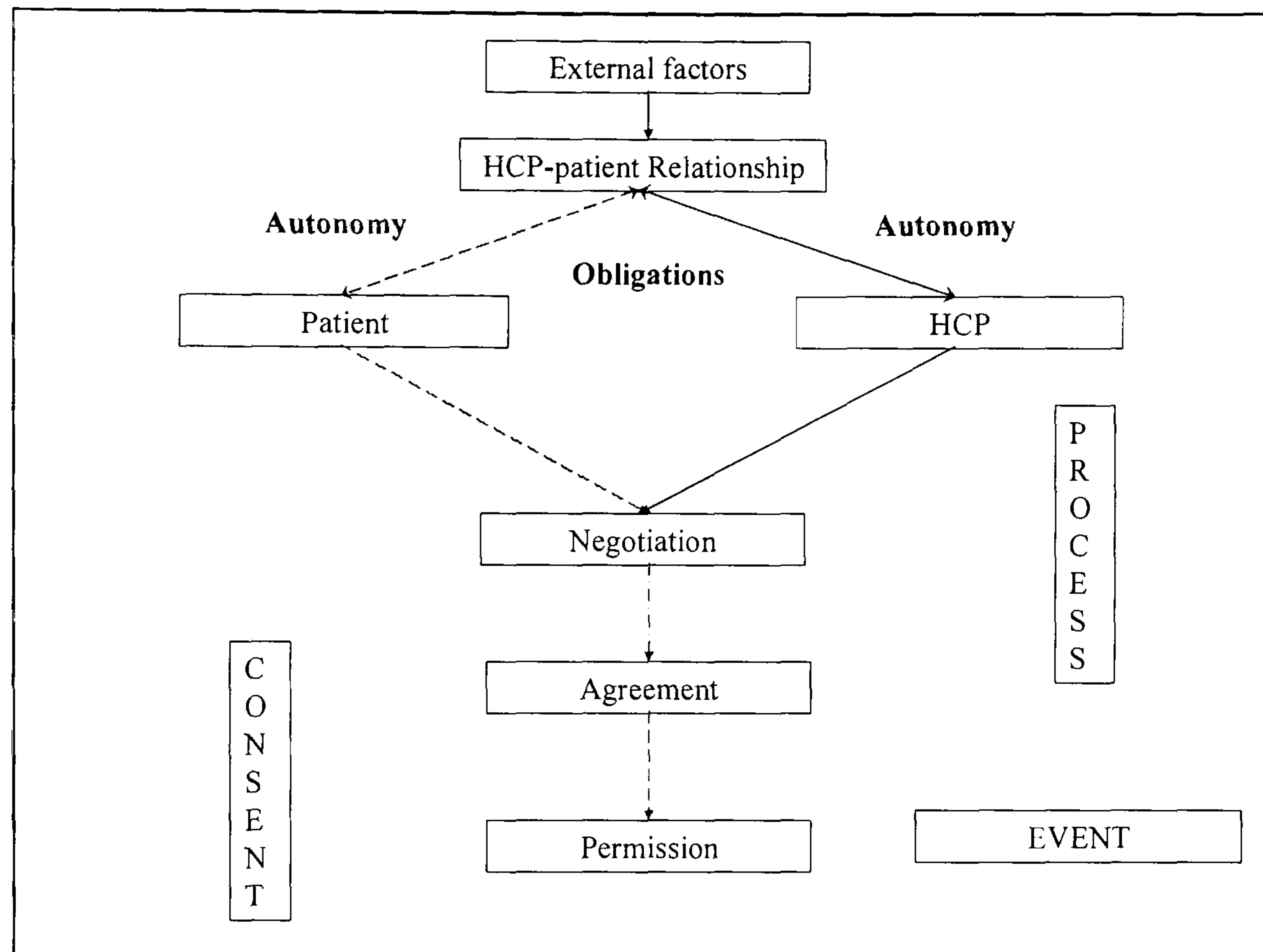


Figure 2: Model of Consent

Because consent is justified by autonomy, and is an expression of autonomy, the patient must be competent to make the decision. The patient should also be sufficiently well informed, which requires an understanding of the implications of the treatment chosen. The professional has a duty to facilitate patients' autonomy by supporting them throughout the decision-making process. The extent of the disclosure should be determined through negotiation with the patient having the right to waive information, or even to cede the treatment decision to the professional. However, where patients choose to waive their right to information, or to cede the treatment decision, the professional should ensure that they appreciate the implications of their choice. Any decision made by the patient, should be made, not in the absence of any influence (both the HCP and the patient's loved ones may be allowed to influence the patient), but in the absence of undue influence that attempts to control the patient's decision by unfairly exploiting the patient's weaknesses or vulnerability. A consent that satisfies these criteria is valid until

withdrawn by the patient, or until circumstances change so as to undermine the rationale for the decision.

Consent_p protects the patients' right to control the underlying primary right of bodily integrity, which may be communicated explicitly or implicitly. However, there is no room for presumed consent. Nor is there any need for consent_p to be obtained to non-intervention decisions. However, consent_A does require that patients be involved in any such decision, and that they are provided with the opportunity to influence the HCP's decision: even if patients lack the power to require a particular treatment, a respect for their autonomy requires that they be engaged in the process, are informed of the reasons for the decision, given an opportunity to disagree and are asked for their agreement. Although consent_p cannot independently drive the obligation to disclose alternative treatments to the professional's preferred option, when combined with the HCP's duty of care, disclosure of alternatives is required. This obligation is further justified by the inclusion of consent_A as an attribute.

Since not all medical interventions involve a direct infringement of bodily integrity, any regulatory model needs to account for those indirect interferences. These include treatments where the HCP prescribes and directs the treatment but it is the patient who performs the final act. For example, taking oral medication, applying topical creams and ointments or self-injecting (e.g diabetes). In all of these cases the HCP's agency is mediated through the patient. Although the patient acts intentionally, the HCP's involvement is a relevant causal factor. Given the imbalance of knowledge and power, and the reasonableness of relying on the expert's advice it is arguable that the HCP is causally responsible for the patient's act and that the patients are acting, in performing the final act of treatment, as the HCP's agents. Even if this argument is not accepted, these types of treatment may still be covered by consent_A, which I argued was an important attribute of consent to medical treatment. Thus, any regulation of consent should be able

to deal with treatment where the patient performs the final act. This ensures that consent protects the negative aspects of individual autonomy for both direct and indirect medical interventions.

Because of the importance of consent_A, the dialogical process that precedes consent_P should be accounted for in the regulation of consent to medical treatment (Figure 2).

Given the relational nature of any communication, the law should accept that both parties have responsibilities. For example, although the balance of power and knowledge lies with the professional, patients should be responsible for letting the professional know how much information is wanted, what their baseline understanding is and whether they are happy to give consent on the basis of the information disclosed. The professional should do what is reasonable to facilitate autonomous decision-making. This means that the standard of disclosure should not be based solely on what was disclosed but should take account of how the two parties have conducted the process of communication that culminated in the particular disclosure made.

The law must also deal with the consequences of an ineffective or absent consent. Perhaps the most serious failures are where the HCP has shown a complete lack of respect for both the welfare and the autonomy of the patient. This should be a rare occurrence but may nonetheless occur where an HCP coerces or deceives a patient in order to obtain consent to a procedure where the motivation was primarily to benefit the HCP (e.g. unnecessary work for personal gain). The complete failure to obtain consent is also a serious failing. Perhaps less serious are those cases where the consent has been obtained negligently, for example, by simply forgetting to disclose a relevant risk. Legal regulations should arguably acknowledge the differing degrees of infringement in the remedies available to the claimant.

Because autonomy is the moral basis for consent, whether the risk materialises or whether the patient would have made a different decision should be irrelevant to the question of liability. These factors, however, may affect the amount of any damages awarded. As I discussed earlier, liability for consent and outcome responsibility should be determined independently, although a valid consent would be needed to include the patient in the apportionment of responsibility. This, however, does not mean that patients can only be held responsible when a risk materialises if that risk has actually been disclosed. Where patients have agreed to consent knowing that certain risks have not been disclosed then there is no reason why they should not be held as responsible for the undisclosed risks as for those that have been disclosed.

Finally, the law must allow the competent patient's refusal of consent to act as an effective refusal of treatment unless to do so would directly harm others. While this protection should be extended to any decision, whether rational or not, the law should require that the HCP challenge any decision that does appear to be irrational and attempt to persuade the patient to change his or her mind. While the law should not force the patients to change their decisions, it should require the HCP to seek both reasons and explanations for the decision. If the patient is unwilling to engage with the HCP to provide these reasons and explanations, the law should allow the professional to transfer the patient's care to another HCP.

PART TWO: CONSENT AND THE LAW

In part one I provided an analysis of the concept of consent and considered the moral arguments justifying the role consent plays. The importance of this role is reflected by the degree of protection it attracts, so I turn now to consider the legal regulation of consent.

Consent to medical treatment, in an ethical sense, crosses two forms of civil legal action; battery and negligence. To avoid liability for battery professionals must obtain a 'real' consent from their patients. However, this does not end their duty and they must make further disclosure to avoid liability for negligence. In chapter five I will explore the legal regulation of consent. This exegesis will indicate some of the problems that beset the law, which will provide the material necessary for the comparison to be made in chapter six between legal practice and the theoretical model of consent developed in part one.

Chapter Five: The Legal Regulation of Consent

The courts repeatedly proclaim the value that the law gives to the individual's right to self-determination. In *S v McC; W v W*, Lord Reid stated: 'There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will ... The real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty'.⁶⁴⁴ Similarly, in *Nancy B v Hotel-Dieu De Quebec*, Dufour J quoted with approval the words of Professor Beaudoin (a justice of the Quebec Court of Appeal) who stated: 'For a competent person of the age of majority, the making of his own decisions with respect to his own body is the legal expression of the principle of personal autonomy and of the right to self-determination'.⁶⁴⁵ This right exists regardless of the consequences for the individual. Thus, in *Airedale NHS Trust v Bland*,⁶⁴⁶ Lord Keith stated; 'Even when his or her own life depends on receiving medical treatment an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination'.⁶⁴⁷ In *Re T (Adult: Refusal of Treatment)*, Lord Donaldson MR went so far as to proclaim: 'An adult patient who ... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered'.⁶⁴⁸

For the law to protect personal autonomy, it must prohibit an invasion of that right and provide for sanctions when a breach does occur. This protection is achieved by allowing individuals a personal sphere of control mediated by consent. Thus: 'Traditionally ...

⁶⁴⁴ *S v McC; W v W* [1972] AC 24, 43, HL.

⁶⁴⁵ *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385, 391 (Quebec Superior Court).

⁶⁴⁶ *Airedale NHS Trust v Bland* [1993] 1 All ER 821, HL.

⁶⁴⁷ *Ibid.*, 860 per Lord Keith.

⁶⁴⁸ *Op cit* n.510, 786. Lord Donaldson MR did consider that a woman's choice may be limited by the prospect of that choice resulting in the death of a viable fetus however it has since been held that this is not the case: *Op cit* n.55; *Op cit* n.531. See also *Re B (Consent to Treatment: Capacity)* [2002] EWHC 49.

[consent] is deemed to be a means of protecting the right to self determination which it is held all people have. In other words, rules about the provision of consent are a method of providing for the protection of the autonomy of the individual'.⁶⁴⁹ In this context, the personal sphere is the right to bodily integrity and a breach of consent renders the actor liable in tort law for a battery and in criminal law for at least a battery and possibly one of the more serious offences under the Offences Against the Person Act 1861.⁶⁵⁰ As Cardozo J famously stated: 'every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages'.⁶⁵¹

This right to refuse treatment follows from the legal protection that allows individuals to claim a right to bodily integrity. The most expansive protection of this right is found in tort, and my focus is on this branch of law. Within tort law, it is battery that provides the most obvious protection⁶⁵² and grounds the right to refuse treatment.⁶⁵³ As I suggested in part one, the idea of control is inherent in the concept of a right and that control is facilitated through consent. This protection of personal autonomy requires both the underlying right to bodily integrity, and the secondary right of consent. As such it is necessary to consider both the extent of the protection of bodily integrity and the nature of the control allowed by consent in the law of battery.⁶⁵⁴

⁶⁴⁹ McLean, S. Maher, G. *Medicine, Morals and the Law* (1983) Aldershot: Gower Publishing Co. Ltd, 79.

⁶⁵⁰ *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 882 per Lord Scarman, HL; *Op cit* n.646, 860 per Lord Keith. Law Commission Consultation Paper No. 135, *Consent in the Criminal Law* (1995).

⁶⁵¹ *Schloendorff v Society of New York Hospital* 211 N.Y. 125, 129 (1914).

⁶⁵² In *Collins v Wilcock* [1984] 1 WLR 1172, 1177, Goff LJ stated, 'The fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, may amount to a battery'.

⁶⁵³ *Re B*, *Op cit* n.648; *Op cit* n.646; *Op cit* n.510.

⁶⁵⁴ Seabourne, G. 'The Role of the Tort of Battery in Medical Law' (1995) 24 *Anglo-American Law Review* 265.

Battery

Trinidad stated that: ‘A battery is a direct act of the defendant which has the effect of causing contact with the body of the plaintiff without the latter’s consent. At the present time battery is usually brought only for intentional acts though actions for reckless or careless acts are not precluded’.⁶⁵⁵ In the context of deliberate medical interventions it is only the first part of this definition that is relevant. There are two elements to examine. First is the restriction to ‘direct act[s]’ that cause ‘contact with the body of the plaintiff’. The second is the meaning and limits of consent.

Despite the lack of clarity arising from *Collins v Wilcock*,⁶⁵⁶ in which Goff LJ stated that: ‘a battery is the actual infliction of unlawful force on another person’,⁶⁵⁷ directness is still required for contact to be battery.⁶⁵⁸ According to Blackstone J,⁶⁵⁹ the meaning of direct is ‘immediate’ – as opposed to consequential or ‘mediate’. However this is of little help. Surgical operations would certainly be direct, as would the physical contact required to examine the patient, take blood or give an injection. However, consider the situation in which a doctor writes a prescription for a patient who takes it to the pharmacy where it is filled out and then taken home before, some hours later, the patient ingests a tablet. Could this amount to a battery where an effective consent had not been obtained?⁶⁶⁰ It is submitted that this would almost certainly not be actionable as a battery. The connection between the doctor’s prescription and the non-consensual contact with the offending tablets is insufficiently direct. However, consider the same scenario except, instead of writing a prescription for the drug, the physician hands the patient a plastic cup containing the tablets, which the patient then ingests (alternatively, the doctor leaves the

⁶⁵⁵ Trinidad, F.A. ‘Intentional Torts: Some Thoughts on Assault and Battery’ (1982) 2 *Oxford Journal of legal Studies* 211, 216.

⁶⁵⁶ *Op cit* n.652.

⁶⁵⁷ *Ibid.*, 1177.

⁶⁵⁸ *Fowler v Lanning* [1959] 1 QB 426; *Letang v Cooper* [1965] 1 QB 232, CA.

⁶⁵⁹ *Scott v Shepherd* (1773) 2 W. Blackstone 892.

⁶⁶⁰ See: Seabourne, *Op cit* n.654, 270.

cup on the side and merely indicates to the patient that she should take the tablets). Is this sufficiently direct to constitute a battery?

In *Mink v University of Chicago*, a number of women were given diethylstilbestrol (DES) as part of a medical research programme.⁶⁶¹ The women were not told that they were part of an experiment, nor were they told that the pills - administered to them during their pre-natal care – were DES. The plaintiffs alleged, *inter alia*, that the defendants committed battery by experimenting on them without their consent. The administration of DES was alleged to be an ‘offensive invasion of their persons’. Grady, J acknowledged that most cases involving a lack of knowledge concerned the doctrine of ‘informed consent’, which should be bought in negligence. However, ‘The plaintiffs in this action are in a different position from patients who at least knew they were being given some form of drug ... [and] may bring a battery action grounded on the total lack of consent to DES drug treatment’.⁶⁶² In deciding that the defendants were liable for battery, Grady J stated:

We find the administration of a drug without the patient’s knowledge comports with the meaning of offensive contact. Had the drug been administered by means of a hypodermic needle, the element of physical contact would clearly be sufficient. We believe that causing the patient to physically ingest a pill is indistinguishable in principle.⁶⁶³

In the US, the American Restatement (Second) of Torts (1965) erased the need to show that, in battery, the force was direct. However it may be argued that Grady’s judgment should be equally applicable in this jurisdiction. Grady held that a non-consensual injection would be a sufficiently direct application of force to constitute a battery. It follows, that if ‘causing the patient to physically ingest a pill is indistinguishable in

⁶⁶¹ *Mink v University of Chicago* 460 F.Supp. 713 (1978).

⁶⁶² *Ibid.*, 717.

⁶⁶³ *Ibid.*, 718.

principle' then that action would also be a battery. It may also be feasible to draw an analogy between this situation and *Scott v Shepherd* in which the defendant threw a lighted firework into a crowded market place.⁶⁶⁴ The firework was thrown onwards by two of the stall-holders acting in self-preservation. It finally exploded in the plaintiff's face causing him to lose an eye. The act was held to be sufficiently direct because the intermediaries were not acting under the control of their own independent rational wills. The onward passage of the firework was considered to be a continuous chain of events set in motion by the defendant. In *Mink*, it could equally be argued that the women, by virtue of their lack of knowledge and power within the doctor-patient relationship, were not free to act controlled only by their own rational will. As such, it is arguable that the ingestion of the pill was simply another link in the chain initiated by the doctor.⁶⁶⁵

It is equally arguable that if *Mink* were heard in this jurisdiction it would have a different outcome. It may be significant that the drug was provided as part of a research programme rather than simply as therapy. Given judicial reluctance to find doctors liable for battery (see later), it is unlikely that, in a therapeutic context, English courts would accept Grady's argument that causing someone to ingest a tablet is equivalent in principle to injecting them with a hypodermic syringe.⁶⁶⁶ Although it is arguable that the women may be acting under undue influence and hence that they are akin to a passive instrument in the hands of the doctor, an English court may be more likely to argue that the act of ingesting was distinct from the doctor's act of providing her with the tablet and that the connection was an indirect one. Even if the court did adopt Grady's approach it is

⁶⁶⁴ *Op cit* n.659.

⁶⁶⁵ See the criminal law case of *Haystead v Chief Constable of Derbyshire* [2000] 3 All ER 890; [2000] 2 Cr. App. R. 339, in which it was held that it was sufficiently direct for the force to be applied through a 'medium controlled by the actions of the assailant'.

⁶⁶⁶ In one US jurisdiction that treats informed consent as an aspect of the law of battery, rather than negligence, the Supreme Court even held, contrary to Grady J's opinion, that a therapeutic injection was insufficiently invasive to constitute a battery: *Morgan v MacPhail* 704 A.2d 617 (1997).

extremely unlikely that it would be extended to include prescription drugs. Rather, the courts would probably hold that any liability would be in negligence rather than battery.

Consent and Battery

Consent justifies rather than excuses the contact consented to.⁶⁶⁷ Thus, in *Freeman v Home Office*, Sir John Donaldson MR stated: ‘consent ... deprives the act of its tortious character’,⁶⁶⁸ and in *Airedale NHS Trust v Bland*, Lord Mustill noted: ‘The reason why the consent of the patient is so important is not that it furnishes a defence in itself, but because it is usually essential to the propriety of medical treatment’.⁶⁶⁹ Consent functions as a justification because a lack of consent forms part of the offence.⁶⁷⁰ Thus, as McCowan J noted: ‘the burden of proving absence of consent is on the plaintiff’.⁶⁷¹ Although in criminal law consent does not justify contact causing actual bodily harm,⁶⁷² it is likely that it would be effective in civil law, which is concerned with a private complaint and the correction of a wrong rather than the more public concerns of criminal law. In any case, in the present context of consent to medical treatment, a valid consent is also completely effective in the criminal law.⁶⁷³

Although consent functions as a complete justification to medical treatment, it is not the only justification recognised by the law. Where treatment is required to prevent a risk of harm to others, treatment may be justified by the public interest in preventing that harm materialising. Most noticeably this arises in the public health context of communicable

⁶⁶⁷ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 73.

⁶⁶⁸ *Freeman v Home Office* [1984] 1 All ER 1036, 1044, CA.

⁶⁶⁹ *Op cit* n.646, 889, HL.

⁶⁷⁰ *Freeman v Home Office (No.2)* [1984] 1 QB 524, 539, HC. Although the case went to appeal, this point was not disputed: *Freeman v Home Office (No.2)* [1984] 1 QB 524, CA. That lack of consent forms part of the offence in English law was also noted by McHugh J in the Australian case *Department of Health & Community Services (NT) v JWB and SMB* (1992) 66 ALJR 300, 337.

⁶⁷¹ *Op cit* n.670, 539.

⁶⁷² See *R v Brown* [1993] 2 WLR 556, HL.

⁶⁷³ *Attorney General's Reference (No. 6 of 1980)* [1981] 1 QB 715, 719. Lord Lane CJ actually specified ‘reasonable surgical treatment’, but it is likely that anything accepted as legitimate medical practice would be justified by the patient’s consent.

diseases and where the patient poses a risk because of mental illness.⁶⁷⁴ It should also be noted that mental health law also allows non-consensual treatment of the competent person's mental health condition where there is a risk of self-harm.⁶⁷⁵ A general exception to the need for consent is where the defendant's contact 'is acceptable in the ordinary conduct of everyday life'.⁶⁷⁶ Finally treatment may also be justified by the doctrine of necessity, but only where the patient lacks the competence to give a valid consent.⁶⁷⁷

1. Competence

Although this thesis primarily concerns the competent adult, the relevant population cannot be defined without determining who is competent. Furthermore, if competency is decision-specific and related to the complexity of the decision, it is necessarily related to the informational element of consent: whether someone is competent should be determined by reference to the complexity of the information needed for a legally valid consent.⁶⁷⁸ Because of this relationship, a basic understanding of competence is relevant to the context of any discussion of consent. Finally, given the relationship between information and competence, how the law regulates these two issues is relevant to whether the law is coherent. For these reasons, I will consider how the law determines competency.

In *Re T*, Lord Donaldson MR stated: 'The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity, but it is a presumption that can be rebutted'.⁶⁷⁹ An early indication of the legal requirement is found in Cardozo J's classic statement, which referred to a 'sound mind'.⁶⁸⁰ Although vague, this appears to

⁶⁷⁴ Ss. 35-38 Public Health (Control of Disease) Act 1984 ; ss. 3(2)(c), 58, 62, 63 Mental Health Act 1983

⁶⁷⁵ Ss. 3(2)(c), 62 Mental Health Act 1983

⁶⁷⁶ *Op cit* n.667, 73 per Lord Goff.

⁶⁷⁷ *Op cit* n.667, 73-74 per Lord Goff. When the Mental Capacity Act 2005 comes into force in 2007, medical treatment may also be justified by proxy consent (s.9).

⁶⁷⁸ Maclean, A. *Op cit* n.611.

⁶⁷⁹ *Op cit* n.510, 796.

⁶⁸⁰ *Op cit* n.651, 129.

be a low level test, which suggests that those persons capable of making the decisions required in an ordinary adult life will be competent to make their own treatment decisions. In *Chatterton v Gerson*, Bristow J stated: ‘In my judgment once the patient is informed in broad terms of the nature of the procedure ... and gives her consent, that consent is real’.⁶⁸¹ Since there is little point in requiring the transfer of information if the information will not be understood, the law must, at least, require that the patient is capable of understanding ‘in broad terms the nature of the procedure’.⁶⁸² This test is still easy to satisfy.

In *Re C*, Thorpe J accepted the test of capacity proposed by one of the expert witnesses,⁶⁸³ which requires the individual: ‘(1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs’.⁶⁸⁴ In *Cambridgeshire CC v R*, Hale J cited the *Re C* test and stated: ‘The test of competence ... has always been the capacity to understand the nature and effect of the transaction or other action proposed’.⁶⁸⁵ Unlike the *Re C* test, this view of competency does not require that the person ‘believes’ the information. Furthermore, although requiring an understanding of the ‘effect’, Hale J’s test avoids explicit reference to risks. However, the *Mental Health Act Code of Practice* quotes the tripartite *Re C* test as the appropriate test for competence and states that the knowledge required for consent includes: ‘the purpose, nature, likely effects and risks of th[e] treatment including the likelihood of its success and any alternatives to it’.⁶⁸⁶

⁶⁸¹ *Chatterton v Gerson* [1981] 1 All ER 257, 265.

⁶⁸² Gunn, M. ‘The Meaning of Incapacity’ (1994) 2 *Medical Law Review* 8; Brazier, M. ‘Competence, Consent and Proxy Consents’. In: Brazier, M., Lobjoit, M. (eds.) *Protecting the Vulnerable: Autonomy and Consent in Health Care* (1991) Routledge: London 34, 36.

⁶⁸³ *Re C (Adult: Refusal of treatment)* [1994] 1 WLR 290; [1994] 1 All ER 819.

⁶⁸⁴ *Ibid.*, 292 per Thorpe J. When Thorpe J restated the test at 295, he dropped the ‘balancing risks and needs’ element. It is suggested that this has happened merely as shorthand and that Thorpe J accepted the need to balance ‘risks and needs’ since it is clear that he considered it very important that the risk of dying had altered from 85% to 15% following conservative treatment.

⁶⁸⁵ *Cambridgeshire CC v R* [1995] 1 FLR 50, 53.

⁶⁸⁶ *Mental Health Act Code of Practice* (1999) London: HMSO, paras 15.10 and 15.13.

Following *Re C*, the Law Commission adopted a ‘functional’ approach to capacity. Incompetence was the inability ‘to make a decision on the matter in question, or ... to communicate a decision’.⁶⁸⁷ A person is unable to make a decision if:

he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make a decision.⁶⁸⁸

The Law Commission would also require the person to ‘be able to use the information which he or she has successfully understood in the decision-making process’.⁶⁸⁹ It was, however, recommended that the ‘belief’ requirement of the *Re C* test should be dropped. The Law Commission argued that: ‘Emphasising that the person must be able to use the information ... deflects the complications of asking whether a person needs to “appreciate” information as well as understand it’.⁶⁹⁰ The proposal to drop the ‘belief’ element of the *Re C* test was followed by the Court of Appeal in *Re MB*.⁶⁹¹ Furthermore, the government has taken this approach in the Mental Capacity Act 2005, which comes into force in 2007 and makes competence subject to the ability to: understand, retain, weigh up and use the information and communicate the decision.⁶⁹²

In *Re T*, Lord Donaldson MR argued that the capacity required for a decision depended on the importance of that decision. He stated: ‘What matters is that doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the

⁶⁸⁷ The Law Commission, *Report on Mental Incapacity* No.231 (1995) London: HMSO, para 3.14: Draft Bill, clause 2(1). ‘Mental disability’ means ‘any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning’ (Draft Bill, clause 2(2)).

⁶⁸⁸ *Ibid.*, para 3.16: Draft Bill, clause 2(2) (a).

⁶⁸⁹ *Ibid.*, para 3.17.

⁶⁹⁰ *Ibid.*, para 3.17.

⁶⁹¹ *Op cit* n.55.

⁶⁹² Mental Capacity Act 2005, s.3(1).

capacity required'.⁶⁹³ This suggests that capacity is task dependant and varies with the importance, or risk, of the decision. This sliding-scale risk-related standard of competence has received both academic support and criticism.⁶⁹⁴ It has, however, received subsequent judicial approval from the Court of Appeal in *St George's Healthcare NHS Trust v S*,⁶⁹⁵ and appears to be part of English law.

2. Voluntary Consent

For consent to be valid it must have been freely given: consent gained by threats or fear of violence will be vitiated. Other, subtler, forms of pressure may also vitiate consent. Whether or not the pressure is overt, it must have affected the individual to such a point that they can no longer be held responsible for their act. Thus, in *Olugboja*, Dunn LJ accepted that: “‘consent’ ... covers a wide range of states of mind ... ranging from actual desire ... to reluctant acquiescence’,⁶⁹⁶ but, as Young suggested:

pressure may get to such a degree that the act will lose its voluntariness. Just where that point is a question of fact and different tribunals of fact will come to different answers depending on the decade in which they are sitting and the community standards of the relevant time and place.⁶⁹⁷

In *Latter v Braddell* the plaintiff was a housemaid accused by her employer of being pregnant.⁶⁹⁸ Although protesting, she submitted to an examination by the doctor

⁶⁹³ *Op cit* n.510, 796.

⁶⁹⁴ For arguments against a risk-related standard see: Wicclair, M.R. ‘Patient decision-making capacity and risk’ (1991) 5 *Bioethics* 91; Wicclair, M.R. *Op cit* n.611; May T. ‘Assessing Competency Without Judging Merit’ (1998) 9 *The Journal of Clinical Ethics* 247; Maclean, A. *Op cit* n.611, 281. For arguments in favour of a risk-related standard see: Drane, J. ‘The Many Faces of Competency’ (1985) 15 *Hastings Center Report* 17; Brock, D.W. *Op cit* n.610; Wilks, I. *Op cit* n.610.

⁶⁹⁵ *Op cit* n.531, 693.

⁶⁹⁶ *R v Olugboja* [1982] QB 320 at 331; Gardner, S. ‘Appreciating *Olugboja*’ (1996) 16 *Legal Studies* 275, 279-30.

⁶⁹⁷ Young, P.W. *The Law of Consent* (1986) The Law Book Company Ltd: North Ryde (NSW), 17.

⁶⁹⁸ *Latter v Braddell* (1881) 50 LJQB 166, Common Pleas Division; (1881) 50 LJQB 448, CA.

summoned by her employer. Her case ultimately failed but the contrasting judgments illustrate the difficulty of determining an issue dependent on a matter of degree.

Lopes J stated:

I do not think it was correct to tell the jury that to maintain this action the plaintiff's will must have been overpowered by force or the fear of violence ... A submission to what is done, obtained through a belief that she is bound to obey her master and mistress; or a consent obtained through fear of evil consequences to arise to herself, induced by her master's or mistress's words or conduct, is not sufficient. In neither case would the consent be voluntarily given. It would be a consent in one sense, but a consent to which the will was not a party.⁶⁹⁹

On the other hand, Lindley J stated:

The plaintiff was not a child; she knew perfectly well what she did and what was being done to her by the doctor ... upon the evidence there is no reason whatever for supposing that any examination would have been made or attempted if she had told the doctor she would not allow herself to be examined. Under these circumstances I am of the opinion that there was no evidence of want of consent as distinguished from reluctant obedience or submission to her mistress's orders, and that in the absence of all evidence of coercion, as distinguished from an order which the plaintiff could comply with or not as she chose, the action cannot be maintained.⁷⁰⁰

⁶⁹⁹ *Latter v Braddell* (1881) 50 LJQB 166, 167-8.

⁷⁰⁰ *Ibid.*, 168.

When the case reached the Court of Appeal the plaintiff's case was dismissed since her submission was 'not through fear of violence'.⁷⁰¹ The requirement of force or violence is not the current law and in this sense *Latter v Braddell* may 'safely be consigned to the archives'.⁷⁰² Lindley J's argument, in the Common Pleas hearing, was that the housemaid could still have refused consent and that, had she done so, she would not have been compelled to submit. It is suggested that this argument, although not explicit, is – like the Court of Appeal's judgment – relying on the lack of force present. However, as Lopes J's argument makes clear, coercion arises where the plaintiff believes that she has little option but to submit. Thus, the plaintiff only consented because she feared losing her job and her home if she acted otherwise. It is submitted that Lopes J's judgment would be the preferred argument today and this is supported by *R v McCoy*.⁷⁰³

The complainant had broken the rules of her employment as an airhostess by failing to use her seat belt during descent, which meant that she would either be grounded or dismissed. Since she was in debt and her work permit depended on her remaining in her current employment she was under pressure to remain on flying duty. Her boss, the appellant, suggested that this would be possible if she accepted a caning as an alternative punishment. The appellant was convicted of criminal assault and appealed. His appeal was dismissed partly because the caning was '*malum in se*'. However, the court also argued that her agreement was not really consent, 'but only submission under duress'.⁷⁰⁴

Taylor ACJ stated:

To my mind the evidence makes it abundantly clear that [the] complainant was coerced ... Under duress she reluctantly acquiesced in the infliction on her of a form of punishment which was repugnant.

⁷⁰¹ *Latter v Braddell* (1881) 50 LJQB 448 per Bramwell LJ.

⁷⁰² Grubb A. 'Consent to Treatment: The Competent Person', in: Grubb A. Laing, J (eds.) *Principles of Medical Law* (2nd ed., 2004) Oxford: Oxford University Press 131, 202, n. 422.

⁷⁰³ *R v McCoy* [1953] 2 SA 4.

⁷⁰⁴ *Ibid.*, 5.

She merely submitted ... submission, according to the authorities, is totally different from consent.⁷⁰⁵

Whether an external influence is 'undue' is a matter of degree. Lopes J's argument and the judgment in *McCoy* suggest that this point is reached when the decision is no longer the individual's *own* decision: the decision was made only to avoid an unjust threat and the threat was irresistible. The question of what circumstances are sufficient to vitiate consent arose in *Freeman v Home Office*.⁷⁰⁶ The plaintiff was serving a prison sentence and was given certain drugs to control his violent and anti-social behaviour. He brought an action for battery claiming, inter alia, that his consent under such circumstances could not be valid. His counsel submitted that the pressures and discipline of prison life meant that a prisoner would never be able to give a valid consent. Sir John Donaldson MR approved the statement made by the judge at first instance,⁷⁰⁷ who said: 'The right approach, in my judgment, is to say that where, in a prison setting, a doctor has the power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so'.⁷⁰⁸ This is not very helpful in determining when consent is vitiated by duress. All that may be taken from the case is that certain situations must alert the court to the possibility but, 'whatever the circumstances, the issue of voluntariness is an issue of fact'.⁷⁰⁹

Lord Donaldson returned to the issue of undue influence in *Re T*.⁷¹⁰ T was pregnant and required a caesarean section following a road traffic accident. Her mother was a Jehovah's Witness, and shortly after her visit, T refused any blood transfusions that may become necessary. After the operation she deteriorated and required ventilation on the

⁷⁰⁵ *Ibid.*, 11-12.

⁷⁰⁶ *Op cit* n.668.

⁷⁰⁷ *Ibid.*, 1044-5.

⁷⁰⁸ *Freeman v Home Office* [1984] 2 WLR 130, 145.

⁷⁰⁹ *Op cit* n.702, 203.

⁷¹⁰ *Op cit* n.510.

intensive therapy unit. While there, she required a life-saving transfusion and the court was asked to consider whether her prior refusal was still operative. In the Court of Appeal, Lord Donaldson MR argued that others could advise the patient:

But the doctors have to consider whether the decision is really that of the patient. It is wholly acceptable that the patient should have been persuaded by the merits of such a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. The real question in each such case is: does the patient really mean what he says or is he merely saying it for a quiet life, to someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?⁷¹¹

This approach was followed by the Court of Appeal in *Mrs U v The Centre for Reproductive Medicine*.⁷¹²

3. Real Consent

For any consent to be valid it must relate to the act performed. Thus, consent to an operation on the right ear will not be sufficient to negate liability for battery if the surgeon operates on the left ear, even where the left ear was more diseased than the right.⁷¹³ This is true even where the operation is beneficial to the patient.⁷¹⁴ The courts have held that a patient may consent to 'leave the nature and extent of the operation to be performed to the discretion of the surgeon'.⁷¹⁵ However, consent to a particular act will be insufficient unless it is 'real'. Bristow J laid down the elements of a 'real consent' in

⁷¹¹ *Op cit* n.510, 797.

⁷¹² *Mrs U v The Centre for Reproductive Medicine* [2002] EWCA Civ 565, [22].

⁷¹³ *Mohr v Williams* 104 NW 2 (1905). See also: *Cull v Royal Surrey County Hospital* (1932) 1 BMJ 1195 in which a surgeon was liable for battery when he removed the plaintiff's uterus (womb) even though she had only consented to an abortion.

⁷¹⁴ *Devi v West Midlands RHA* (1981) CA, Transcript 491.

⁷¹⁵ *Breen v Baker* (1956) *The Times* 27th January.

Chatterton v Gerson,⁷¹⁶ in which the plaintiff's action for battery failed because '[she] had been under no illusion as to the general nature of the operations performed by the defendant'.⁷¹⁷ Bristow J stated:

In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass.⁷¹⁸

This was confirmed by the House of Lords in *Sidaway v Governors of Bethlem Royal Hospital*.⁷¹⁹

Bristow J's reasoning behind his decision to deny an action in battery may be criticised because he made no attempt to consider the purpose of obtaining the patient's consent. The only case used in support of his decision was the Canadian case of *Reibl v Hughes*.⁷²⁰ The Ontario Court of Appeal reversed the first instance decision because battery was inappropriate when a doctor acts in good faith. Instead of basing his decision on reasoned legal argument and principle Bristow J appeared to resort to policy. He claimed: '... it would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass'.⁷²¹ No attempt was made to relate the obligation to obtain consent with the patient's right to self-determination as clearly stated by Justice Cardozo more than 60 years earlier. Bristow J ignored the issue of informed consent that had troubled the American courts.⁷²²

⁷¹⁶ *Op cit* n.681.

⁷¹⁷ *Ibid.*, 258.

⁷¹⁸ *Ibid.*, 264-5.

⁷¹⁹ *Hills v Potter* [1984] 1 WLR 641; *Op cit* n.668; *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 AC 871.

⁷²⁰ *Reibl v Hughes* (1978) 21 OR (2d) 14.

⁷²¹ *Op cit* n.681, 265.

⁷²² *Op cit* n.36, 114 – 150.

When Bristow J gave his judgment, *Reibl v Hughes* had only reached the Court of Appeal. However, the Supreme Court's decision is compatible with Bristow J's and, since the issues of risk and "informed consent" were considered more fully, it is instructive to consider that case. In *Reibl* the plaintiff underwent carotid artery surgery, which, although competently performed, resulted in a massive stroke leaving him with a right-sided paralysis.⁷²³ The plaintiff had formally consented but alleged that he had not been adequately informed of the risks (estimated at 10% risk of a stroke and a 4% risk of death). At first instance the trial judge held that the risks involved were material rather than collateral and that the defendant was liable in battery. In the Supreme Court, Laskin CJC – giving the judgment of the court – stated that: 'In my opinion, these findings do not justify the imposition of liability for battery'.⁷²⁴

The Supreme Court considered Morden J's test – described in *Kelly v Hazlett*⁷²⁵ – for determining whether a failure to disclose risks would support liability in battery or negligence.⁷²⁶ Morden J distinguished 'the matter of consequential or collateral risks from the basic nature and character of the operation or procedure'.⁷²⁷ He argued that a failure to disclose 'collateral risks' was more properly considered in negligence. However:

The more probable the risk the more it could be said to be an integral feature of the nature and character of the operation. Further, even if a risk is truly collateral, but still material, it could be said that its disclosure is so essential to an informed decision to undergo the operation that lack of such disclosure should vitiate the consent.⁷²⁸

Laskin CJC rejected this distinction. He stated:

⁷²³ *Reibl v Hughes* (1981) 114 DLR (3d) 1.

⁷²⁴ *Ibid.*, 8-9.

⁷²⁵ *Kelly v Hazlett* (1977) 75 DLR (3d) 536.

⁷²⁶ This test was adopted by Haines J, the trial judge in *Reibl*.

⁷²⁷ *Op cit* n.725, 558-559.

⁷²⁸ *Ibid.*, 559.

I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view, unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of the anterior duty of due care, comparable in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.⁷²⁹

The nature of a procedure also includes its purpose. Thus, in *Appleton v Garrett* the defendant performed unnecessary dental work on the plaintiffs for purely financial gain and the judge held that the plaintiffs' consents were not 'real'.⁷³⁰ Furthermore, the patient must know the identity of the treating professional. In *R v Richardson* the appellant dentist continued treating her patients even though she had been suspended from the General Dental Council's register.⁷³¹ She was charged with assault and the judge ruled that her patients' apparent consents were vitiated because she allowed them to think she was still registered. She changed her plea to guilty and then appealed against the judge's ruling.

The Court of Appeal allowed her application. Otton LJ stated:

the Crown contended that the concept of the "identity of the person" should be extended to cover the qualifications or attributes of the dentist on the basis that the patients consented to treatment by a

⁷²⁹ *Op cit* n.723, 10-11.

⁷³⁰ *Appleton v Garrett* [1997] 8 Med LR 75.

⁷³¹ *R v Richardson* (1998) 43 BMLR 21, CA.

qualified dentist and not a suspended one. We must reject that submission ... the complainants were fully aware of the identity of the appellant. To accede to the submission would be to strain or distort the everyday meaning of the word “identity”, the dictionary definition of which is “the condition of being the same”.⁷³²

Effectively the Court of Appeal rejected the argument that the consent was to <dental treatment by a registered dentist> in favour of <dental treatment by Ms Richardson>.

Although the head-note states that: ‘a person’s professional status or qualifications did not constitute part of their identity’,⁷³³ Otton LJ rejected the Crown’s argument that ‘there was no distinction between an unqualified dentist and one who is suspended’.⁷³⁴ It may, therefore, have been important that she was a qualified dentist even though she was not registered at the time.

Richardson may be compared with *R v Tabassum*.⁷³⁵ Three women consented to be shown how to perform a breast examination by the accused, who was preparing a computer software package on breast cancer. The women all stated that they only consented to the examination because they believed the accused to be medically qualified. However, no sexual motive was alleged. The Court of Appeal held that the women had not given a true consent since, although they understood the nature of the act, they had not consented to the quality of the act. The women knew that the act was a breast examination and that it was for the purpose of preparing the software package. Thus, the Court of Appeal considered that the women’s consent was to <breast examination for the purposes of preparing a medical software package by a medically qualified person> rather than simply <breast examination for the purposes of preparing a medical software package>. Although *Richardson* was distinguished because the decision concerned the

⁷³² *Ibid.*, 26.

⁷³³ *Ibid.*

⁷³⁴ *Ibid.*, 26.

⁷³⁵ *R v Tabassum* [2000] Lloyd’s LR Med 404, CA.

identity of the actor rather than the nature or quality of the act it is arguable that the only relevant factor in *Tabassum* was that the accused was not medically qualified,⁷³⁶ which emphasises the courts' reluctance to find doctors liable for battery.

The Legal Regulation of Consent in Negligence

Legal liability in negligence requires three things: a duty of care; a breach of that duty; and a legally recognised form of damage caused by the breach. Since the duty of care is established by the professional-patient relationship it is only the latter two elements that require examination. A suitable starting point is the leading case of *Sidaway v Governors of Bethlam Royal Hospital*, in which the issue of consent and the standard of information disclosure reached the House of Lords for the first (and only) time.⁷³⁷

Sidaway and the Standard of Disclosure

1. The Facts and Judgments

The plaintiff underwent an operation to relieve recurrent neck pain. It was performed competently but the small risk (<1%) of paraplegia associated with the operation materialised and the plaintiff was left partially paralysed. She sued in negligence alleging that the defendant had failed to inform her of this risk. At first instance Skinner J held that, while the defendant had informed the plaintiff of the risk of damaging the nerve roots (approximately 1%), he had failed to inform her of the possible damage to her spinal cord (with the attendant risk of paralysis). Applying the *Bolam* test, however, Skinner J held that the plaintiff's claim failed. The Court of Appeal affirmed the decision and the plaintiff appealed to the House of Lords.

It was unanimously held that the plaintiff's appeal failed because she had been unable to prove that the surgeon had breached his duty of care. Their Lordships took the

⁷³⁶ See also the Canadian case: *R v Bolduc and Bird* [1976] 3 CCC 294, SCC.

⁷³⁷ *Sidaway v Governors of Bethlam Royal Hospital* [1985] 1 AC 871.

opportunity to consider the standard of risk disclosure expected of the doctor. Broadly speaking: ‘There are three distinct strands’ detectable in their Lordships’ judgments,⁷³⁸ although Lord Templeman’s speech might be considered sufficiently distinct to be a fourth approach.⁷³⁹

Lord Scarman began with the premise that it is the patient’s right to accept or reject the proffered treatment.⁷⁴⁰ He argued that: ‘a doctor’s duty of care extends not only to the health and well-being of his patient but also to a proper respect for his patient’s rights [thus], the duty to warn can be seen to be a part of the doctor’s duty of care’.⁷⁴¹ He then went on to rightly and importantly recognise that factors other than the patient’s health might be relevant and this: ‘may lead him to a different decision from that suggested by a purely medical opinion’.⁷⁴² Thus, the doctor’s duty is to both advise a particular medical treatment and to provide sufficient information to allow the patient to make the decision.⁷⁴³ As to the substance of this duty, Lord Scarman rejected the *Bolam* principle and opted instead for the ‘prudent patient’ standard adopted in *Canterbury v Spence*.⁷⁴⁴ This requires disclosure of ‘material’ risks and, ‘a risk is ... material when a *reasonable person*, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy’.⁷⁴⁵ This limits the role of the medical experts to determining the probability and seriousness of a risk materialising and also the ‘character of the risk’.⁷⁴⁶ The judgment of whether the risk should have been disclosed, however, is for the court to make based on the ‘prudent patient’ test. There was one caveat to this test: the

⁷³⁸ *Op cit* n.702, 184.

⁷³⁹ Montgomery, J. *Health Care Law* (2nd ed., 2003) Oxford: Oxford University Press, 243.

⁷⁴⁰ *Op cit* n.737, 882.

⁷⁴¹ *Ibid.*, 885.

⁷⁴² *Ibid.*, 886.

⁷⁴³ *Ibid.*, 886.

⁷⁴⁴ *Op cit* n.582.

⁷⁴⁵ *Ibid.*, 787; emphasis added by Lord Scarman.

⁷⁴⁶ *Op cit* n.737, 889.

risk need not be disclosed: ‘if upon a reasonable assessment of his patient’s condition he takes the view that a warning would be detrimental to his patient’s health’.⁷⁴⁷

Lord Diplock argued that the doctor’s duty of care was indivisible and included risk disclosure.⁷⁴⁸ His Lordship considered that the *Bolam* test was simply a modern restatement of the ancient rule of common law.⁷⁴⁹ Thus, he stated: ‘no convincing reason has in my view been advanced ... that would justify treating the *Bolam* test as doing anything less than laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient’.⁷⁵⁰

Lord Diplock’s judgment contained two other notable points. First, he argued that:

the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not.⁷⁵¹

He then distinguished the patient who asked questions, in which case ‘the doctor would tell him whatever it was the patient wanted to know’, from unenquiring patients who must rely on the doctor’s skill and judgment to define what they are told. Second, he suggested that the only possible effect of risk disclosure would be to deter patients ‘from undergoing the treatment which in the expert opinion of the doctor is in the patient’s interest to undergo’.⁷⁵² The implication of this statement, followed - as it is - by

⁷⁴⁷ *Ibid.*, 889-890.

⁷⁴⁸ *Ibid.*, 893-895.

⁷⁴⁹ *Ibid.*, 892.

⁷⁵⁰ *Ibid.*, 893.

⁷⁵¹ *Ibid.*, 895.

⁷⁵² *Ibid.*, 895.

endorsement of the *Bolam* standard, is that doctors are under no obligation to inform patients of a risk if they reasonably believe that knowledge will deter them from giving consent.

Lord Bridge, with whom Lord Keith agreed, also held that the *Bolam* test was the appropriate standard.⁷⁵³ He examined the role of medical expertise in risk disclosure and noted that, in *Reibl*, Laskin CJC argued that medical experts are necessary to determine what risks are associated with a particular procedure but that the materiality of risk should not be determined by expert medical evidence alone. In a somewhat confused and self-contradictory discussion Lord Bridge stated:

I fully appreciate the force of this reasoning, but can only accept it subject to the important qualification that a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice must primarily be a matter of clinical judgment.⁷⁵⁴

In other words, Lord Bridge accepted it was the patient's right to know but only if rubber-stamped by 'clinical judgment'. However, while the force of Laskin's reasoning had not convinced him that the professional standard was inappropriate, it was enough for Lord Bridge to hold that adopting the *Bolam* test did not hand the matter over entirely to the medical profession. Thus, where 'disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it ... for example, the ten per cent. risk of a stroke from the operation which was the subject of ... *Reibl*', it would not be reasonable for a body of medical opinion to hold that the risk should not be disclosed.⁷⁵⁵

⁷⁵³ *Ibid.*, 896.

⁷⁵⁴ *Ibid.*, 900.

⁷⁵⁵ *Ibid.*, 900.

Although not specifically mentioning the *Bolam* test, Lord Templeman's judgment was arguably closer to Lord Bridge's than Lord Scarman's or Lord Diplock's judgment. Thus, while it was the patient's right to decide and the doctor's duty to provide adequate information: 'At the end of the day, the doctor, bearing in mind the best interests of the patient ... must decide what information should be given to the patient and in what terms that information should be couched'.⁷⁵⁶ Lord Templeman distinguished 'general' from 'specific' risks:⁷⁵⁷ for a general risk it is sufficient that patients are aware 'that a major operation may entail serious consequences'.⁷⁵⁸ If patients want more information this must be specifically asked for. Lord Templeman's argument relied on the view that too much information may be just as harmful as too little information. In addition, patients' medical conditions may make them ill prepared to cope with detailed information, which doctors should not thrust upon them. It is sufficient if patients are aware that the procedure is risky, but still in their best interests unless they specifically request further information or the risk is of a 'special nature'.

Unfortunately, Lord Templeman did not provide a clear explanation of the distinction between a 'general' and a 'specific' risk. At one point his argument suggests that for a general risk the patient simply needs to know that the operation carries the risk of 'serious consequences'.⁷⁵⁹ Later, however, he stated that: 'In the case of a general danger the court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered'.⁷⁶⁰ This is inconsistent with previous statement, since to be aware of the 'kind of harm' requires information of a different order to that needed to know that 'serious consequences' might follow. Like Lord Bridge, Lord Templeman turned to the ten per cent risk of stroke in *Reibl* for an illustration of what would count as a special risk. However, he also made a

⁷⁵⁶ *Ibid.*, 905.

⁷⁵⁷ *Ibid.*, 902-903.

⁷⁵⁸ *Ibid.*, 902.

⁷⁵⁹ *Ibid.*, 902.

⁷⁶⁰ *Ibid.*, 903.

point of including the four per cent risk of death as a 'specific risk'. Since death can occur as a consequence of any operation, especially where a general anaesthetic is involved, Lord Templeman must have placed a great weight on the probability of a particular harm in determining whether it is specific to the operation.

Echoes of the *Bolam* test are discernable in Lord Templeman's argument that if doctors fail to disclose a risk, for which disclosure was the accepted medical practice, then the court will find them liable unless they can justify their actions. However, where medical practice

is divided or does not include express mention, it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation ... was sufficient to alert the patient to the general dangers of which the harm suffered is an example.⁷⁶¹

This, less ambiguously than Lord Bridge's argument, reserved for the court the right to choose between two opposing schools of thought within the medical profession.

However, Lord Templeman tempered this statement by deciding that the court should be slow to hold a conscientious doctor liable for failing to disclose a 'specific item of information'.⁷⁶² The general tenor, therefore, of Lord Templeman's judgment is that, while the court has the final word, doctors are acting conscientiously in the patient's best interests and - unless the patient has specifically requested the information in question - will only be found liable where they have unjustifiably acted independently of medical practice.

⁷⁶¹ *Ibid.*, 903.

⁷⁶² *Ibid.*, 903.

2. *Sidaway* and the Standard of Care

Given the variance between the judgments it is not surprising that commentators disagreed on the interpretation and implications of the case. Kennedy and Grubb argued that Lord Diplock was in the minority and that the majority rejected the *Bolam* test.⁷⁶³ Kennedy went so far as to claim that: ‘The message of *Sidaway* is clear. Those who advise doctors already know it. Medical paternalism has had its day’.⁷⁶⁴ At the other end of the scale, Brazier concluded that: ‘the House of Lords in *Sidaway* set the standard by which the adequacy of disclosure would be judged by reference to professional custom and practice’.⁷⁶⁵ Williams argued that *Sidaway* qualified the *Bolam* test but, by rejecting the prudent patient test, the House of Lords had undermined the law’s declared commitment to autonomy and left it in an ‘unsatisfactory state’.⁷⁶⁶ Giesen and Hayes also considered that *Sidaway* qualified the *Bolam* test and thus may be greeted with cautious optimism.⁷⁶⁷ Teff suggested that, while *Sidaway* diverged only slightly from the *Bolam* test, the judgment ‘provides some basis for further development’.⁷⁶⁸ Newdick, argued that any distinction between Lord Diplock and the ‘majority’ was a ‘matter of semantics’, merely serving to clarify rather than change or reject *Bolam*.⁷⁶⁹ Newdick, however, unlike most of the other commentators, plausibly suggested that the *Bolam* test remained the most appropriate test provided the courts developed a set of principles that ‘give

⁷⁶³ Kennedy, I. ‘The Patient on the Clapham Omnibus’. In: *Treat Me Right: Essays in Medical Law and Ethics* (1988) Oxford: Clarendon Press 175; Grubb, A. ‘Contraceptive Advice and Doctors – A Law Unto Themselves’ (1988) 47 *The Cambridge Law Journal* 12, 13. See also, Lee, S. ‘Towards a Jurisprudence of Consent’, in: Eekelaar, J., Bell, J. (eds) *Oxford Essays in Jurisprudence* (1997) Oxford: Oxford University Press 199, 216; Lee, S. ‘Operating Under Informed Consent’ (1985) 101 *Law Quarterly Review* 316.

⁷⁶⁴ Kennedy, I. *Ibid.*, 210.

⁷⁶⁵ Brazier, M. ‘Patient autonomy and consent to treatment: the role of the law?’ (1987) 7 *Legal Studies* 169, 182.

⁷⁶⁶ Williams, K. ‘Pre-operative Consent and Medical Negligence’ (1985) 15 *Anglo-American Law Review* 169, 179-180.

⁷⁶⁷ Giesen, D., Hayes, J. ‘The Patient’s Right to Know – A Comparative View’ (1992) 21 *Anglo-American Law Review* 101, 103.

⁷⁶⁸ *Op cit* n.523, 450.

⁷⁶⁹ Newdick, C. ‘The Doctor’s Duties of Care Under *Sidaway*’ (1985) 36 *Northern Ireland Legal Quarterly* 243, 247 and 249-250.

expression to the standards of conduct *rightly* required of doctors by the medical profession itself'.⁷⁷⁰

It is submitted that these disparate views resulted from the inherent ambiguity of the *Bolam* test. It is possible to interpret the test either to leave the standard of care entirely within the hands of the medical profession, or to retain for the court the right to determine that the relevant common practice is not reasonable.⁷⁷¹ If this latter view is adopted then Lord Diplock's and Lord Bridge's converge. Although Lord Templeman did not discuss the standard in terms of the *Bolam* test, the general gist of his argument, despite its lack of clarity,⁷⁷² is compatible with the latter view of that standard.⁷⁷³ If, however, the *Bolam* test is given Lord Scarman's interpretation, then the judgments diverge and, as Montgomery noted: 'it is impossible to find a majority view'.⁷⁷⁴

3. Answering Questions

While the issue was *obiter*, the doctor's response to questioning and his obligation to tell the truth was considered in *Sidaway*. Although not specifically addressing the issue, Lord Scarman implied that a doctor should respond truthfully to any direct questions. He argued that the moral ideal would be to disclose what that particular patient subjectively needed to know but the law was constrained by practical considerations to an objective obligation.⁷⁷⁵ Since it was for simply evidentiary difficulties that he accepted the 'prudent patient' test, it follows that if patients, through direct questioning, alerts the doctor to their own particular needs, then the doctor would be obliged to meet them.⁷⁷⁶

⁷⁷⁰ *Ibid.*, 250 (emphasis added).

⁷⁷¹ See, Lord Woolf. 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 *Medical Law Review* 1, 6.

⁷⁷² Jones, M.A. *Medical Negligence* (1996) London: Sweet & Maxwell, 341.

⁷⁷³ See e.g.: Teff, H. *Op cit* n.523, 449.

⁷⁷⁴ *Op cit* n.739, 245.

⁷⁷⁵ *Op cit* n.737, 888.

⁷⁷⁶ Except possibly when covered by the therapeutic privilege.

Lord Diplock commented that: ‘No doubt if the patient in fact manifested this attitude [of wanting to be fully informed] by means of direct questioning, the doctor would tell him whatever it was the patient wanted to know’.⁷⁷⁷ This was unqualified but was stated as if in the alternative to the *Bolam* test, which implies that direct questioning creates an exception to the *Bolam* test and the doctor’s duty becomes to provide whatever information is requested. The difficulty with this is that questioning can be more or less specific and the extent of the response may be similarly varied. It is submitted that, given his otherwise wholehearted support of *Bolam*, Lord Diplock would also gauge the appropriateness of the doctor’s response to direct questions by the *Bolam* test unless the questions were so precise as to require a particular answer.

Lord Bridge stated: ‘when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctors duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires’.⁷⁷⁸ Again, this seems fairly explicit in relation to precise questions but Lord Bridge’s statement also leaves the vague or general question at the mercy of the *Bolam* test. Similarly, Lord Templeman allowed that a direct question creates a greater duty of disclosure: ‘If she had [asked questions]... she could and should have been informed that there was an aggregate risk of between one per cent and two per cent risk of some damage either to the spinal cord or to a nerve root’.⁷⁷⁹ However, for Lord Templeman: ‘this further information would only have reinforced the obvious’.⁷⁸⁰ The conclusion that may be drawn from their Lordships’ judgments is that direct questioning requires a truthful and complete response. Thus, precise questions should be given precise answers.

⁷⁷⁷ *Op cit* n.737, 895.

⁷⁷⁸ *Ibid.*, 898.

⁷⁷⁹ *Ibid.*, 902.

⁷⁸⁰ *Ibid.*, 902.

In respect of more general questions, it is submitted that their Lordships' statements are ambiguous. Take Lord Bridge's dictum that the answer must be as 'full' as the questioner requires. The problem here is that the doctor must try and determine from the question what it is that the patient wishes to know. Questions may be quite general and the doctor is left with discretion to determine the exact response. In these circumstances their Lordships have not ruled out the *Bolam* test as a guide to the standard expected. Even where the question appears to be specific, it may be that the patient had something more general in mind. For example, the question: 'What are the risks of this procedure?' has more than one possible interpretation. It might mean any one of the following:

1. What risks do you think are significant:
2. What risks do you think I need to know about:
3. What are *all* the risks:
4. What are the common risks:
5. What are the most serious risks?

The third option is the only one of these five possibilities that denies the doctor any discretion and even here the situation is not clear-cut. Are doctors obliged to disclose every adverse consequence ever recorded, or only those recorded in major textbooks, or those recorded in academic journals, or only those that they are - or ought to be - aware of? It is submitted that they would only be expected to disclose those risks that they ought to be aware of and this would be judged in relation to their fellow professionals.⁷⁸¹ The *Bolam* test creeps back in.

Developments in the Standard of Care Since Sidaway

1. Pre-*Bolitho*

Because these cases are now largely historical in significance I will deal with them briefly. There are two relevant Court of Appeal cases and both interpreted *Sidaway*

⁷⁸¹ See: *Crawford v Board of Governors of Charing Cross Hospital* (1953) *The Times*, 8 December, CA. Also, see later discussion of *Blyth v Bloomsbury HA* [1993] 4 Med LR 151, CA (decided 1987).

restrictively. In *Blyth v Bloomsbury*, the *Bolam* test was applied to determine the doctor's duty to disclose in response to general questions.⁷⁸² In *Gold v Haringey* the Court of Appeal applied *Bolam* to disclosure of information regarding non-therapeutic interventions.⁷⁸³ A widely held view amongst academics at the time was that *Bolam* provided a carte blanche for common practice and some saw *Sidaway* as removing that privilege.⁷⁸⁴ With that in mind, it is not surprising that these judgments received heavy criticism.⁷⁸⁵

One of the problems with the *Bolam* test is that the courts may apply it uncritically allowing the standard of care to be set by the medical profession. This view, which is reflected in Lord Scarman's judgment (see above), is supported by the judgments in both non-disclosure and other cases of clinical negligence.⁷⁸⁶ However, the courts, albeit 'comparatively rare[ly]',⁷⁸⁷ have exercised their right to reject expert medical evidence.⁷⁸⁸ In *McAllister v Lewisham and North Southwark HA*,⁷⁸⁹ Rougier J accepted that the *Bolam* test was the appropriate standard for determining disclosure. However, following Lord Bridge's judgment in *Sidaway*, he noted the caveat that there were certain risks that ought

⁷⁸² *Blyth v Bloomsbury HA* [1993] 4 Med LR 151, CA (decided 1987).

⁷⁸³ *Gold v Haringey HA* [1988] 1 QB 481, CA.

⁷⁸⁴ Lord Woolf recently commented, extra judicially, that far from removing the privilege, *Sidaway*: 'In practice ... has come to mean that the patients are entitled to know only what their doctor thinks they should': *Op cit* n.771, 8.

⁷⁸⁵ Montgomery, J. 'Power/Knowledge/Consent: Medical Decisionmaking' (1988) 51 *Modern Law Review* 245, 248; Kennedy, I. 'Consent to Treatment: The Capable Person'. In: Dyer, C. (ed) *Doctors, Patients and the Law* (1992) Oxford: Blackwell Scientific Publications 44, 68-69; Healy, J. *Medical Negligence: Common Law Perspectives* (1999) London: Sweet & Maxwell, 152, 161; Grubb, A. *Op cit* n.763; and Lee, S. 'A Reversible Decision on Consent to Sterilisation' (1987) 103 *Law Quarterly Review* 513. Lee argued: 'the Court of Appeal's approach in *Gold* ... represents a distorted view of *Sidaway*' (at 514); *Op cit* n.765, 183; *Op cit* n.767, 104

⁷⁸⁶ *Op cit* n.771; Brazier, M., Miola, J. 'Bye-Bye Bolam: A Medical Revolution?' (2000) 8 *Medical Law Review* 85; Maclean, A. 'Beyond Bolam and Bolitho' (2002) 5 *Medical Law International* 205.

⁷⁸⁷ Jones, M.A. 'Informed Consent and Other Fairy Stories' (1999) 7 *Medical Law Review* 103, 116.

⁷⁸⁸ This is true of both non-disclosure and ordinary negligence cases. For examples of the latter, see: *Bowers v Harrow HA* [1995] 6 Med LR 16; Roch LJ's judgment in: *Joyce v Merton, Sutton and Wandsworth HA* [1996] 7 Med LR 1, 13-14; *Djemal v Bexley HA* [1995] 6 Med LR 269, 277; *Sharpe v Southend HA* [1997] 8 Med LR 299, 303; and Turner J's judgment in *R v Family Health Service Appeals Unit ex parte Singh* (1995) Unreported Transcript: John Larking 21st January.

⁷⁸⁹ *McAllister v Lewisham and North Southwark HA* [1994] 5 Med LR 343.

to be disclosed regardless of common practice,⁷⁹⁰ since: ‘within certain limitations, a patient is entitled to be given sufficient information on the risks of an operation to allow him or her to exercise a balanced judgment: after all it is their life that is going to be affected’.⁷⁹¹

Although the courts of first instance have been willing to challenge the opinion of expert witnesses the Court of Appeal has arguably been more deferential.⁷⁹² *Eyre v Measeaday* (a case in contract) concerned an unsuccessful sterilisation.⁷⁹³ One of the plaintiff’s allegations was that the surgeon had not warned her of the risk of failure and thus there was an implied collateral warranty that she would be rendered irreversibly sterile. In rejecting her claim for breach of contract, Purchas LJ stated that: ‘in withholding this information the defendant was following a practice acceptable to current professional standards and was acting in the best interests of the plaintiff’.⁷⁹⁴ Although the plaintiff did not pursue a claim in negligence, it is clear from this statement, that she would have been unsuccessful.⁷⁹⁵

The dichotomy seen in the courts’ judgments is, at least in some cases, arguably caused by the court focusing on the status of the experts,⁷⁹⁶ while in other cases it focuses on the opinion expressed by the expert witnesses.⁷⁹⁷ Where judges focus on the body of

⁷⁹⁰ Unless there was a ‘cogent clinical reason’ to justify withholding the information: *Ibid.*, 351.

⁷⁹¹ *Ibid.* 351. See also *Smith v Tunbridge Wells HA* [1994] 5 Med LR 334, 339; *Gascoine v Sheridan* [1994] 5 Med LR 437, 441-444, in which Mitchell J was able to find a similar authority in Lord Diplock’s judgment in *Sidaway*; *Doughty v North Staffordshire HA* [1992] 3 Med LR [1991] 81; and *Newell and Newell v Goldenberg* [1995] 6 Med LR 371, 374.

⁷⁹² See *Gold and Blyth* above. But, see *Loveday v Renton* [1990] 1 Med LR 117, CA.

⁷⁹³ *Eyre v Measeaday* [1986] 1 All ER 488, CA.

⁷⁹⁴ *Ibid.*, 497.

⁷⁹⁵ See also, *Palmer v Eadie* Lexis Transcript 18 May 1987, CA.

⁷⁹⁶ See e.g. *Abbas v Kenney* [1996] 7 Med LR 47, 57 per Gage J: ‘Since Mr Shepherd is acknowledged to be a very experienced and distinguished surgeon, it seems to me quite impossible to conclude that the defendant fell below the ordinary skill of a surgeon practising in this field’.

⁷⁹⁷ See, *Judge v Huntingdon HA* [1995] 6 Med LR 223 at 227; *Waters v West Sussex HA* [1995] 6 Med LR 362, 366-369; *Early v Newham HA* [1994] 5 Med LR 214, 216. For a rare pre-*Bolitho* example of the Court of Appeal looking beyond the expert’s qualifications, see: *Loveday v Renton* [1990] 1 Med LR 117, 125. Stuart-Smith LJ stated: ‘The mere expression of opinion or belief by a

professionals they almost invariably find in favour of the doctors. Where the spotlight is more appropriately on the opinion expressed then the judgment may go either way depending on the reasonableness of the opinion. That the Court of Appeal appears to have focused more deferentially on the body of professionals, rather than the opinion that body expresses, is demonstrated by *Ratty v Haringey HA*.⁷⁹⁸ The trial judge accepted the plaintiff's experts' opinion but the Court of Appeal reversed the judgment on this point.⁷⁹⁹ Kennedy LJ accepted that the *Bolam* test as applied in *Maynard* was the proper approach. He stated: 'it was important in the present case, once it was accepted that Mr Mann and Mr Addison represented a responsible and respectable body of colo-rectal opinion, to accept without qualification their formulation of the Marnham rule'.⁸⁰⁰

Prior to *Bolitho*, the law regarding the standard of care expected from doctors was noticeably inconsistent. This flowed from two sources. First was the disparate judgments given by their Lordships in *Sidaway*. Second, and perhaps of more fundamental importance, is the inherent ambiguity within the *Bolam* test. This ambiguity allowed the courts, particularly the Court of Appeal, to adopt a deferential attitude to medical opinion based on the status of the expert witness. By focusing on whether the professional body was responsible rather than applying the normative question to the proffered opinion the courts have arguably been too quick to accept the common practice as reasonable. In doing so, the courts have applied what should be an ethical test as if it were a sociological one.⁸⁰¹ As Montrose argued: 'it is important to distinguish between average practices and

witness, however eminent ... does not suffice. The court has to evaluate the witness and the soundness of his opinion'.

⁷⁹⁸ *Ratty v Haringey HA* [1994] 5 Med LR 413, CA. See also *De Freitas v O'Brien* [1995] 6 Med LR 108, especially at 114. Although not a non-disclosure case, *De Freitas* is another example of the Court of Appeal applying the normative test to the 'body' rather than the opinion.

⁷⁹⁹ Although liability was upheld in relation to the plaintiff's damaged bladder and ureters.

⁸⁰⁰ *Ratty v Haringey HA* [1994] 5 Med LR 413, 416. See also: Evans LJ at 419 and Balcombe LJ at 420. See also the first instance cases of *Stobie v Central Birmingham HA* (1994) 22 BMLR 135, 144 per Turner J; *Heath v West Berkshire HA* [1992] 3 Med LR 57, 59; *Bancroft v Harrogate HA* [1997] 8 Med LR 398, 404

⁸⁰¹ Montrose, J.L. 'Is Negligence an Ethical or a Sociological Concept?' (1958) *Modern Law Review* 259.

average standards, between what the ordinary man does and the ordinary man thinks ought to be done. His practice is not a necessary determinant of his ethics'.⁸⁰²

2. *Bolitho*, Beyond *Bolam*?

In *Bolitho v City and Hackney HA* the House of Lords again considered the *Bolam* test, albeit not in the context of disclosure.⁸⁰³ Lord Browne-Wilkinson held:

the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.⁸⁰⁴

Lord Browne-Wilkinson's argument clearly retains the court's right (and duty) to critically analyse the expert witnesses' evidence to ensure that the opinion, and not just the body, is reasonable. However, he heavily qualified his statement by suggesting that: 'In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion'.⁸⁰⁵ This again suggests that the status of the witness will go a long way to satisfying any test of reasonableness even before the expert has proffered an opinion. Thus, Lord Browne-Wilkinson emphasised that: 'in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable'.⁸⁰⁶

⁸⁰² *Ibid.*, 262.

⁸⁰³ *Bolitho v City and Hackney HA* [1998] AC 232, HL.

⁸⁰⁴ *Ibid.*, 241-242.

⁸⁰⁵ *Ibid.*, 243.

⁸⁰⁶ *Ibid.*, 243.

The academic response following *Bolitho* was mixed. Grubb enthused that: ‘The defences of *Bolam* have been breached. The court’s role as the final arbiter of the quantum of care has been reasserted’.⁸⁰⁷ He argued that Lord Browne-Wilkinson’s exclusion of risk disclosure from his judgment could be plausibly interpreted *only* to mean that: ‘the duty to disclose was a separate issue, to which *Bolam* and *Bolitho* were not relevant’.⁸⁰⁸ Thus:

the effect of *Bolitho* is to enable, indeed require, the courts to cast aside *Sidaway*, based as it is on a flawed interpretation of *Bolam*, and adopt the view that the content of the duty to inform is a matter for the court to determine, guided by but not ruled by the approach(es) to informing patients adopted by the medical profession.⁸⁰⁹

He concluded that English law will soon be unable to resist the prudent patient standard. Other commentators, however, have been more pessimistic: Mason and McCall Smith, for example, commented that,

The House of Lords has grudgingly confirmed that, in theory at least, the courts retain the power to establish standards of care, but ... their Lordships find it acceptable to challenge medical opinion only when the latter has no rational basis. This attitude is taking on an atmosphere of stubbornness and is becoming almost unique in face of the now universal acceptance of a patient’s right to decide on his or her own treatment.⁸¹⁰

⁸⁰⁷ *Op cit* n.702, 195.

⁸⁰⁸ *Ibid.*, 196. Brazier and Miola in fact suggested that his proviso should be interpreted as meaning that Lord Browne-Wilkinson believed that *Bolam* had already been restrained in the context of information disclosure: Brazier, M., Miola, J. ‘Bye-Bye *Bolam*: A Medical Revolution?’ (2000) 8 *Medical Law Review* 85, 108.

⁸⁰⁹ *Op cit* n.702, 196. See also, Scott, W. ‘*Bolam* and *Bolitho*: A new standard of care for doctors?’ (1998) 148 *New Law Journal* 64.

⁸¹⁰ Mason, J.K. McCall Smith, R.A. *Law and medical Ethics* (5th ed., 1999) Edinburgh: Butterworths, 283. In the 2002 6th edition, by Mason, McCall Smith and Laurie, the ‘atmosphere of stubbornness comment has been omitted. In the 2005 7th edition the author’s criticism of *Bolitho* is much more muted.

Keown was cautiously optimistic. While suggesting: '*Bolitho* is a significant and welcome decision to the extent that it reins in the *Bolam* test', he complained that the judgment did not go far enough.⁸¹¹ The shortcoming arose because:

it is not clear whether medical opinion may be disregarded only if it is illogical. What if the logic is flawless but the premise unsound or unpersuasive? For another [thing], Lord Browne-Wilkinson limits his comments to diagnosis and treatment and does not include the disclosure of risks.⁸¹²

Thus: '*Bolitho* is a step in the right direction, but the road is long'.⁸¹³ Teff similarly suggested that the court's scrutiny of expert evidence is a willingness to assess the 'internal consistency' of their arguments rather than 'a readiness to override responsible medical opinion'.⁸¹⁴ This restricts the court to an assessment of witness credibility 'rather than a more extensive pragmatic assessment of what the court deems reasonable'. Thus, although he welcomed: 'Reassertion at the highest level of the court's role in scrutinizing professional practice',⁸¹⁵ he concluded that because of the partisan nature of expert witnesses: 'A "hard look at the evidence" may in fact prove necessary more often than *Bolitho* intimates'.⁸¹⁶

Healy argued that, following *Bolitho*,

the model for considering professional practice is whether the opinions of the 'defence's experts are "truthfully expressed", "honestly held", or supported by "distinguished medical men"... That this in fact never affects how the professional standard test is seen to apply is obvious by the complete absence of case examples of any

⁸¹¹ Keown J. 'Reining in the *Bolam* test' (1998) 57 *The Cambridge Law Journal* 248, 249.

⁸¹² *Ibid.*, 249.

⁸¹³ *Ibid.*, 249.

⁸¹⁴ Teff, H. 'The Standard of Care in Medical Negligence – Moving on from *Bolam*?' (1998) 18 *Oxford Journal of Legal Studies* 473, 479.

⁸¹⁵ *Ibid.*, 481.

⁸¹⁶ *Ibid.*, 483.

such enquiry. In real terms, it enables the court in all but extreme cases to assume a less hands-on approach to the malpractice claim.⁸¹⁷

Thus, he claimed: 'The professional standard model, by its terms and wording, is constructed to restrict the court's freedom to critically evaluate the defendant's conduct beyond the context of professional approved practice'.⁸¹⁸ This view of the *Bolam* test and its application in practice is cynical but not indefensible. The judgment in *Bolitho* is certainly capable of being interpreted as placing too great an emphasis on the status of the expert witnesses and, given the inherent ambiguity of the *Bolam* test, it is arguable that *Bolitho* has changed nothing especially as far as risk-disclosure is concerned. As Montgomery noted: 'The crucial point to be made about these statements is that they are really nothing new. As Lord Browne-Wilkinson himself pointed out, the opportunity to impose judicial standards has always been stressed by the courts'.⁸¹⁹

Some academics have considered *Bolitho's* impact with the benefit of subsequent case law. Brazier and Miola argued that *Bolitho* will make a difference to malpractice litigation because it was decided 'amidst a host of other relevant developments affecting the provision of health care'.⁸²⁰ These changes include: more demanding guidelines issued by a number of medical bodies, including the General Medical Council (GMC) and the Royal Colleges; The government's intention to establish national standards; the attitude of the Law Commission; and the coming into force of the Human Rights Act 1998.⁸²¹ Thus, although *Bolitho* alone would be unlikely to have a huge impact, in conjunction with these other developments the judiciary will come under increasing pressure to scrutinise professional practice. The effects of *Bolitho*, they claimed, can

⁸¹⁷ Healy, J. *Op cit* n.785, 66.

⁸¹⁸ *Ibid.*, 67.

⁸¹⁹ Montgomery, J. *Op cit* n.297, 375.

⁸²⁰ Brazier, M., Miola, J. 'Bye-Bye Bolam: A Medical Revolution?' (2000) 8 *Medical Law Review* 85, 112.

⁸²¹ *Ibid.*, 110-113, 114.

already be seen in the Court of Appeal decision in *Marriott v West Midlands HA*.⁸²² Further, in the context of information disclosure they noted the combined effects of *Pearce v United Bristol Healthcare NHS Trust*,⁸²³ and *Smith v Tunbridge Wells HA*,⁸²⁴ which signalled ‘that announcements of the stillbirth of ‘informed consent’ in England were premature’.⁸²⁵

Lord Woolf has since commented, extra judicially, that he was ‘attracted’ by the Brazier and Miola article, which supported his belief ‘that the courts are going to take Lord Browne-Wilkinson’s injunction to review the logical basis of the expert medical testimony seriously’.⁸²⁶ Other commentators, however, were more cautious. Thus, Montgomery, Skegg and Jones all argued that it was too early to determine the impact of *Bolitho*.⁸²⁷ In a survey of 64 cases carried out in 2001, 4 years after *Bolitho*, I found that *Bolam* and *Bolitho* were inconsistently applied and that there was little evidence to support Brazier and Miola’s position.⁸²⁸ Even cases, such as *Marriott*, which they strongly relied on, are open to more critical analysis that reveals much less support for their opinion than they claimed.⁸²⁹ That survey, however, was not specific to disclosure cases and it is to those cases that I now turn.

In *Pearce v United Bristol Healthcare NHS Trust*, the Court of Appeal was asked to consider the standard of risk disclosure required to enable the claimant to decide whether to accept the defendant’s advice to follow a conservative non-interventional approach.⁸³⁰ The claimant, who was pregnant, had gone past the expected date of delivery and was

⁸²² *Marriott v West Midlands HA* [1999] *Lloyd’s Law Reports Medical* 23, CA.

⁸²³ *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMLR 118, CA.

⁸²⁴ *Smith v Tunbridge Wells HA* [1994] 5 Med LR 334.

⁸²⁵ *Op cit* n.820, 113.

⁸²⁶ The quote is from Lord Woolf, *Op cit* n.771, 10.

⁸²⁷ *Op cit* n.297, 375; Skegg, P.D.G. ‘English Medical Law and “Informed Consent”: An Antipodean Assessment and Alternative’ (1999) 7 *Medical Law Review* 135, 145-146; *Op cit* n.787, 117-118.

⁸²⁸ Maclean, A.R. ‘Beyond Bolam and Bolitho’ (2002) 5(3) *Medical Law International* 205.

⁸²⁹ *Ibid.*, 212-213.

⁸³⁰ *Op cit* n.823.

extremely concerned for the safety of her fetus. She saw the consultant obstetrician, who counselled her that the safest course was to allow labour to begin naturally. He did not disclose that there was a small (0.1-0.2%) risk of stillbirth, which unfortunately materialised. The woman brought a claim for failure to disclose the risk, which was rejected both at first instance and by the Court of Appeal. This is an important case because the Master of the Rolls held that *Bolitho* applied to risk disclosure and he considered the impact of that judgment on the doctor's duty to disclose.

Despite the fact that the claimant lost her case, Lord Woolf MR's judgment does appear, at first glance, to advance the cause of patient autonomy. He argued that:

if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.⁸³¹

However, the appellant's case was dismissed, which weakens the strength of any support the judge's words may imply. Speaking the right words is far easier than putting those words into practice and it is only when that happens that the words are likely to achieve their maximum practical impact.

Another weakness of the case, however, is the implication that the duty to disclose a risk 'which would affect the judgment of a reasonable patient' only applies where that risk is obviously and objectively significant. Although reluctant to discuss the meaning of 'significant' in terms of 'precise percentages', Lord Woolf MR appeared to focus on 10%, which had been presented by one of the experts as the level of risk that would incur a duty of disclosure. He then argued that the 0.1-0.2% risk in this case was not significant. Lord Woolf MR was correct to suggest that 'precise percentages' have little

⁸³¹ *Ibid.*, 124.

to do with the significance of a risk. However, his judgment was somewhat confused in that he then did exactly that which he had counselled against.

The main difficulties with his approach are that it ignored the nature of the risk and related the relevance of the risk to an objectively reasonable patient without requiring that the subjective position of the patient be taken into account. These difficulties are compounded by Lord Woolf MR's apparent reliance on the expert medical witnesses to determine that the risk was not significant. Since the judgment of significance preceded the assessment of whether disclosure would have affected the reasonable patient's decision it acts as a filtering device, which, being placed in the medical profession's hands, undermines the apparent weight given to patient autonomy: before the reasonable patient test is engaged the medical expert acts as gatekeeper determining the significance of the risk and 'insignificant' risks are excluded from further consideration⁸³²

The nature of the risk is crucial to its significance. In *Pearce* the risk was of a stillbirth. If it was suggested to someone that they should consent to a course of action that would result in death in 1:500 – 1:1000 occasions it is arguable that they would consider the risk to be significant if not common. The supposed lack of significance of the risk of stillbirth seems ridiculous when contrasted to the lesser (0.05%) risk of vasectomy failure and yet it is accepted that it is negligent to fail to disclose that risk.⁸³³ A frequency of 1:10 is such a high cut-off that, in the world of modern medicine, it excludes most of the risks of serious permanent harm. A 1:100 risk of permanent paralysis, for example, may be seen as a very significant risk but, on the basis of Lord Woolf MR's judgment, disclosure would be left to the doctor's discretion. This apparently exclusive reliance on percentages also excludes the very relevant factors of the risks associated with alternative courses of

⁸³² *Op cit* n.828, 213-214; Maclean, A.R. 'The doctrine of informed consent: does it exist and has it crossed the Atlantic?' (2004) 24(3) *Legal Studies* 386, 408-409.

⁸³³ See the Family Planning Association website at: <http://www.fpa.org.uk/guide/contracep/steril.htm#eff> (accessed 4th February 2005). The rate for failure of female sterilization is quoted as: 0.5-0.2%

action. In this case, the risks associated with a caesarean should have been compared with the risks associated with non-intervention in order to determine whether the risk of stillbirth from non-intervention was significant. Finally, the significance of a risk also depends on how it will impact on the patient's life should it materialise. While it may be appropriate to objectify this assessment, Lord Woolf MR's argument does not explicitly include any scope for the patient's circumstances to be considered.⁸³⁴ As I have argued elsewhere, if the prudent patient standard is relevant then: 'The question should not be whether the doctor thinks the risk is significant but whether the reasonable person, pregnant, post term and concerned to deliver a healthy baby, would find the risk significant'.⁸³⁵

Brazier and Miola suggested that:

Even the cynic must concede that, whatever the outcome on the facts, the 'reasonable doctor' test received a body blow in *Pearce*. It survives only if the 'reasonable doctor' understands that he must offer the patient what the 'reasonable patient' would be likely to need to exercise his right to make informed decisions about his care.⁸³⁶

While it is true that this argument does reduce the test to that of the 'reasonable patient' it is subject to the crucial caveat of who decides what counts as 'a significant risk which would affect the judgment of a reasonable patient'.⁸³⁷ Following Lord Woolf MR's approach, the courts would still rely on the experts to determine the significance of a particular risk.⁸³⁸ As I have noted elsewhere:

This approach turns the Brazier and Miola argument back on its head. The standard becomes: the doctor must disclose those risks

⁸³⁴ Other than the patient's ability to comprehend and utilise the information.

⁸³⁵ Maclean, *Op cit* n.832, 409.

⁸³⁶ *Op cit* n.820, 110. See also, Grubb, A. 'Medical Negligence: Duty to Disclose after Bolitho' (1999) 7(1) *Medical Law Review* 61, 63.

⁸³⁷ *Op cit* n.823, 124.

⁸³⁸ The expert opinion would still be subject to the *Bolitho* caveat.

that the reasonable doctor believes the reasonable patient ought to find significant to a decision. This view may be cynical, but the judgment in *Pearce*, and the court's apparent reliance on percentages and expert assessment of significance, does nothing to dispel that cynicism.⁸³⁹

The practical impact of *Pearce* remains to be seen. In theory it has inched towards a standard marginally more respectful of patient autonomy than *Bolam simpliciter*. However, as I have argued, Lord Woolf MR's judgment is not wholly consistent or coherent and leaves the standard open to divergent interpretations. It would be speculative to try and second guess the direction the courts will take, although if the previous trend is continued the law will, in fits and starts, stumble towards the doctrine of informed consent as espoused in *Canterbury v Spence*. This continued trend towards the prudent patient standard is confirmed by *Wyatt v Curtis*, which concerned the duty to disclose the risks of chicken pox to a pregnant woman.⁸⁴⁰ Sedley LJ generously interpreted Lord Woolf's test to recognise the patient's subjective appreciation of the risks, which was conspicuously absent from Lord Woolf's judgment. Sedley LJ stated:

Lord Woolf's formulation refines Lord Bridge's test by recognising that what is substantial and what is grave are questions on which the doctor's and the patient's perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception.⁸⁴¹

Thus, what may not be significant to the doctor may well be relevant to the patient's decision and ought to be disclosed.

⁸³⁹ *Op cit* n.828, 214.

⁸⁴⁰ *Wyatt v Curtis* [2003] EWCA Civ 1779, CA.

⁸⁴¹ *Ibid.*, [16]

This goes further than what Lord Woolf actually said - or did – in *Pearce* (see above), and appears to reflect the Brazier and Miola interpretation of the judgment. However, although a Court of Appeal judgment, it was *obiter* to the decision as the appeal concerned one doctor trying to join a second doctor in liability. Since the first doctor had been found liable for the failure to disclose, and the appeal concerned the liability of the second doctor, it was not a case of doctor against patient but doctor against doctor. These particular circumstances may allow the court the luxury of a more generous interpretation of the duty to disclose and means that their words do not have to be backed by action. Lord Woolf’s test is capable of Sedley LJ’s interpretation, but the meaning of a test lies in both the words and its application. Since the Court of Appeal in *Wyatt* did not need to apply the test, it remains uncertain how sensitive to the patient’s subjective appreciation it will be in practice.

3. Information Disclosure and Understanding

It would be too onerous to insist on ensuring actual understanding,⁸⁴² however, the courts have held that the professional’s duty does not end with simple disclosure.⁸⁴³ In *Smith v Tunbridge Wells HA*,⁸⁴⁴ Moorland J argued that the doctor’s duty to inform included the use of appropriately simple language, ‘which the doctor perceives ... will be understood by the patient so that the patient can make an informed decision as to whether or not to consent to the recommended surgery or treatment’. Thus, the doctor’s duty is to: ‘take reasonable care to ensure that his explanation of the risks is intelligible to his particular patient’.⁸⁴⁵ This duty requires the doctor to have some regard to the patient’s condition and, where a patient is less receptive, for example because of illness or the after-effects of

⁸⁴² See: Somerville, M.A. ‘Structuring the Issues in Informed Consent’ (1981) 26 *McGill Law Journal* 740, 778.

⁸⁴³ *Lybert v Warrington HA* (1995) 25 BMLR 91; [1996] 7 Med LR 71, CA; Williams. K. ‘Comprehending Disclosure: Must Patients Understand The Risks they Run’ (2000) 4 *Medical Law International* 97.

⁸⁴⁴ *Op cit* n.824.

⁸⁴⁵ *Ibid.*, 339.

medication or treatment, the onus lies with the doctor to adapt his practice of disclosure accordingly, which may require repetition of the information on a subsequent occasion.⁸⁴⁶

*Deriche v Ealing Hospital NHS Trust*⁸⁴⁷ concerned a doctor who was aware that the patient had already been counselled regarding the risks of chicken pox infection to the patient's fetus. Buckley J decided in favour of the claimant because the defendant failed 'to ensure that she [the claimant] fully understood the nature of the risks under discussion'.⁸⁴⁸ This decision, while only first instance, appears to require that the doctor does indeed ensure understanding. As suggested earlier, this is an onerous duty and one that the courts have generally shied away from. In *Deriche*, Buckley J relied on the expert witness' evidence, which he took to say that the defendant should have ensured his patient 'fully understood the nature of the risks and should not simply have taken Dr Adedze's notes as read'.⁸⁴⁹ It is submitted that the gist of this is that the defendant should have made certain that she was aware of the risks and that they were potentially serious for the fetus. This is a lesser duty than ensuring 'understanding', which would require the doctor to enquire into the patient's appreciation of the risk, rather than simply whether she understood enough to recite the risks back to the doctor. However, since it was not fully explained, the extent of the duty is uncertain and will only be clarified by subsequent case law.

There may also be a duty to ensure that a misunderstanding does not occur. This duty is limited to reasonable misunderstandings where patients have already indicated their concern to their physician.⁸⁵⁰ In *Cooper v Royal United Hospital Bath NHS Trust*,⁸⁵¹ the poor communication and lack of coordination between the doctors caring for the claimant

⁸⁴⁶ *Smith v Salford HA* [1994] 5 Med LR 321; (1994) 23 BMLR 137, 149. See also: *Lybert v Warrington*, *Op cit* n.843.

⁸⁴⁷ *Deriche v Ealing Hospital NHS Trust* [2003] EWHC 3104.

⁸⁴⁸ *Ibid.*, [44].

⁸⁴⁹ *Ibid.*, [42].

⁸⁵⁰ *Crouchman v Burke* (1997) 40 BMLR 163, 176.

⁸⁵¹ *Cooper v Royal United Hospital Bath NHS Trust* [2005] EWHC 3381.

meant that she was understandably confused about her options. It also meant the hospital ‘team’ made erroneous assumptions about her wishes, which resulted in the claimant being presented with a management plan that led to the failure to detect a recurrence of her breast cancer. Butterfield J held that the defendants were liable in negligence for misleading the claimant and depriving her of ‘her right to choose the treatment she would prefer and address the risks that she ... not Dr Goddard was facing’.⁸⁵²

In *Cooper* the misunderstanding clearly arose from the doctors’ failure to communicate effectively, both with each other and with the patient. The approach in that case may be contrasted with *Al Hamwi v Johnston*, in which the origin of the misunderstanding was unclear and the doctor had provided the patient with factually correct information. In finding for the defendant, Simon J concluded that there was no duty to ensure understanding and misunderstandings were inevitable in clinical practice.⁸⁵³ Thus, ‘clinicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided’,⁸⁵⁴ but this was satisfied by the provision of accurate information and required nothing more than a superficial enquiry as to whether the patient understood the information. The restricted nature of the duty is indicated by Simon J’s acceptance that the defendant’s approach was appropriate when she stated:

I understand it is alleged that in response to the fact that (the Claimant) changed her mind in the course of the consultation I should have asked her why she had changed her mind. I would never ask a patient to explain or justify the decision they have made. I would not

⁸⁵² *Ibid.*, [58].

⁸⁵³ *Al Hamwi v Johnston, The North West London Hospitals NHS Trust* [2005] EWHC 206; [2005] Lloyd’s Rep Med 309, [69].

⁸⁵⁴ *Ibid.*, [69].

do so because I would be concerned that by doing so the patient may interpret this as criticism of their choice.⁸⁵⁵

This limited approach to ensuring that patients understand the information and are truly exercising their autonomy may be affected by the context of the counselling. *Al Hamwi* concerned the advice given to the claimant about having amniocentesis to detect fetal chromosomal abnormality. It is perfectly correct, as the judge noted, that clinicians should not allow their religious beliefs to colour their advice.⁸⁵⁶ However, a distinction can be made between directive advice based on personal religious or moral views and directive advice based on clinical and social factors. Given the emphasis on the fact that the patient was provided with written information, Miola suggested that: ‘the impression given is that what is important is the imparting of information and that its effective communication – actual understanding on the part of the patient – is less critical’.⁸⁵⁷ Simon J’s judgment, which allowed the clinician to simply accept the patient’s decision without question, implies that any duty to ensure understanding is limited to the way in which information is presented and does not include a requirement to challenge a decision. It may, of course, be relevant that the decision was not wholly irrational. It remains open whether the clinician has a duty to enquire into the patient’s understanding where the decision appears to be objectively irrational.

4. The Professional’s Duty to Persuade

Apart from the limited duty to facilitate understanding, Simon J’s judgment in *Al Hamwi* indicates that clinicians are not under a duty to persuade, or attempt to persuade patients to change their minds if their decisions seem unwise. This follows from Simon J’s acceptance that ‘Counselling should be non-directive, avoiding influencing or dictating

⁸⁵⁵ *Ibid.*, [73].

⁸⁵⁶ *Ibid.*, [64].

⁸⁵⁷ Miola, J. ‘Autonomy Rued OK?’ (2006) 14 *Medical Law Review* 108, 111-112.

the parents' decision and allowing them a sense of control over the pregnancy'.⁸⁵⁸ It also follows from his approval of the defendant's approach to accepting the patient's decision without question (see above). That there is currently no legal duty to (attempt to) persuade is confirmed more explicitly by the judgment in *Attwell v McPartlin*,⁸⁵⁹ in which the judge argued:

It is for the patient, not the doctor, to decide whether the risks of any particular treatment or procedure are acceptable. It would, in my opinion, be a novel and serious departure for established practice throughout a wide range of professional relationships ... to hold that a doctor is under a legal duty, not just to advise and warn fairly and appropriately but to persuade or ... to express his wishes in such a way as to secure compliance. Some doctors may wish to make an effort to persuade a reluctant patient to act in what the doctor sees as the patient's best interests; some doctors may even feel the need to adopt an overbearing or bullying attitude in order to secure compliance. But, in the end, in the ordinary case it is for the professional to advise and for the patient ... to decide. There is no scope for a duty to "push".⁸⁶⁰

Although there is no duty to attempt to persuade the patient, the High Court has held that there is a duty not to present the information in such a way that patients' right to make their own decisions is usurped. In *Thompson v Bradford*, the parents of a young boy with an unusual perianal abscess that required surgery were told that they could proceed with immunising their child.⁸⁶¹ This resulted in him contracting polio. Wilkie J held that, while the defendant had not acted negligently in advising the parents to proceed with

⁸⁵⁸ *Op cit* n.853, [44]. The quote is from an Obstetrics textbook. See also *Enright v Kwun* [2003] EWHC 1000.

⁸⁵⁹ *Attwell v McPartlin* [2004] EWHC 829.

⁸⁶⁰ *Ibid*, [60].

⁸⁶¹ *Thompson v Bradford* [2004] EWHC 2424.

immunisation, he was negligent ‘for the way in which he gave advice’.⁸⁶² The defendant had been ‘unnecessarily dismissive’ of the parents’ concerns and had ‘failed to inform them that the recurrent perianal abscess was unique in his experience and extremely unusual’,⁸⁶³ which caused the parents to passively accept ‘his confident advice’.⁸⁶⁴ However, the decision was reversed on appeal on the grounds that contracting polio following immunisation was an unforeseeable consequence that undermined any possible duty to advise postponing immunisation.⁸⁶⁵ The Court of Appeal rejected the argument that the unusual presentation of the abscess should have put the doctor on alert that the risks of vaccination may be affected and the reasonable general practitioner was entitled to rely on the information in the “Green Book”, which advised that ‘[m]inor infections without fever or systemic upset are not reasons to postpone immunisation’.⁸⁶⁶ This essentially factual reason for allowing the appeal allowed the Court of Appeal to avoid dealing with Wilkie J’s criticism of the defendant for his dismissively paternal approach to advising the claimants.

These cases appear to indicate that the courts have accepted that counselling should be non-directive although it is acceptable for doctors to indicate what they recommend.⁸⁶⁷ Information should be presented as factual numerical risks and the patients left to make their own decision.⁸⁶⁸ There is no duty to attempt to persuade the patient. In *Attwell*, the judge appears to have accepted that doctors may attempt to persuade patients and may even do so in an ‘overbearing or bullying’ way. In *Thompson*, the High Court appears to have rejected that approach as undermining patient autonomy. However, when *Thompson* reached the Court of Appeal, the relevance of the doctor’s manner was side-stepped.

⁸⁶² *Ibid.*, [27].

⁸⁶³ *Ibid.*, [27].

⁸⁶⁴ *Ibid.*, [32].

⁸⁶⁵ *Thompson v Bradford* [2005] EWCA Civ 1439; [2006] Lloyd’s LR Med 95.

⁸⁶⁶ *Ibid.*, [11]. For information on the “Green Book” see:

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/fs/en>.

⁸⁶⁷ *Op cit* n.576, para 51 per Lord Phillips MR.

⁸⁶⁸ *Enright v Kwun* [2003] EWHC 1000, [56].

Arguably, this leaves the legal rules in a confused state, making it difficult for HCPs to know what is allowed and what is expected of them. This is particularly so as the judge in *Atwell* appears to have failed to appreciate the distinction between rational persuasion and other methods of getting the patient to make the desired decision. While rational persuasion respects, and is arguably required to respect, autonomy, “bullying” is unacceptable and is an example of undue influence.

5. Non-Treatment Decisions

While there is an obligation to disclose information about the alternative treatments available,⁸⁶⁹ there is no obligation to provide particular treatments. Consent is the expression of the negative right to self-determination and it affords no positive claims to a right to treatment. This was made clear by the Court of Appeal in *R(Burke) v GMC*.⁸⁷⁰

Lord Phillips MR stated:

The doctor will describe the treatment that he recommends or, if there are a number of alternative treatments that he would be prepared to administer in the interests of the patient, the choices available, their implications and his recommended option. In such circumstances the right to refuse a proposed treatment gives the patient what appears to be a positive option to choose an alternative. In truth the right to choose is no more than a reflection of the fact that it is the doctor’s duty to provide a treatment that he considers to be in the interests of the patient and that the patient is prepared to accept.⁸⁷¹

Although there is no right to particular treatments,⁸⁷² it is at least arguable that Article 8 of the ECHR - incorporated into domestic law by the Human Rights Act 1988 - allows

⁸⁶⁹ *Smith v Salford HA* (1994) 23 BMLR 137, 148.

⁸⁷⁰ *Op cit* n.576.

⁸⁷¹ *Ibid.*, para 51.

⁸⁷² *North West Lancashire HA v A, D & G* [1999] Lloyd’s Rep Med 399, CA.

patients the right to be involved in, or at least to be informed of, decisions not to offer treatment. In *Glass v UK*,⁸⁷³ the European Court of Human Rights (ECtHR) held that the claimant's rights under Article 8 had been breached by doctors who failed to seek the court's authorisation when their management plan differed from what Mrs Glass believed to be in her son's best interests. In *W v UK*, which involved decisions regarding children who had been taken into care, the ECtHR stated:

In the Court's view, what therefore has to be determined is whether, having regard to the particular circumstances of the case, and notably the serious nature of the decisions to be taken, the parents have been involved in the decision-making process ... to a degree sufficient to provide them with the requisite protection of their interests.⁸⁷⁴

If parents have an article 8 right to be involved in the decision-making process regarding their children then, given that Article 8 protects individual autonomy,⁸⁷⁵ it is arguable that individuals should also be involved in the decision-making process about their medical treatment. While such a right is not traditionally available through either battery or negligence, and thus is not protected by the legal regulation of consent to medical treatment, it is arguably a right that the courts should protect.

6. The Therapeutic Privilege

Although the doctrine is generally associated with 'informed consent' and the 'prudent patient' standard of information disclosure, a similar doctrine operates in English law as a component of the professional standard of disclosure.⁸⁷⁶ As Grubb suggested: 'The need for a "therapeutic privilege"... is at the heart of the majority view in *Sidaway* that at least *prima facie*, *Bolam* should apply'.⁸⁷⁷ Thus, if a reasonable body of physicians would withhold the information because it might 'harm' the patient then the requisite standard of

⁸⁷³ *Glass v UK* [2004] 1 FLR 1019, ECtHR

⁸⁷⁴ *Op cit* n.595, 50.

⁸⁷⁵ *Pretty v UK* (2002) 35 EHRR 1, 17, ECtHR.

⁸⁷⁶ *Op cit* n.787, 113.

⁸⁷⁷ *Op cit* n.763, 13.

care would be satisfied. That the principle is part of English law is shown by Lord Templeman's judgment in *Sidaway*. He stated: 'the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor's own obligation to say or do nothing which the doctor is satisfied will be harmful to the patient'.⁸⁷⁸ In *McAllister v Lewisham*, Rougier J referred to this: 'as "the therapeutic privilege", as was stated in a recent Australian case, a phrase descriptive of the situation where a doctor may be genuinely and reasonably so convinced that a particular operation is in the patient's best interests that he is justified in being somewhat economical with the truth where recital of dangers is concerned'.⁸⁷⁹ This, he argued, was wholly in keeping with the principle of the *Bolam* test.

Disclosure and Causation

In order to succeed in negligence, the claimant must prove that the damage suffered was caused by the defendant's negligence. In non-disclosure cases the risk itself is not caused by the defendant's negligence. Instead, the defendant's negligence must have caused the claimant to be exposed to this non-negligent risk. This means that, to complete the causal association between the defendant's negligence and the damage, claimants must show that, but for the negligent failure to disclose the risk, they would have adopted a different course of action and so avoided harm. Thus, in *Bolam v Friern*,⁸⁸⁰ McNair J directed the jury:

If you do come to the conclusion that proper practice requires some warning to be given, the second question which you have to decide is: If a warning had been given, would it have made any difference? The only man who really can tell you the answer to that question is the plaintiff, and he was never asked the question.⁸⁸¹

⁸⁷⁸ *Op cit* n.737, 904.

⁸⁷⁹ *Op cit* n.789, 352.

⁸⁸⁰ *Bolam v Friern* [1957] 1 WLR 582.

⁸⁸¹ *Ibid.*, 590.

This raises two issues: first, should the test be subjectively based on what this patient would have done or should it be objectively based on the ‘reasonable patient’; second, what counts as a different course of action? Both of these raise questions about the protection of patient autonomy. If the test is subjective and the second question interpreted broadly then patient autonomy is protected far more than it is by an objective test and an insistence that the patient must have completely rejected the proffered intervention.⁸⁸²

1. The Nature of the Test

In *Bolam*, McNair J treated causation as subjective. He stated: ‘At any rate ... you might well take the view that unless the plaintiff has satisfied you that he would not have taken the treatment if he had been warned, there is really nothing in this point’.⁸⁸³ On this limited evidence the issue is treated as a straightforward causation problem with claimants having to prove on the balance of probabilities that they would have refused the treatment had they been in possession of all the facts. This subjective test⁸⁸⁴ was affirmed by Bristow J in *Chatterton v Gerson*: ‘When the claim is based on negligence the plaintiff must prove ... that had the duty not been broken she would not have chosen to have the operation’.⁸⁸⁵ Although the test is overtly subjective, Bristow J later appeared to introduce an objective element.⁸⁸⁶ He stated: ‘I should add that ... I would not have been satisfied that if properly informed Miss Chatterton would have chosen not to have [the operation]. The whole picture on the evidence is of a lady desperate for pain relief, who has just been advised by Mr Crymble to let Dr Gerson try again’.⁸⁸⁷ Thus, as Grubb noted:

⁸⁸² The very requirement of causation arguably undermines autonomy. I will deal with this in the following chapter.

⁸⁸³ *Op cit* n.880, 591.

⁸⁸⁴ *Op cit* n.772, 364.

⁸⁸⁵ *Op cit* n.681, 265.

⁸⁸⁶ Healy, J. *Op cit* n.785, 208.

⁸⁸⁷ *Op cit* n.681, 267. For other evidence of a mixed approach see: *Hills v Potter* [1984] 1 WLR 641; *Smith v Barking, Havering and Brentwood HA* [1994] 5 Med LR 285, 289 (Decided 1988); *Moyes v Lothian HB* [1990] 1 Med LR 463, 468, OH.

The net effect of Bristow J's approach, therefore, appears to be a hybrid test of causation. The starting point is subjective: what the particular patient would have chosen to do, if informed. The patient's expressed view, then, undergoes an objective appraisal as to whether it is reasonably believable. In other words, the particular patient is expected to behave as, and will be judged as if he were, a reasonable patient (unless the contrary can be explicitly proved).⁸⁸⁸

This mixed approach to causation has subsequently been applied (*obiter*) by the Court of Appeal in *Pearce v United Bristol Healthcare NHS Trust*.⁸⁸⁹

Sometimes the objective element of the test can work for the claimant but this will generally be where the procedure is an elective life-style choice or where it is particularly risky and medical opinion is divided as to its appropriateness. In *McAllister v Lewisham and Southwark HA*,⁸⁹⁰ the plaintiff succeeded in establishing liability for a failure to warn her of the risks associated with surgery to correct a cerebral arterio-venous malformation. In allowing her claim, Rougier J applied a complex test involving both subjective and objective elements. The main subjective elements were the plaintiff's 'own personality' and the fact that she thought she would have sought a second opinion.⁸⁹¹ The objective elements included the expert evidence that the decision to operate was by no means straightforward and there would have been divided medical opinion. Thus, Rougier J argued that:

[a] second opinion would have been much more keenly aware of the dangers of operating and would, in whatever way it was expressed, have not been in favour of operation. That I feel would have tipped the

⁸⁸⁸ *Op cit* n.702, 197.

⁸⁸⁹ *Op cit* n.823. The objective approach is underscored by Lord Woolf MR's argument (at 125) that: 'if *Mrs Pearce had been able to understand* what she had been told about the increased risk, her decision would still have been to follow, reluctantly, the advice of the doctor'.

⁸⁹⁰ *Op cit* n.789.

⁸⁹¹ *Ibid.*, 353.

balance in Mrs McAllister's mind. After all, few would want to undergo surgery of this magnitude and risk unless they felt that the arguments in favour were, if not compelling, at least very much more powerful than those against.⁸⁹²

This clearly objective standard was arguably also relevant in Rougier J's acceptance that the plaintiff's employment situation was such that at least she would have delayed the surgery.⁸⁹³ Finally, the objective component is most clearly seen in Rougier J's argument that the judge can make a decision regarding the plaintiff's hypothetical decision even where the plaintiff herself was 'reluctant to hypothesise ... provided there exists sufficient material upon which he can properly act'.⁸⁹⁴

The case law suggests that the English courts, while purporting to adopt a subjective standard, subject the plaintiff's evidence to objective scrutiny so that it will only be accepted if it accords with what the judge believes is objectively reasonable. The rationale behind this is the risk of hindsight and self-serving testimony, which accords with the reasoning in the United States and Canada that led to their courts more openly adopting an objective standard.⁸⁹⁵ Robinson CJ explained that a subjective test would be 'purely hypothetical ... hardly ... more than a guess, perhaps tinged by the circumstances

⁸⁹² *Ibid.*, 353-354.

⁸⁹³ See also *Smith v Tunbridge Wells HA*, *Op cit* n.824, in which Morland J clearly sympathized with the plaintiff, a sexually active young man who had not been warned of the risk of impotence following an operation for a rectal prolapse (at 341).

⁸⁹⁴ *Op cit* n.789, 353. See also: *Gowton v Wolverhampton HA* [1994] 5 Med LR 432, 435-436. It is arguable that, for 'elective' treatment such as family planning or cosmetic surgery, it will be far easier to convince the court that the plaintiff's subjective assertions are objectively reasonable. This follows because refusing treatment (or seeking alternatives) does not have the same implications for the individual's long-term health. Where treatment is 'necessary', as opposed to a lifestyle-choice, claimants will face a much harder task in convincing the court that they would have refused consent if properly informed of the risk. See: Robertson, G. 'Informed Consent Ten Years Later: The Impact of *Reibl v Hughes*' (1991) 70 *The Canadian Bar Review* 423.

⁸⁹⁵ *Op cit* n.582, 791 per Robinson CJ (delivering the judgment of the court); *Op cit* n.723, 14-17; Earle, M. 'The Future of Informed Consent in British Common Law' (1999) 6 *European Journal of Health Law* 235, 241.

that the uncommunicated hazard has in fact materialized'.⁸⁹⁶ This would place 'the physician in jeopardy of the patient's hindsight and bitterness'.⁸⁹⁷

Although the English courts have retained the subjective standard of causation, the application of that standard in practice has been strongly constrained by the use of objective criteria to determine the credibility of the plaintiff's assertions. The use of these objective criteria means that it is improbably difficult for patients to succeed unless they are claiming a course that the judge accepts as 'reasonable'. As, Jones suggested:

Generally speaking, where objectively a reasonable patient would have accepted the risk and proceeded with the treatment, it is extremely difficult for the plaintiff to demonstrate that she would not also have acted in that way, unless there is something peculiar to the plaintiff's circumstances which might explain why she would have acted differently.⁸⁹⁸

Skegg also noted the difficulties for plaintiffs and concluded:

In practice, health care practitioners can take it upon themselves to expose patients to risks, without the patients having consented to run those risks, with little likelihood of their being answerable to their patients if the patients discover what has been done.⁸⁹⁹

Although the subjective test is the most respecting of the patient's self-determination, it may be difficult to apply it in practice without allowing the concept of reasonableness to creep in. As Healy stated: 'it seems likely that, whether in name or not, the courts will in most cases consider an assortment of subjective and objective factors before reaching its

⁸⁹⁶ *Op cit* n.582, 790 per Robinson CJ.

⁸⁹⁷ *Ibid.*, 790-791.

⁸⁹⁸ *Op cit* n.787, 120.

⁸⁹⁹ Skegg, P.D.G. 'English Medical Law and "Informed Consent": An Antipodean Assessment and Alternative' (1999) 7 *Medical Law Review* 135, 149.

decision'.⁹⁰⁰ Giesen and Hayes suggested that a wholly subjective test is possible and that German law has found a way of dealing with the problem of hindsight. They argued that the Federal Supreme Court of Germany in a 1984 ruling took the 'correct' approach in requiring the plaintiff to give a 'plausible reason' in the face of a 'real conflict' to explain why he would have refused consent.⁹⁰¹ While this may be preferable to a purely objective test, it would be difficult to accept arguments as plausible unless the reason provided by the claimant is at least credible, and the most credible reasons are those that are objectively 'reasonable' based on the knowledge that the judge possesses of the patient's circumstances. This does not mean that the reasoning must be rationally logical but that the process of reasoning is one that would make sense to a 'reasonable man' as perceived by the judge. As such, the 'plausible reason' test is unlikely to be any less objective than the mixed test applied in England.

Even if the courts were able to adopt a purely subjective standard this would still fall short of the right to give or refuse consent that the patient possesses since the patient may give or refuse consent for no reason whatsoever.⁹⁰² The postcedent requirement for reasons, whether subjective, credible or wholly objective, undermines the antecedent right to decide irrespective of having a reason for the decision. The very requirement to prove the causal link, while a necessary element of negligence liability undermines the patient's right to irrational self-determination. I will return to this in the following chapter.

2. The Content of the Test

The test in *Chatterton* appears to imply that, in order to prove causation, claimants must show that they would have undertaken a different course of action. Although this test describes the basic position subsequent developments have made it easier to recover damages. As mentioned earlier, in *McAllister Rougier J* allowed causation because he

⁹⁰⁰ Healy, J. *Op cit* n.785, 211.

⁹⁰¹ *Op cit* n.767, 121-122.

⁹⁰² *Op cit* n.55, 553.

accepted that, at the very least, the patient would have delayed surgery. More recently, this very issue came before the Court of Appeal in *Chester v Afshar*.⁹⁰³ The claimant was a 51-year-old journalist who suffered severe back pain. Although she was reluctant to undergo surgery, Mr Afshar reassured her sufficiently for the claimant to give consent. Unfortunately, following the surgery she was left with severe neurological deficit. At trial, the court accepted that Mr Afshar had failed to disclose the risk of nerve damage or paralysis and that, had he done so, she would at least have sought second and third opinions before deciding whether to undergo the operation. The trial judge awarded damages for the failure to disclose and Mr Afshar appealed against the decision.

Following the majority decision in the Australian case of *Chappel v Hart*,⁹⁰⁴ and basing the judgment on the individual's right to self-determination, the Court of Appeal held that:

The object is to enable the patient to decide whether or not to run the risks of having that operation at that time. If the doctor's failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he were not to be held responsible when the very risk about which he failed to warn her materialises and causes her an injury which she would not have suffered then and there ... It would in our judgment be unjust to hold that the effective cause of the claimant's injury was the random occurrence of the 1 to 2% risk referred to above rather than the defendant's failure to bring such risk to her attention.⁹⁰⁵

⁹⁰³ *Chester v Afshar* [2002] EWCA Civ 724.

⁹⁰⁴ *Chappel v Hart* [1998] HCA 55; [1999] *Lloyds Law Reports Medical* 223; (1998) 72 ALJR 1344, HCA.

⁹⁰⁵ *Op cit* n.903, [47].

The House of Lords subsequently upheld the Court of Appeal decision. Their Lordships in the majority justified what they saw as ‘a narrow and modest departure from traditional causation principles’⁹⁰⁶ by arguing that, because of the patient’s right to autonomy,⁹⁰⁷ to do otherwise would strip the duty to disclose ‘of all practical force’ and render it ‘devoid of all content’.⁹⁰⁸ Following *Chester*, the current test for causation appears to be that claimants will succeed if they can show that disclosure of the risk would simply have altered their decision. Claimants no longer need to show that they would have refused consent to the proffered treatment.

As a final point, damages may sometimes be awarded even though the claimant has been unable to prove causation in relation to the materialised risk. These cases are where the materialised risk had additional consequences that might have been avoided had the claimant been forewarned. In *Newell and Newell v Goldenberg*, for example, the omission to mention the risk that the man’s sterilisation might fail put strain on the marriage when his wife became pregnant.⁹⁰⁹ The judge sympathised with the claimant in the worry that his wife may have been unfaithful and he awarded damages to compensate for the distress caused.⁹¹⁰

Legally Recognised Damage

The final aspect of legal liability is the type of harm that the courts are prepared to recognise. Traditionally the courts have accepted that damages may be awarded to compensate for physical harm, or – in more limited circumstances - psychiatric harm or economic loss. Where the damage arises as a result of an undisclosed risk materialising the situation is relatively unproblematic since the harm is obvious. However, where the claim is simply that consent was invalid and the procedure was a battery, the situation is

⁹⁰⁶ *Chester v Afshar* [2004] UKHL 41 [24] per Lord Steyn.

⁹⁰⁷ *Ibid.*, [18-24] per Lord Steyn; [77] per Lord Hope; [92-93] per Lord Walker.

⁹⁰⁸ *Ibid.*, [86-87], per Lord Hope. See also Lord Walker at [101].

⁹⁰⁹ *Newell and Newell v Goldenberg* [1995] 6 Med LR 371.

⁹¹⁰ See also the Scottish case *Goorkani v Tayside HB* 1991 SLT 94.

less straightforward. Where the procedure is medically indicated, then it is arguable that the patient has benefited from its performance.⁹¹¹ This is particularly problematic where the treatment was life-preserving since the courts generally consider life to be a benefit.⁹¹² Although in *Malette v Shulman*, a Jehovah's Witness was awarded \$20,000 following a blood transfusion contrary to an advance directive, the English approach may be different.⁹¹³ Thus, commenting on *Malette* in *Re T*, Butler-Sloss LJ stated: 'I do not believe an English court would give damages in those particular circumstances'.⁹¹⁴

A similar problem arose in negligence with the wrongful pregnancy cases, in which an unwanted pregnancy results from the defendant's negligence leaving the claimants with the cost of raising an unplanned child. In *MacFarlane v Tayside HB*,⁹¹⁵ the House of Lords held that the birth of a healthy child was an unquantifiable blessing that could not be offset against the economic loss arising from the maintenance costs associated with raising the child. Subsequently, in *Rees v Darlington HA*,⁹¹⁶ the House of Lords acknowledged that the mother's autonomy had been infringed. With a majority of 4:3, their Lordships awarded the conventional sum of £15,000 in recognition of the harm done.

It would be possible for the courts to award a similar amount in other cases where the harm was primarily to the claimant's autonomy. Mason and Brodie in fact criticised the decision in *Chester* because, they argued, the harm was to the patient's autonomy rather than the physical consequences of the risk materialising.⁹¹⁷ Thus, they suggested that an award of a conventional sum, as in *Rees*, would have been more appropriate. Given that

⁹¹¹ Gavaghan, C. 'Anticipatory Refusals and the Action of "Wrongful Living"' (2000) 5 *Medical Law International* 67, 72-75.

⁹¹² *Ibid.*; *McKay v Essex AHA* [1982] 1 QB 1166, CA; *Op cit* n.263; 72-75.

⁹¹³ *Malette v Shulman* (1990) 67 DLR (4th) 321.

⁹¹⁴ *Op cit* n.510, 800. See also, Staughton LJ's similar comment at 805.

⁹¹⁵ *Op cit* n.263.

⁹¹⁶ *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52, HL.

⁹¹⁷ Mason, K. Brodie, D. 'Bolam, Bolam – wherefore art thou Bolam?' (2005) 9(2) *Edinburgh Law Review* 298, 305.

Article 8 of the ECHR,⁹¹⁸ protects the right to personal autonomy,⁹¹⁹ it is arguable that an infringement of this right should be acknowledged by an appropriate award of damages. In *Cornelius v De Taranto*, for example, the court made an award of £3000 for the mental distress caused by a breach of confidence in order to recognise the seriousness of breaching a protected human right.⁹²⁰ However, in the wrongful pregnancy cases the award may reflect judicial sympathy for the harshness of a law that precludes any recovery at all for the maintenance costs associated with the unplanned child. The award of damages in these cases may simply be a way of mitigating that harshness and thus the courts may be less inclined to make a similar award in other cases.

Summary

In this chapter I have described the current legal regulation of consent. I noted that battery law regulates direct invasions of bodily integrity but all other interventions fall within the penumbra of the law of negligence. It is battery law that allows the patient the right to refuse treatment, regardless of the reason, and it is this branch of law that requires the patient to be competent and for consent to be given without undue influence. While battery law has the advantage of focusing on the right to bodily integrity, which allows patients to exercise their autonomy by giving or withholding consent, it is readily satisfied by minimal disclosure of the nature and purpose of the procedure in broad terms. Further disclosure is required to satisfy the HCP's duty under negligence law.

The duty to disclose in negligence law most importantly covers risks and alternative treatments. Currently the duty is determined by the professional standard but phrased in such a way as to approach the prudent patient standard. Incorporated within this standard is the therapeutic privilege, which retains for the HCP a degree of paternalistic control

⁹¹⁸ The right to private and family life.

⁹¹⁹ *Op cit* n.875, 17.

⁹²⁰ *Cornelius v De Taranto* [2001] EMLR 12, [65-69]. The case went to appeal, but this aspect was not overruled by the Court of Appeal: (2002) 68 BMLR 62.

over the information disclosed. The law requires disclosure of information in a way that is sensitive to the need to support patient understanding. However, there is no requirement to ensure understanding. Furthermore, there is no duty to make more than a cursory enquiry of whether the patient has understood and there is certainly no duty to challenge an irrational decision or try to persuade patients to change their minds. Like the duty to disclose, the rules regarding causation have become more sensitive to individual autonomy. The law now allows that causation is satisfied if claimants can show that they would simply have made a different decision had the risk been disclosed. While this is more sensitive to autonomy than a rule that required claimants to prove that they would have refused consent, it still requires that the change of decision is credible. This means that it must be objectively reasonable, which is arguably inconsistent with the antecedent right to refuse treatment (which can be for irrational or no reason).

Chapter Six: Rationalising the Law and Ethics of Consent

In this chapter I will compare the current legal regulation of consent against the model developed in part one and I will argue that the current regulation of consent falls short. However, this is not to suggest that the shortfall must be met by direct legal regulation. There are a number of alternative responses, which include allowing further development of the common law, legislation with or without a code of practice and a regulatory body, an enhanced role for professional regulation, or some combination of these. Ultimately the decision is a political one that will be guided by the cost, the support of the various lobbies and the vision of the type of healthcare system that the Government wants to develop: a market approach to healthcare would support a very different regulatory model of consent than would more social, welfare or communitarian visions.

The model I have developed might be categorised as socio-liberal: respect for individual autonomy is seen as the guiding principle but that autonomy is situated in the professional-patient relationship, which is in turn part of the wider network of relationships that constitutes the community. This allowed me to argue for a model of consent that incorporates both consent as a permission and consent as agreement. It also justifies a clear distinction between harm caused by an infringement of the right to consent and the harm caused by the materialisation of a risk. Furthermore, the relational aspect of both autonomy and consent requires that the obligations arising from the professional-patient relationship fall on both parties and not just the professional.

The Split Between Battery and Negligence

Perhaps the first thing to note about the legal regulation of consent is the distribution of the rules between the two distinct torts of battery and negligence. In principle my model of consent might support this approach with battery governing consent as permission while negligence regulates consent as agreement. Since battery makes unjustified contact

unlawful, the individual is granted a legally protected right to bodily integrity. In allowing the individual to waive this right, by granting consent, the tort focuses the law's attention on the wrong done to the victim rather than on the behaviour of the actor. This makes the tort conceptually attractive because it is consistent with the central theory of consent as permission. Negligence, on the other hand, focuses on the duty of the professional while allowing the patient's behaviour to be taken into account through the defence of contributory negligence. Since there is no need for bodily contact, negligence encompasses both treatment decisions – including those not involving direct contact – and non-treatment decisions. Thus, negligence is better situated than battery to regulate consent as agreement.

The major problem with this view is that the current legal regulation arose not for conceptual reasons but because the judiciary were reluctant to hold doctors liable for battery.⁹²¹ As Brazier noted:

Save in the area of police powers, trespass as a means for the vindication of civil liberties seem sadly to be regarded with suspicion by our courts ... A judgment in trespass for a failure in communication, an over-zealous desire to make the right decision for a patient, may be seen as putting the doctor on a par with a police officer who beats up a suspect. And this is not simply an emotional response. The overlap between the tort of battery and the crime of assault cannot be ignored.⁹²²

This reluctance was given practical effect when risk disclosure was divorced from the requirements of consent in battery and made a duty in negligence.⁹²³

⁹²¹ Harrington, J.A. 'Privileging the medical norm: liberalism, self-determination and refusal of treatment' (1996) 16 *Legal Studies* 348, 352; Giesen, D. *Op cit* n.598, 22. Such reluctance may be seen in *Davis v Barking, Havering and Brentwood Health Authority* [1993] 4 *Medical Law Reports* 85, 90 per McCullough J. Also, see: *Sidaway*, *Op cit* n.737, 885 per Lord Scarman.

⁹²² *Op cit* n.765, 180. See also Grubb, A. *Op cit* n.702, 172-173.

⁹²³ See, for example: *Sidaway*, *Op cit* n.737, 885 per Lord Scarman

This split between negligence and battery has a number of consequences. First, because it reflects a judicial reluctance to use the tort of battery, the usefulness of that tort is undermined and it only becomes relevant where there has been a gross failure to obtain consent or where the HCP has acted in bad faith. Thus, where a dentist secured his patient's consent to expensive dental restorative work by convincing them it was clinically necessary he was liable in battery.⁹²⁴ However, where an anaesthetist, acting in good faith and beneficently, performed a caudal (local) anaesthetic even though the patient had only consented to a general anaesthetic he was not liable.⁹²⁵ On the one hand this limits its usefulness as a general means of regulating consent to medical treatment. On the other hand it does allow the courts to condemn a particularly serious failure to respect the patient's autonomy by finding the defendant liable for battery.

A second consequence of the split is that risk disclosure is regulated in negligence rather than battery. This again undermines the use of battery as means of regulating consent to medical treatment. The split was made for largely pragmatic, rather than conceptual, reasons and this leads to uncertainty regarding the purpose of risk disclosure: if it is not necessary for consent then what is its purpose and why does causation require that the claimant would have made a different consent decision had the information been disclosed? However, if risk disclosure is necessary for consent then it ought to be required for the patient's consent to be real. In the Canadian case of *Reibl v Hughes*, although he acknowledged that an 'informed choice' requires knowledge of the risks, Laskin CJC held that the duty to disclose risks derives from a general 'anterior' duty of care arising by virtue of the doctor's role.⁹²⁶ However, if patients require knowledge of the risks to make an 'informed choice' then it is arguable that they require that knowledge in order to truly exercise their autonomy. If the law of battery is to protect individual

⁹²⁴ *Op cit* n.730.

⁹²⁵ *Davis v Barking, Havering and Brentwood Health Authority* [1993] 4 Medical Law Reports 85.

⁹²⁶ See n.729.

autonomy then it should require disclosure of those risks that are essential to an informed choice. To make risk disclosure part of the doctor's general duty of care is to shift the emphasis away from a patient-centred right to autonomy. Thus, the patient's right to be informed of risks is currently a derivative right dependent on the doctor's duty of care rather than the individual's right to self-determination.

A third consequence of the split is that it affects the question of competency, although this point does not seem to have been acknowledged in practice. In principle one need only be competent to understand the information necessary to make the consent decision.⁹²⁷ Since risk information is unnecessary for a real consent then there is no need for the patient to understand it. However, the current *Re C* test includes the ability to weigh up the risks as part of the decision-making process.⁹²⁸ In *Cambridgeshire CC v R*, Hale J. avoided explicit reference to risks. However, the *Mental Health Act Code of Practice* quotes the tripartite *Re C* test as the appropriate test for competence and states that the knowledge required for consent includes: 'the purpose, nature, likely effects and risks of th[e] treatment including the likelihood of its success and any alternatives to it'.⁹²⁹ Although the Mental Capacity Act 2005 and the draft Code of Practice do not refer specifically to risks (the Code talks of 'likely consequences')⁹³⁰ the test of capacity in the Act is similar to, and informed by, the *Re C* test,⁹³¹ which may mean that the ability to understand the risks of the procedure will continue to be part of the test of competency. This is particularly likely as HCPs will be making the competency assessments and currently risk disclosure is widely seen as a necessary part of consent in medical ethics and practice.⁹³²

⁹²⁷ Gunn, M. *Op cit* n.682.

⁹²⁸ *Op cit* n.683, 292 per Thorpe J.

⁹²⁹ *Op cit* n.686, paras 15.10 and 15.13.

⁹³⁰ Draft Mental Capacity Act Code of Practice (2005) para 3.18.

⁹³¹ The Lord Chancellor. *Making Decisions* (1999) Cm 4465, para 1.6; *Op cit* n.687, para 3.15; Mental Capacity Act s.3(1).

⁹³² Mayberry, M. Mayberry, J. *Consent in Clinical Practice* (2003) Abingdon: Radcliffe Medical Press Ltd, 82-91.

Because risk disclosure is regulated by the duty of care in negligence law it is arguable that where the patient is unable to understand the risk information then, rather than this making the patient incompetent to consent, it simply negates the duty to disclose. This follows because it would be nonsensical to require a duty to do something that is futile.⁹³³ Thus, unless there is some reason for risk disclosure other than the need to decide whether or not to consent to treatment then there is no duty to disclose it where the patient is unable to understand it. The patient could still give a valid consent justifying medical treatment but would lose the right to complain about a failure to disclose the risk. That the duty to disclose risk relates to the treatment decision is evident in the court's approach to liability where the risk materialises and claimants are required to prove causation by showing that the information would have affected their decision.⁹³⁴

While this conceptual inconsistency may be ignored in practice it does reflect a failure of the law to be truly sensitive to the patient's autonomy as the principle underlying the right to give or withhold consent. It may also threaten the coherent development of the law. Unclear or inconsistent reasons underlying the rules risks divergent interpretations of those rules that may result in the development of an increasingly incoherent law. Furthermore, any development of the legal rules should relate to the reasons justifying the existence of the duty given substance through those rules: if the duty to disclose is related to consent then any change in the duty ought to be consistent with the justifications for requiring consent. However, if the duty is predicated on some other ground then its development should be sensitive to that basis. It is, therefore, problematic that the justification for risk disclosure in negligence is uncertain.

⁹³³ *Op cit* n.646; *LCB v UK* (1998) 27 EHRR 212, 222.

⁹³⁴ See n.880-n.908.

There are four ways in which to conceptualise the negligence-based duty to disclose.⁹³⁵ First, the duty may be seen as wholly independent of consent. Second, consent in battery can be valid but nonetheless negligently obtained if the professional has failed to disclose a material risk. Third, there are two ‘consents’: one a legal consent required by the law of battery, the other an ethical consent predicated on the patient’s right to autonomy, which must be obtained if the professional is to avoid liability in negligence. The fourth possibility is the same as third but the ethical consent, instead of being based on patient autonomy, is driven by the healthcare professional’s duty of beneficence. Space does not permit an exploration of which model is most plausible and I have argued elsewhere that the third and fourth models are the most coherent being equated to the prudent patient and the reasonable doctor standards respectively.⁹³⁶ The important point here is that each of these four models is a possible interpretation and this lack of conceptual clarity carries the potential for an inconsistent or incoherent development of the law.

Currently, therefore, the legal regulation of consent is conceptually unclear and inconsistent. While this does not preclude a rational development of the law, it does increase the risk that the law will develop inconsistently with the underlying ethical justification for the existence of the rights that the law protects and the concomitant duties it imposes. Given the primary reason for the way in which the law has developed – the judicial reluctance to use the law of battery – it seems unlikely that the conceptual confusion will be clarified by the common law. Furthermore, even if the split between negligence and battery could be reversed and risk disclosure included as part of a ‘real’ consent, reliance on the law of battery may still not be the answer since the requirement for directness restricts the extent of the tort to healthcare interventions that involve some

⁹³⁵ *Op cit* n.832, 399.

⁹³⁶ *Op cit* n.832, 399-401.

degree of contact between the HCP and the patient.⁹³⁷ This means that negligence would still be required for ‘consent’ to the non-contact interventions and for decisions not to provide a particular intervention.⁹³⁸ While reserving battery law for serious infringements of patient autonomy may be defensible, and - as I mentioned earlier – would fit with my model, it can only deal with those cases where the infringement involves direct bodily contact. Arguably, therefore, it may be better to acknowledge the need for a specific law that can be more sensitive to the context of healthcare.

Consent and Negligence

Although negligence may be an appropriate vehicle for regulating consent as agreement, it falls short of the ideal with respect to consent as permission. The first weakness is the conceptual basis for negligence. While battery focuses on the wrong done to the patient, negligence concentrates on the behaviour of the healthcare professional.⁹³⁹ Since autonomy is the primary justification for consent, patient-centred regulation is more appropriate than professional-centred law.⁹⁴⁰ The role of consent is to give the actor permission to do something that would otherwise be illegitimate. For patients to be able to give that permission they must control those things that will be affected by the act. If it is the patient’s permission that is important then it makes sense to focus the regulation on whether patients are given an adequate opportunity to exercise that control. Ideally, then, regulation of consent should start by focusing on the conditions under which patients are required to make consent decisions and not whether the professional has acted reasonably in creating those circumstances.

⁹³⁷ See *Morgan*, *Op cit* n.666, 620; Jackson, E. “‘Informed Consent’ to Medical Treatment and the Impotence of Tort’ in McLean, S.A.M. (ed) *First Do No Harm* (2006, Forthcoming) Aldershot: Ashgate 271, 274.

⁹³⁸ *Op cit* n.787, 105.

⁹³⁹ See the related point made by Skegg, *Op cit* n.899, 148.

⁹⁴⁰ *Op cit* n.362, 91.

Since it may be necessary to refer to what may be reasonably expected of the healthcare professional (and provider) in order to determine the extent of necessary circumstances, this point may be dismissed as simply a matter of emphasis. But, this emphasis may affect the ease with which compromises to patient autonomy are accepted. If consent is seen primarily as a role specific obligation the rules may be more readily tempered by the role specific principle of beneficence, which perhaps explains the law's readiness to accept the paternalistic therapeutic privilege (see below) and the apparent distinction between the level of risk disclosure required for non-therapeutic interventions (e.g. sterilisation) as opposed to therapeutic procedures (e.g. management of pregnancy and delivery). Despite this, if the conceptual criticism were the sole problem then it may be reasonable to accept the status quo. However, the law of negligence has other shortfalls that raise questions regarding its suitability as a vehicle for regulating consent.

A second weakness of negligence is that traditionally it requires the claimant to demonstrate actual damage.⁹⁴¹ This is easiest to show where the damage is physical although, under certain conditions, the claimant may also be able to recover where the only damage is economic loss. In cases where there is uncertainty how a third party might have behaved, the claimant may also recover for loss of chance.⁹⁴² The loss of chance claim may be characterised as the loss of an opportunity to control, as far as possible, one's life. It is, therefore, an autonomy-based claim. However, in cases involving the possibility of avoiding the materialisation of medical risks, the English courts have so far refused to recognise the relevance of such a claim. While the possibility of such a claim succeeding has not been completely ruled out,⁹⁴³ the House of Lords' decision in *Gregg v*

⁹⁴¹ *Op cit* n.899, 149.

⁹⁴² *Spring v Guardian Assurance* [1995] 2 AC 296; *Allied Maples Group Ltd v Simmons & Simmons* [1995] 1 WLR 1602, CA.

⁹⁴³ The House of Lords in *Hotson v East Berkshire HA* [1987] AC 750 refused to allow population statistics to be used to circumvent the balance of probabilities test for causation through the use of a 'loss of chance' argument. This has received both academic criticism (Stauch, M. 'Causation, Risk, and loss of Chance in Medical Negligence' (1997) 17 *Oxford Journal of Legal Studies* 205) and support (Hill, T. 'A Lost Chance for Compensation in the Tort of Negligence by the House of

Scott makes it of diminishing likelihood.⁹⁴⁴ In *Rees v Darlington*, however, the House of Lords has recognised a breach of autonomy as a form of damage allowing recovery of a conventional sum.⁹⁴⁵ The damage in that case also included the claimant's pregnancy, which was characterised as physical harm. It is, therefore, uncertain whether the courts will recognise an infringement of autonomy when it occurs in the absence of recoverable physical damage. Apart from the fact that the undisclosed risk may not materialise, there are other types of relevant information that if undisclosed 'tend not to result in physical injury' and are 'marginalised' by the need to show actual damage.⁹⁴⁶

The likelihood of the courts allowing claims where harm to autonomy is the only damage may be increased by virtue of the Human Rights Act 1998. It is arguable under Article 8 (the right to a private and family life) that this type of damage should be recognised by the courts independently of any physical harm. However, this is speculative and the current requirement that the breach of duty caused physical harm, exemplified by the House Lords decision in *Chester v Afshar*, remains a weakness if autonomy and consent are seen as important rights. It might be countered that the courts have, on occasion, provided compensation for the consequences of an infringement of autonomy even though the primary claim fell at the causation hurdle. In *Newell & Newell v Goldenberg*, Mantell J held that the plaintiffs' decisions would not have been altered by disclosure of the risk that the vasectomy might fail.⁹⁴⁷ However, he was prepared to award damages for the distress and anxiety caused by the discovery that Mrs Newell was pregnant. Although this provided a small amount of compensation to the plaintiffs it still required some tangible damage. As such, it fails to recognise that individuals are harmed just because a choice that was theirs to make has been unjustly taken away from them. Thus, it remains

Lords' (1991) 54 *Modern Law Review* 511; Lunney, M. 'What price a chance?' (1995) 15 *Legal Studies* 1).

⁹⁴⁴ *Gregg v Scott* [2005] UKHL 2.

⁹⁴⁵ *Op cit* n.916.

⁹⁴⁶ See, Jackson, E. *Op cit* n.937, 283.

⁹⁴⁷ *Op cit* n.909. See also, *Goorkani*, *Op cit* n.910.

that, while the law espouses the importance of patient autonomy, the current rules of causation and damage belie the judicial rhetoric. As McLean has noted:

Patients may be aggrieved if all information is not disclosed, on grounds which sit uncomfortably within the traditional negligence framework ... They may feel that their right to self-determination was shown insufficient respect where a risk was concealed, even if that risk does not actually occur.⁹⁴⁸

Related to this problem is the inconsistency between what the law claims to be the patient's right and what it is prepared to compensate. The law proclaims that the patient can make any decision regardless of reason.⁹⁴⁹ However, it is then only prepared to compensate those cases of a failure to disclose where claimants provide credible evidence that they would have made a different decision. To be credible, claimants must provide accessible reasons. This is inconsistent: there is a right to refuse treatment for irrational reasons (or even no reason) but in trying to show causation in a failure to disclose case a claimant's purported refusal of treatment must be rational. This arises because of the need to show that the breach of duty caused actual damage. If outcome responsibility were severed from the issue of consent and dealt with separately the inconsistency would be removed since liability for failure to consent would no longer be dependent on showing that a different decision would have been made and the harm from the risk materialising avoided. Separating consent and outcome responsibility would allow these distinct harms to be dealt with in a less blunt way, which would facilitate a more just response. However, because liability for negligence requires a bad outcome, it cannot entirely separate consent and outcome responsibility.

⁹⁴⁸ *Op cit* n.362, 91.

⁹⁴⁹ *Op cit* n.510, 786.

I have already mentioned the problem of emphasis that undermines reliance on negligence. This emphasis is the root cause of a third weakness: the standard of care required. Because negligence focuses on the actor it is understandable that the standard of care is expressed in terms of what the reasonable person would have done in the same circumstances. For professional practice the *Bolam* test is the standard and, traditionally, this has been interpreted to allow significant deference to the professional with the test being determined by expert evidence of common practice.⁹⁵⁰ There have always been instances when the court has rejected such evidence but it is only since the recent House of Lords judgment in *Bolitho* that commentators have suggested that this deference is disappearing.⁹⁵¹ However, in a review of post-*Bolitho* negligence cases, I found little evidence for that optimism.⁹⁵²

The consequence of the *Bolam* test is that the degree of disclosure is determined by professional practice. At its best the standard requires what can be reasonably expected of the professional. While this standard may initially seem fair, such a judgment is parasitic on the determination of reasonableness. At its worst, the standard becomes a sociological comparison between what the defendant did and what other doctors are doing. As Lord Scarman suggested in *Sidaway*, this places the standard wholly in the hands of the profession and is insensitive to the patient's needs and, as Giesen comments: 'The effect ... has been to render the informed decision-making of the patient merely a subordinate aspect of the therapeutic process'.⁹⁵³

In *Pearce*, Lord Woolf MR delivered a judgment hailed by some as being sufficiently sensitive to the patient's needs. Lord Woolf MR decided, after consideration of *Sidaway* and *Bolitho*, that:

⁹⁵⁰ See, for example, Lord Scarman's statement in *Sidaway*, *Op cit* n.737, 880.

⁹⁵¹ See the discussion in chapter four.

⁹⁵² *Op cit* n.828.

⁹⁵³ Giesen, D. *Op cit* n.598, 23.

if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.⁹⁵⁴

Crucially, however, before the sensitivity to the patient's need can influence the doctor's duty the risk must be classed as significant and it appears that this is determined by reliance on the medical expert.⁹⁵⁵ Thus, following *Pearce*, the standard remains largely insensitive of the patient's needs.

As I noted in chapter five, Sedley LJ's *obiter dictum* in *Wyatt v Curtis* provides a generous interpretation of *Pearce* that appears to be more responsive to the patient's subjective appreciation of risk and effectively equates the standard with the prudent patient test.⁹⁵⁶ However, since the interpretation was *obiter* and Sedley LJ did not need to apply the test it remains uncertain how it will be applied in practice. If subsequent courts follow Lord Woolf's lead and refer the question of significance back to the medical expert then any sensitivity to the patient is on shaky ground unless the expert evidence is predicated on more than just that expert's subjective opinion or anecdotal experience. It is arguable that, if the reasonable patient is truly to have a voice in court, then it ought to be based on empirical evidence.⁹⁵⁷ While the judges rely on their own, or the medical experts', intuition, the judgments risk being insensitive to the needs of the reasonable patient let alone the actual patient. This weakens the protection for the patient's autonomy and retains a degree of self-protection for the medical profession since it allows the medical experts a powerful voice in determining the reasonableness of their colleague's behaviour.

⁹⁵⁴ *Op cit* n.823, 124.

⁹⁵⁵ See the discussion in chapter four.

⁹⁵⁶ *Op cit* n.840, [16].

⁹⁵⁷ Maclean, A.R.. 'Giving the Reasonable Patient a Voice: Information Disclosure and Empirical Evidence' (2005) 7 *Medical Law International* 1.

Despite perhaps retaining too much reliance on the medical expert witness, *Pearce* and *Wyatt* have arguably introduced a standard of disclosure that is equivalent to that required by the doctrine of informed consent.⁹⁵⁸ This doctrine does appear to focus more on the patient, as the standard requires doctors to disclose material risks, the significance of which is defined by reference to the reasonable patient. In the seminal case, *Robinson* CJ articulated the appropriate test by quoting with approval from an academic commentary that stated:

[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy.⁹⁵⁹

Even this standard of disclosure is open to criticism as, by determining the duty by reference to the hypothetical objective reasonable patient, it fails to protect individual autonomy.⁹⁶⁰ A further problem with the doctrine of informed consent, at least from the claimant's perspective, is that it may make little difference to the likelihood of success. The objective test of causation adopted in the US and Canada limits the advantages of the prudent patient test.⁹⁶¹ Given that we already have a subjective test of causation, it is likely that we will retain that standard and this is reinforced by Lord Woolf's approach in *Pearce*.⁹⁶² In theory this should give the claimant a better chance of success but, as I argued earlier, it is difficult for the courts to assess credibility without importing objective elements into the test and so weakening the claimant's case.

⁹⁵⁸ While it remains predicated on the *Bolam* test and the expert witnesses are still relied on it remains distinct from the doctrine. See Maclean, *Op cit* n.832.

⁹⁵⁹ *Op cit* n.582, 787, quoting from: Waltz & Scheuneman 'Informed Consent to Therapy' (1970) 64 *NWUL Rev.* 628, 640.

⁹⁶⁰ Giesen, D. *Op cit* n.598, 27-28.

⁹⁶¹ Robertson, G. *Op cit* n.894, 435.

⁹⁶² *Op cit* n.823, 124.

If the law of negligence settled on the prudent patient standard with a subjective test of causation then, given that the law sets out only minimally acceptable behaviour, it would arguably have a standard that provides a reasonable degree of protection for patient autonomy (balancing patient autonomy against the facilitation of healthcare and the protection of HCPs from unjust claims). However, one of the problems with the law, even with this more acceptable standard, is that it focuses on the actual risks disclosed rather than on the process of disclosure. If the law concentrated on regulating the dialogical process involved in consent as agreement it might solve some of the difficulties of trying to determine whether a risk is significant or material to a decision. Focusing on the process itself, rather than the outcome of the process, would also allow the law more readily to acknowledge that the process engages two parties in an imperfect process of communication that generates and requires mutual obligations of trustworthy behaviour.

This is not to suggest that the law should not be concerned with which risks were actually disclosed. Rather, by focusing on the process and the way in which the two parties communicated the law can achieve a more holistic understanding of whether the HCP respected the patient's autonomy. Looking at the way in which the two parties approached and engaged with the dialogue may provide an insight into whether a failure to disclose a particular risk was culpable. For example, if it became clear from the discussion between the HCP and the patient that the patient had particular concerns then this should affect the duty to disclose.⁹⁶³ Lord Woolf MR genuflected towards this idea in *Pearce* when he acknowledged that precise percentages were unhelpful in determining whether a risk should be disclosed. However, by ignoring the evidence concerning the dialogue (the woman's concern for her unborn child was clearly described in the case report) and by asking the medical experts for their opinion on the significance of the risk,

⁹⁶³ This can work both ways in that it may be clear from the dialogue that patient did not wish to be informed of the risks.

Lord Woolf MR ultimately ignored the process of communication between the claimant and defendant.

An additional issue related to the standard of disclosure is how far the law recognises a right to waive information. This is not a question that the courts have been asked to adjudicate on but, while the courts may accept the patient's right to waive the HCP's duty to disclose, the prudent patient standard could be rigidly applied which would mean that all the risks that would be required by the 'reasonable' patient would need to be disclosed irrespective of the wishes of the particular patient. Whether patients are currently allowed to waive information perhaps depends on whether the law focuses on the patient's rights or the HCP's duties. Since the law of negligence is duty based the argument that the patient has no right to waive the information is stronger than it would be under a rights based approach. It could still be seen as negligent to fail to disclose a risk even if the patient does not want to know the risk.

In the US case of *Putensen v Clay Adams Inc.* the California Court of Appeals appeared to accept that the doctor's duty to disclose was relieved by a specific request 'not to be told the intricacies' of the procedure.⁹⁶⁴ The courts in England may well adopt a similar approach as it seems unjust to blame professionals for failing to disclose if they have been asked not to.⁹⁶⁵ It should be noted, though, that in *Putensen* two further factors were relevant. First, the plaintiff had independently looked into the procedure and 'stated she was aware of what was involved'.⁹⁶⁶ Second, the Court's justification for accepting that the doctor was relieved of the duty to disclose relied heavily on the therapeutic privilege. Although it is arguable that the courts would acknowledge the right to waive information,

⁹⁶⁴ *Putensen v Clay Adams Inc.* 12 Cal.App.3d 1062, 1083 (1970). See also: *Cobbs v Grant* 502 P.2d 1, 12 (1972).

⁹⁶⁵ Heywood, R. 'Excessive Risk Disclosure: The Effects of the Law on Medical Practice' (2005) 7 *Medical Law International* 93, 101.

⁹⁶⁶ *Putensen v Clay Adams Inc.* 12 Cal.App.3d 1062, 1083 (1970).

until they do, and until the rules for doing so are laid down,⁹⁶⁷ some HCPs may be reluctant to accept a waiver in practice. Heywood, for example, argues that the current law is confusing and may lead to doctors acting defensively and ‘taking upon themselves [to] disclose excessive information about risks, which the patient may not need or actually want’.⁹⁶⁸ Quasi legal guidance would help, but the easiest way to resolve the issue would be through legislation.

The fourth problem with negligence is crucially related to the question of how far the courts protect patient autonomy. It is the question of which conception of autonomy are the courts relying on when determining these cases, and are they consistent in their application? If tort law is fundamentally a system of corrective justice, which associates responsibility with the desert-based principle of fault, it is arguable that it reflects a liberal conception of autonomy. The liberal approach sees autonomy as essential for responsibility and as integral to the construction of identity (see chapter one). On this view, freedom to choose is necessary for responsibility and where that freedom has been unjustly infringed responsibility for any loss transfers to the wrongdoer. This approach is perhaps evident in the majority judgments in the House of Lords hearing of *Chester v Afshar* (see chapter five).⁹⁶⁹ However, the minority judgments are, if still predicated on autonomy, explicable only by taking a more socially embedded view of autonomy.⁹⁷⁰

Similarly, in the wrongful birth case of *McFarlane v Tayside*,⁹⁷¹ the House of Lords limited the consequences of corrective justice by relying on distributive justice arguments that may be justified either by lessening the importance of autonomy or by adopting a less individualistic conception that weakens, or even severs, the association between

⁹⁶⁷ Berg, J.W. ‘Understanding Waiver’ (2003) 40 *Houston Law Review* 281, 334.

⁹⁶⁸ *Op cit* n.965, 95, 96.

⁹⁶⁹ *Op cit* n.906.

⁹⁷⁰ Maclean, A. ‘Risk, consent and responsibility for outcome’ (2005) 14(1) *Nottingham Law Journal* 57, 61, 64.

⁹⁷¹ *Op cit* n.263.

autonomy and responsibility for outcome.⁹⁷² Given the primacy that the law gives autonomy in other medico-legal cases, such as those involving the right to refuse treatment, it is arguable that the better view is to explain the court's approach as based on a more socially-embedded view of autonomy. This, however, is inconsistent with the majority's approach in *Chester*. If the law is to be consistent, coherent and predictable then it should be clear which conception of autonomy is relevant, and that conception should be applied universally rather than utilised in a pick-and-mix fashion to suit judicial intuition or bias.

A fifth problem with negligence is that, if disclosure is predicated on the professional's duty it risks being restricted by his or her duty of care to provide reasonable treatment.⁹⁷³ What this means is that, if the treatment is not something that the professional would recommend, and it is reasonable, under the *Bolam* test, to take this stance, then there arguably may be no duty to disclose the treatment even if another doctor would have recommended it. Although the duty to disclose probably encompasses the disclosure of alternative treatments there are no UK cases directly on this point. The cases have been universally concerned with the disclosure of risks, again emphasising the link between consent and outcome responsibility.⁹⁷⁴ Because of the lack of English authority on this point, it is necessary to look to other jurisdictions. In *Hicks v Ghaphery*,⁹⁷⁵ the Supreme Court of West Virginia held that the informed consent duty to disclose was limited by ordinary negligence principles. Giving the majority opinion, Maynard J quoted from the Californian Court of Appeal case of *Vandi v Permanente Medical Group*:

[I]t would be anomalous to create a legally imposed duty which would require a physician to disclose and offer to a patient a medical procedure which, in the exercise of his or her medical judgment, the

⁹⁷² *Op cit* n.264, 27-30; *Op cit* n.970, 64-65.

⁹⁷³ See, Jackson, E. *Op cit* n.937, 277.

⁹⁷⁴ *Op cit* n.899, 149.

⁹⁷⁵ *Hicks v Ghaphery* 571 SE.2d 317, 335 (2002).

physician does not believe to be medically indicated ... if the procedure is one which should have been recommended it would be negligence under ordinary medical negligence principles and there is no need to consider an additional duty of disclosure.⁹⁷⁶

What this means is that where a responsible school of thought would not recommend a treatment then there would be no duty to disclose it as an alternative treatment.

In *Matthies v Mastromonaco*,⁹⁷⁷ the Supreme Court of New Jersey held that, while ‘Choosing among reasonable treatment alternatives is a shared responsibility of physicians and patients’, doctors only had a duty to disclose those ‘courses of treatment that are medically reasonable’.⁹⁷⁸ Although this means that: ‘physicians do not adequately discharge their responsibility by disclosing only treatment alternatives that they recommend’,⁹⁷⁹ the need to disclose alternatives is governed by the professional standard rather than the prudent patient standard (or, at least, the prudent patient standard is necessarily derivative on the professional standard) and this limits patient autonomy. If a similar limit were placed on disclosure in England then the doctor would only need to find an expert witness to support his view that a particular treatment need not be recommended and, unless his position was illogical, it would not help the patient to find a countervailing opinion.

The duty may protect the patient from a doctor recommending a somewhat controversial treatment, as in *Matthies*, but it may limit disclosure the other way: if a more controversial, or perhaps outdated, treatment would be more attractive to the patient – for whatever reason – the doctor would not be obliged to disclose it to the patient. It also restricts the patient’s ability to act in accordance with his or her character. The patient

⁹⁷⁶ *Vandi v Permanente Medical Group* 9 Cal. Rptr.2d 463, 467 (1992).

⁹⁷⁷ *Matthies v Mastromonaco* 733 A.2d 456 (1999).

⁹⁷⁸ *Ibid.*, 460.

⁹⁷⁹ *Ibid.*, 462.

may be risk averse and feel that it is better to be safe than sorry. The doctor's decision, on the other hand may be influenced by a cost-benefit analysis in deciding that an investigation is not medically indicated. Deciding that the likelihood of detecting an abnormality or preventing a risk materialising is not worth the cost of the procedure may be reasonable from the physician's perspective but the physician is not the one who will have to live with the consequences. In *Hicks*, for example, the doctor decided against inserting a vena cava filter in a patient at risk of a deep vein thrombosis. The Supreme Court held that, although the filter would have prevented the patient's death it was a medically reasonable decision not to insert the filter and therefore the doctor was not negligent for failing to disclose the intervention to the patient.⁹⁸⁰

There are three other problems associated with the standard of care required by the duty to disclose. First, is the failure of the courts to develop a duty to challenge an apparently irrational decision and attempt to persuade the patient to change his or her mind. If anything, as I noted in chapter five, the law has followed the lead of the medical profession and has accepted that, at least in some circumstances, the professional's duty is to be non-directive and any disclosure must be neutral. While this stance may be appropriate in relation to the professional's personal moral values, it reflects a barren view of autonomy as isolated independence if it is applied to decisions that risk the patient's health or well-being. As I argued in chapter three, part of the professional's role is to advise and to recommend treatment, which, by definition, cannot be a neutral endeavour. It is debatable whether any act of information disclosure by a human can be neutral since even the order of disclosure may affect the way the listener interprets the information. Furthermore, insistence on neutrality sterilises the dialogue and, while it formally respects consent as permission, it undermines consent as agreement. As a final comment on persuasion, I noted earlier that the courts' approach to persuasion is

⁹⁸⁰ *Op cit* n.975.

confused and inconsistent. As such it currently fails to provide adequate guidance for HCPs.

The second problem is the therapeutic privilege. Kennedy argued that the doctrine ‘allows the doctor proper discretion in the exercise of his duty to disclose’.⁹⁸¹ Provided that the court determines the ‘general circumstances in which the privilege may be invoked’ then the law will be ‘sensitive to the interests of both patient and doctor’.⁹⁸² Professional judgment could then determine whether the patient fell within one of these categories. Kennedy noted that the risk of paternalism lies just beneath the surface of the privilege. Thus, he stated: ‘if the balance is struck in favour of therapeutic privilege, not as a defence but as a rule, by making disclosure a matter for the medical profession, this inevitably means that a doctrine developed for exceptional circumstances will result in diminishing respect for the patient as a person in the majority of cases’.⁹⁸³ For Kennedy, ‘the principle behind the doctrine is the same as that justifying informed consent: namely respect for the patient’.⁹⁸⁴ If this is the case, then it is submitted that the patient should still be allowed the right to decide whether or not to be given the relevant information regardless of any ‘harm’ that may be caused by that information. Providing the patient is aware that the doctor believes the information might be detrimental the choice should remain with the patient. The only exception which might be justified is where the information will significantly impair that patient’s autonomous capacity to use the information and even this exception depends on whether the emphasis of respect is placed on the patient’s future autonomy rather than their present autonomy.

If respect for the person is equated with the individual’s present autonomy then the therapeutic privilege cannot be justified. For Kennedy, however, respecting the patient –

⁹⁸¹ *Op cit* n.763, 187.

⁹⁸² *Ibid.*, 187.

⁹⁸³ *Ibid.*, 187.

⁹⁸⁴ *Ibid.*, 187.

at least as far as the therapeutic privilege is concerned – also engages beneficence. In discussing the issue of consent to clinical research he argued:

it may follow that the ... doctrine of the ‘therapeutic privilege’ ... which extends to doctors the discretion not to fully inform patients if the information would so alarm the patient as to cause him unwisely to refuse a particular treatment, even when ordinarily the doctor is obliged to give that information which a reasonable patient would wish to have, should not apply to the conduct of trials ... There may be some justification for making inroads into the principle of autonomy when treatment is in question. There seems no justification for it when the patient is being asked to volunteer for, and may be exposed to, that which is not directly in his interests.⁹⁸⁵

The acceptance that respect for the patient involves beneficence allows the doctor to make ‘inroads into the principle of autonomy’ and withhold information that may not be in the patient’s best interests. For Kennedy, the patient is sufficiently protected because the onus of proof lies with the doctor.⁹⁸⁶ If, however, the right to give or withhold consent is based solely on the right to self-determination or on the right to autonomy the doctrine of ‘therapeutic privilege’ is an unjustified exception.⁹⁸⁷ It is hypocritical for the law to state that individuals can make whatever decision they like, even if it is harmful, and then deny the individual the very information necessary to make the decision.

Brazier suggested that the ‘prudent patient’ test combined with the ‘therapeutic privilege’ defence may be seen simply as reversing the burden of proof. Thus, ‘Doctors may still rely on custom and practice to withhold information but *they* must prove the custom and

⁹⁸⁵ Kennedy, I. ‘Consent and Randomized Controlled Trials’, in: *Treat Me Right: Essays in Medical Law and Ethics* (1988) Oxford: Clarendon Press 213, 216.

⁹⁸⁶ *Op cit* n.763, 205.

⁹⁸⁷ *Op cit* n.575, 187.

practice'.⁹⁸⁸ However, she went on to argue that this first impression of the doctrine is blinkered since:

the medical judgment relied on to invoke therapeutic privilege must be specific to that patient. It at least requires that the doctor explore his relationship with that individual and probe to discover the potential effect on him of disclosure. It is not dependent on a *general* assumption that disclosure equals harm to the patient.⁹⁸⁹

This is an insightful and important point. Since the professional standard reflects general practice it is not patient specific. The 'prudent patient' combined with the doctrine of 'therapeutic privilege' focuses attention on the individual patient. However, it is arguable that this advantage arises from the different linguistic emphasis of the two tests. If both tests are interpreted in a spirit of respect for the autonomy of the particular patient then the two tests do begin to approach each other and the difference in burden of proof again becomes the distinguishing feature.

The advantage of the prudent patient test is not that it requires the doctor to focus on the individual in front of him. This should also be required under the professional standard. Rather, the advantage is that the prudent patient test makes it harder for the doctor to hide behind professional practice. Under both standards the particular patient should be the focus of what information ought to be disclosed. Thus, the professional standard should be: would a responsible body of doctors consider as reasonable the information disclosed to the particular patient in relation to the procedure. It should not be: would a responsible body of doctors consider as reasonable the information disclosed in relation to the procedure. The problem with the professional standard is that there is no linguistic pressure to consider the individual patient and it is therefore too easy to decide the issue

⁹⁸⁸ *Op cit* n.765, 188.

⁹⁸⁹ *Ibid.*, 188.

generically. The true advantage of the prudent patient standard, then, is that it linguistically pressures one into considering the particular patient.

Healy argued that the doctrine of ‘therapeutic privilege’ relies ‘on the presumption that the typical patient would wish to be cured and healed, and ... may be seen to provide a necessary outlet for the discharge by doctors of their primary ethical duty to heal the ill’.⁹⁹⁰ Healy analysed the doctrine as discussed in *Canterbury* and suggested that it: ‘distils down to a privilege justified by the doctor’s opinion that his patient would be unable to make a rational decision grounded on the information in question’.⁹⁹¹ To support his argument he quoted from *Canterbury*: ‘It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision’.⁹⁹² He went on to point out, however, that the patient’s right to information should not be compromised by the possibility of a decision deemed irrational by the medical staff. This bivalent attitude to the privilege has, Healy noted: ‘enabled other American courts to tamper with the privilege to the extent that in some states, what resulted differed little from the professional standard model’.⁹⁹³

Robertson suggested that there are four reasons why information likely to cause psychological distress should arguably be withheld from the patient:

1. the information may be counterproductive in that the resulting psychological distress might prevent rational decision making;
2. where the patient is being treated for emotional or psychological problems the added distress may compromise that treatment;

⁹⁹⁰ Healy, J. *Op cit* n.785, 115.

⁹⁹¹ *Ibid.*, 119.

⁹⁹² *Op cit* n.582, 789.

⁹⁹³ Healy, J. *Op cit* n.785, 119. For an example of an expansive interpretation of the therapeutic privilege, see: *Nishi v Hartwell* 473 P.2d 116 (1970).

3. 'if disclosure would be likely to cause serious distress or psychological harm, it would be in the best interests of the patient that the information should not be disclosed';
4. where the doctor believes that the treatment is in the patient's best interests and the patient might refuse consent if told of the risks.⁹⁹⁴

As Robertson noted: 'It is the fourth possible reason for withholding information on the basis of the "best interests of the patient" principle that gives cause for concern ... This is a clear example of ... paternalism'.⁹⁹⁵ The danger of this paternalism is particularly great: 'Given that the duty to disclose is regarded as part of the overall duty of care'.⁹⁹⁶ It is also arguable that the third reason is unduly paternalistic. If self-determination forms the basis for consent then the patient should be given the option of waiver where the doctor believes a particular piece of information may be distressing. Furthermore, it may be argued that the patient has the right to be distressed if that is appropriate and the distress – providing it is not incapacitating – may focus the patient's mind more closely on the decision at hand. This may even result in a more appropriate decision. The first reason is also interesting in that it again raises the issue of present and future autonomy as well as the question of whether autonomy requires rationality.⁹⁹⁷ Even on the second point (assuming competency) the choice, as to whether to exercise or waive their right to the information, should be put to the patients. Arguably, then, the doctrine should only apply where the information is likely to cause such distress that the patient is rendered incompetent to make the decision.⁹⁹⁸ In this situation it is in patients' best interests not to be informed since they are then encouraged to exercise the maximum amount of

⁹⁹⁴ Robertson, G. 'Informed Consent to Medical Treatment' (1981) 97 *Law Quarterly Review* 102, 121.

⁹⁹⁵ *Ibid.*, 121.

⁹⁹⁶ *Ibid.*, 122.

⁹⁹⁷ See chapter one.

⁹⁹⁸ See: Stauch, M. Wheat, K. Tingle, J. *Sourcebook on Medical Law* (2nd ed., 2002) London: Cavendish Publishing Ltd, 162.

autonomy as is possible in the circumstances. Were they to be given the information their competence would be compromised and their autonomy neutered.

Berg *et al* argued that:

In practice, it is likely that the [therapeutic] privilege serves to lend false legitimacy to the natural aversion of physicians to disclosing information to patients ... if the scope of the privilege is not severely circumscribed, it contains the potential to swallow the general obligation of disclosure ... [and] in effect permit physicians to substitute their judgment for patients' in every instance of medical decision making.⁹⁹⁹

They went on to note that, because of the overlap between the privilege and the two exceptions to consent of waiver and incompetence, the doctrine could be abolished.¹⁰⁰⁰

The argument is persuasive: if the patient is informed of the potentially distressing nature of the information then a waiver would allow the patient the right to decide 'that they prefer to risk being harmed by being informed than be harmed by having to make choices in the dark of nondisclosure'.¹⁰⁰¹ The doctrine of therapeutic privilege means that it is the doctor that makes this decision and the patient is presented with a *fait accompli*. In fact, it is arguable that the position in favour of waiver is stronger since choosing to receive the information only *risks* harm whereas not being given the choice actually does harm the patient by infringing his or her autonomy. Thus, as Berg *et al* suggested: 'to require this minimal preparatory disclosure does not seem an unreasonable compromise between the competing interests of patients' rights to disclosure and consent, and physicians' ethical obligations to do no harm'.¹⁰⁰²

⁹⁹⁹ Berg, J.W. Appelbaum, P.S. Lidz, C.W. Parker, L.S. *Informed Consent: Legal Theory and Clinical Practice* (2nd ed., 2001) New York: Oxford University Press, 80.

¹⁰⁰⁰ *Ibid.*, 83.

¹⁰⁰¹ *Ibid.*, 83.

¹⁰⁰² *Ibid.*, 83-84.

The overlap with competence falls, as previously discussed, where the disclosure would so affect the individual's ability to use that information that it impedes rather than furthers their autonomy. In this circumstance it might be argued that the patient is not competent to be given that piece of information.¹⁰⁰³ Thus, in most circumstances a waiver is preferable to invoking the doctrine and, for the remainder, the situation may be covered by competence. It seems, therefore, that there may be little need for the doctrine especially as it is insufficiently substantiated by empirical evidence.¹⁰⁰⁴ Furthermore, as Berg *et al* suggested: 'The abolition of the therapeutic privilege might have another salutary effect on the physician-patient relationship ... [since t]he affirmative act of abolishing the privilege might be viewed as a withdrawal of the legitimation of physicians' natural reticence to disclose information'.¹⁰⁰⁵

Despite the fact that the doctrine appears to be encompassed by the *Bolam* test (see chapter five), it is submitted that it should rarely, if ever, be allowed as a justification for withholding information. The doctrine suffers from ambiguity,¹⁰⁰⁶ lack of any justified basis – either empirical or philosophical¹⁰⁰⁷ - and there are arguably sufficient exceptions to disclosure that achieve a more coherent and justifiable balance between respecting patient autonomy and improving health.¹⁰⁰⁸

The third problem is that the standard of care required in urgent and emergency situations remains to be determined. There have been no English cases looking at whether the duty to disclose information and obtain the patient's consent is affected by the urgency of the situation.¹⁰⁰⁹ Logically, one would expect that the duty would be less demanding simply

¹⁰⁰³ *Ibid.*, 83-84.

¹⁰⁰⁴ *Ibid.*, 84.

¹⁰⁰⁵ *Ibid.*, 84.

¹⁰⁰⁶ *Op cit* n.633, 22; *Op cit* n.36, 37.

¹⁰⁰⁷ *Op cit* n.999, 834; Bok, S. *Lying: Moral Choice in Public and Private Life* (1978) New York: Vintage Books, 232-255.

¹⁰⁰⁸ *Op cit* n.999, 83-84; *Op cit* n.633, 166-169.

¹⁰⁰⁹ In *Re F*, *Op cit* n.667, 74, Lord Goff indicated, in an obiter dictum, that non-consensual treatment would be justified by an emergency where there was no 'opportunity to communicate'

because the time constraints may make it impossible to counsel the patient adequately. In the US it has been held that the doctor's duty to obtain the patient's informed consent is relieved by the emergency.¹⁰¹⁰ Clearly, the greater the urgency the less emphasis should be placed on disclosure – there is little point in respecting the patient's autonomy if the patient dies before having the opportunity to exercise that right. But while this may lessen the duty to disclose, it should not relieve the professional of the duty to ask for the patient's permission to treat.¹⁰¹¹ This can be done relatively quickly and it is only where the patient is rendered incompetent by the emergency that the duty should be wholly relieved.¹⁰¹² Because of the unpredictable, and highly variable nature of emergencies it would be impossible to set precise standards of disclosure and any duty must, therefore, be subject to the reasonableness standard.

As a final point, since negligence applies both to a failure to disclose and to careless treatment or diagnosis, a finding of negligence may be seen as implying a general carelessness not warranted by what some may see as less blameworthy than the careless performance of an operation. When a doctor, or other healthcare professional, is sued in negligence this may have both personal and professional consequences: some doctors suffer something akin to a grief reaction; a finding of negligence may be unfairly equated with incompetence and a finding of negligence may have career consequences.¹⁰¹³ Whether or not this is something that should be of concern is, no doubt, a matter of opinion. However, if relevant, it supports an argument for establishing a distinct liability

with the patient. However, there are few emergencies where the patient is competent and no communication at all is possible. In *Re R (A minor) (Wardship: Consent to Treatment)* [1992] Fam 11, 22, Lord Donaldson MR equated the emergency exception with circumstances where 'the patient is unconscious or otherwise incapable of giving or refusing consent'.

¹⁰¹⁰ *Shine v Vega* 709 NE.2d 58, 63-64 (1999); Ketler, S.K. 'The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine after *Schreiber v Physicians Insurance Co. of Wisconsin*' (2001) 95 *Northwestern University Law Review* 1029, 1035.

¹⁰¹¹ *Shine v Vega* 709 NE.2d 58, 64 (1999).

¹⁰¹² *Op cit* n.582, 788-789.

¹⁰¹³ See: Merry, A. McCall Smith, A. *Errors Medicine and the Law*, (2001) Cambridge: Cambridge University Press, 246; Mulcahy, L. 'Threatening Behaviour? The Challenge Posed by Medical Negligence Claims', in: Freeman, M. Lewis, A. (eds.), *Law and Medicine: Current Legal Issues Volume 3* (2000) Oxford: Oxford University Press 81, 82, 85.

for ‘breach of consent to medical treatment’. While better education of doctors and other healthcare professionals may lead to a better understanding of the meaning of negligence liability it may still be appropriate to more clearly distinguish errors of communication from errors of medical treatment or diagnosis.

The Problem of Treatment Refusal

I noted earlier that, in principle, the law protects the individual’s right to refuse treatment regardless of the consequences for that individual (unless the person is mentally ill). The problem I want to highlight here is the gap between principle and practice. There have been a number of cases where an apparently autonomous person has been denied the right to refuse treatment. In most cases this is achieved by finding the person incompetent. Thus, in *Rochdale Healthcare NHS Trust v C*, a pregnant woman was held to be incompetent when she refused a caesarean section because her reasoning seemed irrational to the judge. This was despite the consultant obstetrician believing she was competent to decide and despite the fact that the judge had not actually met or spoken to the woman.¹⁰¹⁴ Interestingly, in none of the eight caesarean section cases was the woman’s decision respected while there were lives at risk.¹⁰¹⁵ Two of the women were clearly competent,¹⁰¹⁶ and a third was arguably so.¹⁰¹⁷ Thorpe LJ commented extra-judicially:

Whatever emphasis legal principle may place upon adult autonomy with the consequent right to choose between treatments, at some level the judicial outcome will be influenced by the expert evidence as to

¹⁰¹⁴ *Op cit* n.361.

¹⁰¹⁵ *Re S* [1992] 4 All ER. 671; *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762; *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 2 FLR 613; *Op cit* n.361; *Re L An Adult: Non-consensual Treatment* [1997] 1 FCR 609; *Op cit* n.55; *St Georges Healthcare NHS Trust, Op cit* n.531; *Bolton Hospitals NHS Trust v O* [2002] EWHC 2871. In *St Georges Healthcare NHS Trust*, the Court of Appeal held that here refusal of treatment should have been respected but this case was heard after the caesarean had been performed.

¹⁰¹⁶ *Re S* [1992] 4 All ER. 671; *Op cit* n.531.

¹⁰¹⁷ *Op cit* n.361.

which treatment affords the best chance of the happy announcement that both mother and baby are doing well.¹⁰¹⁸

A sceptical analysis of the treatment refusal cases would suggest that a refusal is unlikely to be respected where there is a “socially valuable” life at risk.¹⁰¹⁹ Thus, in *Re E*, a 15 year old Jehovah’s Witness was deemed incompetent to refuse a blood transfusion despite the judge stating: ‘I find that A is a boy of sufficient intelligence to be able to take decisions about his own well-being’.¹⁰²⁰ Similarly, in *Re T*, a young woman’s refusal of blood transfusions was held to be invalid because it was inapplicable in the circumstances, misinformed and made as a result of undue influence.¹⁰²¹ Other advance refusals have also been rejected even where made with the knowledge of the person’s doctor and with the assistance of a solicitor.¹⁰²²

In some instances the courts have upheld the individual’s right to refuse, but these are where there is no life at risk, or the life at risk is arguably of limited “social value”, or where the individual’s decision is seen as rational by the judge because continued life would be painful or pointless. Thus, in *Re AK*, a patient with advanced motor neurone disease was held to have made a valid advance directive refusing further treatment after his ability to communicate was lost despite the fact that his competency could not be properly assessed.¹⁰²³ Without the ability to communicate or use his body in any way his life could be seen as lacking any further point. In the *Ms B* case, the claimant’s refusal was upheld as competent because the judge arguably accepted that the life of a paraplegic was of little value if not valued by the individual herself.¹⁰²⁴ If *Ms B* had seen the point in

¹⁰¹⁸ Thorpe LJ. ‘The Caesarean Section Debate’ [1997] 27 *Fam. Law* 663, 663-664.

¹⁰¹⁹ It is not suggested that this is the only explanation for the outcome of the cases; merely that it is a possible one.

¹⁰²⁰ *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 391.

¹⁰²¹ *Op cit* n.510.

¹⁰²² *The NHS Trust v Ms T* [2004] EWHC 1279.

¹⁰²³ *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129, 133.

¹⁰²⁴ *Re B*, *Op cit* n.648.

continuing her life and undergoing rehabilitation she would have been a role model of courage in the face of adversity. As Dame Butler-Sloss stated: ‘I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large’.¹⁰²⁵ However, there is no dignity in being forced to continue life as a paraplegic against one’s wishes.

In *Re C*, a 68 year old chronic paranoid schizophrenic, confined to Broadmoor after he had stabbed his girlfriend, was held to be competent to refuse surgical amputation of a gangrenous leg despite having the delusion that he was a world famous vascular surgeon who had never lost a patient.¹⁰²⁶ Arguably, it was of little social concern whether or not his decision resulted in his death, which would have been of little, if any loss to the community. As a final case to help make the point, consider Ian Brady’s attempt to go on hunger strike to object to the way he had been treated in prison. Hunger strikes have been allowed where the prisoners were political. However, the court held that Brady was incompetent to refuse and that the refusal was a consequence of his personality disorder, which meant that he could be force fed under the Mental Health Act 1983.¹⁰²⁷ It might be argued that this is an example of a person’s refusal being disallowed despite the apparent lack of social value in keeping him alive. However, the social value of Ian Brady’s life arises from the need to ensure that the heinous “moors murderer” was being seen to suffer his punishment for the evil he committed in torturing and murdering children.

The point of this discussion is to note the fragility of patient autonomy in the common law. It may be that legislation with a strict code of practice could bolster the protection of patient autonomy to a degree. Emphasising the right to refuse treatment and providing

¹⁰²⁵ *Ibid.*, [95].

¹⁰²⁶ *Op cit* n.683.

¹⁰²⁷ *R v Collins, ex p Brady* (2000) 58 BMLR 173.

guidelines through a code of practice might limit the cases that are brought to court.¹⁰²⁸

However, the vagueness of the competency criteria allows the court huge leeway and would still permit the judges to manipulate the outcomes of cases to continue to preserve “socially valuable” lives. Legislation could introduce a more robust system of competency assessment but that is beyond the scope of this dissertation and would be unlikely given the recent passage of the Mental Capacity Act 2005. A further possibility that might have a small, but possibly significant, effect would be to emphasise the need for HCPs to challenge apparently irrational decisions. This may either allow patients to acknowledge their errors and change their decisions or it may allow HCPs to understand the patient’s reasoning and accept the rationality of the decision.

The Problems of the Common Law

The first difficulty to note here is that the common law is reactive rather than proactive.

This means that it can only develop in response to an actual case. If an issue is not

brought before the courts then the judges cannot address that issue and determine the

law’s stance. While it may be argued that this means that the law only deals with the most

important questions this is not necessarily the case. The driving force is more likely to be

money rather than an important point of principle. On top of this, cases that do reach

court must be decided within the common law institutional constraints of precedent and

legal policy.¹⁰²⁹ Furthermore, any development is likely to be piecemeal and decisions

may be inconsistent with each other.¹⁰³⁰ All of this leads to a law that may be out of synch

with ethical mores, uncertainty and a lack of predictability, which makes life more

difficult for practitioners trying to decide what the law requires of them.¹⁰³¹ As Jones

¹⁰²⁸ Given that no further caesarean section case have been brought since the Court of Appeal in *St George’s Healthcare NHS Trust v S* (*Op cit* n.531) set down guidelines there is some support for this position. While the same result appears possible through the common law the effect of the guidelines appears to have been limited to the refusal of a caesarean section.

¹⁰²⁹ *Op cit* n.994, 126

¹⁰³⁰ *Op cit* n.899, 150.

¹⁰³¹ See, e.g. Worthington, R. ‘Ethical dichotomies and methods of seeking consent’ (2004) 59 *Anaesthesia* 525, 526.

suggested: ‘Although the case law can gradually fill in some areas of doubt it can never be a comprehensive framework’.¹⁰³² Similarly, Wear argued in relation to the law’s protection of individual autonomy: ‘Unfortunately, the law’s specific focus has come to be on torts; and it thus provides little clear specific guidance regarding how informed consent should actually pursue such self-determination’.¹⁰³³ One example of this uncertainty lies in the amount of information that need be disclosed and whether patients can waive their right to information.¹⁰³⁴

Related to this, the law of tort is limited in the flexibility of its remedies.¹⁰³⁵ The NAO report found that disgruntled patients often want an explanation, an apology or an indication that steps will be taken to prevent the problem recurring.¹⁰³⁶ For the most part the patient only has the option of damages and the remedies of an explanation or an apology are not available. Similarly, the courts have no power to ensure that adequate measures are taken to remedy the situation, whether through changes in the system or through retraining, education or referral to the relevant professional regulatory body. It is arguable that these issues are not the law’s concern and that the profession is capable of managing them through bodies such as the GMC without the court’s involvement. There is certainly strength in the argument that it should not be necessary to go to court to get an apology or an explanation. However, the complaints system does not always work, and the threat of litigation, in what may be seen as a counterproductive manner, may cause the doctor to maintain silence rather than risk an apology being misconstrued as an admission of liability. However, it is precisely because the court and the common law are unable to deal with this that legislation ought to be considered: providing an alternative to the courts with a wider and more flexible range of remedies is an option that is closed to the common law.

¹⁰³² *Op cit* n.787, 106.

¹⁰³³ *Op cit* n.633, 66.

¹⁰³⁴ For further discussion see, *Op cit* n.965.

¹⁰³⁵ *Op cit* n.899, 150.

¹⁰³⁶ NAO. *Op cit* n.3, paras 3.22-3.24.

A further problem with the common law approach to consent is that regulation is, as I suggested earlier, focused more on the outcome of the process that culminates in consent rather than on the process itself. This results in the law devaluing the relational aspect of the professional-patient relationship and establishes a number of dichotomies that treat autonomy as an all-or-nothing concept (consent or no consent; voluntary or involuntary; competent or incompetent) rather than as a variable characteristic, which is capable of degrees of existence.¹⁰³⁷ This is partly to do with liability, at least in negligence, depending on the materialisation of a risk. If outcome responsibility and consent are distinguished, the law could develop a more sensitive approach to regulating the iterative dialogical process between the HCP and the patient. However consent is regulated, the law would be unable to escape the use of thresholds to establish liability, but either through legislation or the development of professional regulation, the law could engage with the variable nature of autonomy and establish a number of thresholds that would allow for different remedies or differing amounts of compensation.

The penultimate problem with common law regulation is that, while it is presently developing in a way that seeks to provide an increased protection for individual autonomy, it could equally well shift in the opposite direction.¹⁰³⁸ The law of negligence has previously seen such oscillations, for example, in the development of the rules used to determine whether a novel claim should be recognised,¹⁰³⁹ and in cases of indeterminate causation.¹⁰⁴⁰ The law also tends to follow the dominant ethical arguments, although with an extensive lag period. What this means is that just as the law reacts to the ethical and

¹⁰³⁷ See Part One; Roter. D. 'The medical visit context of treatment decision-making and the therapeutic relationship' (2000) 3 *Health Expectations* 17, 18.

¹⁰³⁸ See the discussion of the Australian case *Rosenberg v Percival* [2001] 178 ALR 577 in Heywood, R. 'Re-thinking the Decision in Pearce' [2005] *Contemporary Issues in Law* 264, 273-274.

¹⁰³⁹ See *Anns v Merton London Borough* [1978] AC 728; *Junior Books v Veitchi* [1983] 1 AC 520; and *Caparo Industries plc v Dickman* [1990] 2 AC 605.

¹⁰⁴⁰ Rules of causation relaxed in *Fairchild v Glenhaven* [2002] 1 AC 32, but tightened up in *Corus (UK) plc v St Gobain Pipelines plc* [2006] UKHL 20.

social mores so those mores change. The present developments are leading to increased protection for a liberal conception of the autonomous person. There is now, however, a noticeable movement to constrain that approach by highlighting the relational nature of autonomy, the obligations of patients and the relevance of other communitarian concerns. In addition, there is currently concern regarding the ‘compensation culture’ to the point that a Bill has been introduced to reverse, or at least slow down the rise in negligence claims.¹⁰⁴¹ The effects of these developments may be that the law will pull on the reins of ‘informed consent’ and reverse the expansion of liability seen in cases such as *Chester v Afshar*. While this is not necessarily inappropriate the problem is that the piecemeal development of the common law will mean that any such reversal of judicial policy will inevitably cause confusion and a lack of certainty regarding the current rules of disclosure and consent.

A final point is the inability of tort law to engage with or develop a coherent philosophy for the community’s system of healthcare. This is something that is properly the purview of the Government, which has both the authority and the tools to develop such a philosophy. Although the courts may be influenced by Government policy and may be able to fine tune liability they are constrained by precedent and the institution of law.¹⁰⁴² The courts are often reluctant to rely on policy arguments and when they do attend to the wider implications of a judgment it creates the types of problems exemplified by the somewhat arbitrary appeal to distributive justice in the recent series of wrongful pregnancy cases.¹⁰⁴³ It is submitted that the extent of the requirements for a valid and effective consent are – or ought to be - inextricably linked to the whole philosophy of

¹⁰⁴¹ The Compensation Bill, available at: <http://www.parliament.the-stationery-office.co.uk/pa/ld200506/ldbills/035/2006035.htm>. See the prime minister’s speech on the compensation culture delivered to the Institute of Public Policy Research on 26th May 2005, available at: <http://www.number10.gov.uk/output/Page7562.asp>.

¹⁰⁴² Meaning legal principle and policy

¹⁰⁴³ *Op cit* n.263; *Parkinson v. St James and Seacroft University Hospital* [2001] EWCA Civ 530, [2001] 3 All ER 97; *Rees v. Darlington Memorial Hospital NHS Trust* [2002] EWCA Civ 88, [2003] QB 20; *Op cit* n.916.

healthcare in the context of its delivery within the particular community.¹⁰⁴⁴ As such, it may be better to legislate for consent in a way that would be compatible with the values and pragmatic concerns of healthcare as well as being sensitive to the needs of the patients served by the institution of healthcare.

Addressing the Gap between Practice and Principle

There are broadly three alternative approaches. First, the common law could be allowed to continue to develop, guided by criticism and debate. However, as I have suggested, this is a haphazard and uncertain process that could take the protection of patient autonomy into the depths of libertarian isolation or revert to a more protectionist paradigm of limited paternalism through the reliance on medical experts and the development of the therapeutic privilege. It currently seems unwilling or unable to develop the law creatively in a way that is sensitive to a more nuanced and mature view of patient autonomy in the context of the professional-patient relationship. Furthermore, after some thirty years of developing the law in this area we are still left with a situation in which the realities of ‘informed consent’ may be described as a ‘fairy story’, with medical practice falling short of both legal and ethical expectations.¹⁰⁴⁵ It is, therefore, arguable that any amount of ‘tinkering’ with the common law will inevitably be inadequate and that a more radical approach is required.¹⁰⁴⁶

A second approach would be to start from first principle and legislate on the issue. This would have the advantage of allowing the development of a conceptually coherent law, with well defined guidance that reflects the political approach to healthcare and provides secure protection for patient autonomy balanced by the recognition that the right to autonomy is not free floating but is grounded in relationships and the obligations inherent to those relationships. Although Heywood’s suggestion that: ‘The law can never be

¹⁰⁴⁴ *Op cit* n.297, 369.

¹⁰⁴⁵ *Op cit* n.787, 129-130.

¹⁰⁴⁶ See, Jackson, E. *Op cit* n.937, 272.

viewed as a proactive mechanism protecting patients' rights'¹⁰⁴⁷ is a fair criticism of the common law, it is less accurate in relation to new legislation. This is especially so if the legislative process is accompanied by a consultation process, which serves to enhance the consciousness-raising effect of new legislation. Furthermore, if a code of practice and an independent regulator are part of the new legislation, the law can be both proactive and flexible. Added to which, passing new legislation has an important symbolic effect, which would serve to emphasise the relative value the community places in autonomy, self-determination and health.¹⁰⁴⁸ Thus, legislation could be a positive influence on medical practice both at the level of the individual practitioner and at the level of the profession as a whole.¹⁰⁴⁹

The final option is to develop professional regulation so as to allow a more proactive role for the professional regulatory bodies. It is likely that some form of professional regulation will always play an important role in encouraging the virtue of professionalism: regulating the HCP's character dispositions requires an active supervision that falls outside the courts' role. However, there is still the question of whether professional regulation could be developed sufficiently to negate the need for a direct legislative response.

In recent years the GMC, for example, has been active in producing guidelines, which should improve practice and are likely to indirectly influence legal standards.¹⁰⁵⁰ In addition to this they could also be given the power to provide limited remedies, such as a small amount of compensation for the harm done to the patient's autonomy, an explanation, a formal apology and assurance that something will be done to prevent the same thing happening to others. The main problem with that approach is the possible

¹⁰⁴⁷ *Op cit* n.965, 105.

¹⁰⁴⁸ Bordieu, P. 'The Force of Law: Toward a Sociology of the Juridical Field' (1986-1987) 38 *Hastings Law Journal* 814, 840.

¹⁰⁴⁹ *Op cit* n.787, 108.

¹⁰⁵⁰ *Op cit* n.820, 110; *Ibid.*, 133.

perception that the professional regulatory bodies are insufficiently independent of the practitioners and are biased in their favour. The GMC, for example, has over recent years been subject to much criticism¹⁰⁵¹ and, while it has engaged more openly with the public in recent consultation exercises,¹⁰⁵² there may be insufficient public confidence in these bodies at present to support an expanded role. However, given the time and support to develop and become more proactive and independent, professional regulation may gain a new lease of life. Any reliance on professional regulation would need to address the problem of coordinating the different regulatory bodies, such as the GMC and the Nursing and Midwifery Council (NMC), to ensure consistent and coherent regulation of healthcare practice. If that can be addressed, professional regulation may be able to paper over the deficiencies in the common law.

Conclusion

To conclude this chapter, and this part of the thesis, I will briefly summarise my argument. I have analysed the regulation of consent and information disclosure in the torts of battery and negligence. I have tried to show that both of these torts have their deficiencies, which include both conceptual and practical flaws. Battery, for example, has connotations of criminality and fails to deal with non-interventional management or non-contact treatment. Negligence, on the other hand, is constrained by the need to show that the failure to disclose caused legally recognised damage, and carries the baggage of reliance on medical experts and deference to the profession. The standard of care expected is inadequately defined at present and the reluctance of the courts to require a duty to persuade underlines the barren nature of the legal conception of autonomy.

Further, while lacking the criminal associations of battery it does perhaps imply that the

¹⁰⁵¹ See: Smith, R. 'GMC under the cosh' (1998) 316 *British Medical Journal* 945; Smith, R. 'GMC: expediency before principle' (2005) 330 *British Medical Journal* 1; Smith, J. *The 5th Shipman Report, Safeguarding Patients: Lessons from the Past – Proposals for the Future* (2004) cm6394, Chapter 15. Available at: http://www.the-shipman-inquiry.org.uk/5r_page.asp; Irvine, D. *The Doctors' Tale: Professionalism and Public Trust* (2003) Oxford: Radcliffe Medical Press.

¹⁰⁵² In 2005 the GMC held five public seminars entitled 'What is Good Medical Practice?'

doctor is generally negligent rather than that the error was confined to a failure of communication.

Just as there are problems with either tort, so there are difficulties with the combined regulation, which is the current approach taken by the law. Conceptually it makes little sense to distinguish risk information from the ‘nature’ of the procedure and this association of risk disclosure and negligence creates a particular link between consent and responsibility for outcome.¹⁰⁵³ While this may be appropriate, I argued earlier that it was not necessary and legislating for consent would provide an opportunity to rethink that association. Furthermore, the common law’s focus on the end product of the duty to disclose, rather than on the process of dialogue that precedes consent as permission, restricts its sensitivity to individual autonomy. Finally, I also briefly raised some of the problems of regulating consent to medical treatment within the common law system, which includes its reactive rather than proactive approach, its costs and the inflexibility of remedies available.

While none of these problems is fatal on its own, together they add up to a powerful argument in favour of at least considering the value of legislating or developing more extensive professional regulation. This approach is given additional support by three further weaknesses of current English Law. First, the legal requirements remain vague, contested and perhaps not well known by healthcare professionals,¹⁰⁵⁴ although this may have been ameliorated to some extent by the publication of the Department of Health’s guidance.¹⁰⁵⁵ Second, the law has been developed in relation to doctors and it is unclear

¹⁰⁵³ Although negligence allows the judges a greater control over liability than does battery, the requirement for physical damage weakens the protection of autonomy. It also presupposes a particular philosophy towards consent and outcome responsibility that is not intrinsic to the concept of consent.

¹⁰⁵⁴ *Op cit* n.899, 148, 159.

¹⁰⁵⁵ DH. *Op cit* n.514.

whether the same obligations apply to other healthcare professionals.¹⁰⁵⁶ Third, and finally, as Skegg notes, ‘litigation has often been prohibitively expensive’.¹⁰⁵⁷ This may unjustly preclude patients receiving, at least, the recognition that they have been wrongly treated. All of these criticisms are unlikely to be addressed by tinkering with the common law.¹⁰⁵⁸

¹⁰⁵⁶ *Op cit* n.899, 148.

¹⁰⁵⁷ *Ibid.*, 150.

¹⁰⁵⁸ *Ibid.*, 165. Skegg’s argument is that the New Zealand Code of Health and Disability Consumers’ Rights 1996 goes some way to addressing these weaknesses. However, he acknowledges (at 164) that while the Code warrants examination, it unlikely to be directly ‘transplantable’ into English Law.

Summary and Conclusion

In this thesis I have examined the legal regulation of consent to medical treatment and the competent adult. This necessarily involved a consideration of the interaction between various competing ends or values, including: patient autonomy, patient well-being, professional autonomy, beneficence, and justice. I began by exploring the moral basis for consent. I then went on to consider the other moral influences that shape the boundaries arising out of the primary justification. These abstract moral arguments were then situated within the context of the professional-patient relationship. Using this textured moral landscape I then developed a model of consent that became the comparator enabling a critique of the current law.

In chapter one I considered the meaning, value and implications of personal autonomy, which is the primary rationale for protecting the individual's right to consent. Because the capacity and liberty to be autonomous are essential to moral agency, personal responsibility and the integrity of the individual, autonomy is intrinsically valuable and, in any democracy, it deserves legal protection. Without agency, and hence autonomy, reactive attitudes are meaningless - except as training tools - and humanity is lost to automatism. Since the main reasons for valuing autonomy all require a conception of autonomy that at least includes rationality as an integral part, I argued that it is meaningful to distinguish the autonomous person from the autonomous act. This then raised the question of how society should respond to irrational decisions that risk serious, and possibly catastrophic, harm to the decision-maker.

Despite the fact that a bad decision could significantly harm the patient's future autonomy, I argued that a society in which all such important decisions were scrutinised and overridden if made badly would be too high a price to pay since, if that approach were adopted consistently the whole concept of autonomy would be eroded to the point

that its very essence was destroyed. We would have the same freedom to be autonomous as Henry Ford's customers.¹⁰⁵⁹ However, while autonomy may be integral to the humanity of mankind, it is necessarily relational not isolationist and respect for that autonomy does not mean that the individual should be abandoned to his or her fate. As Mill argued, in his discussion of liberty, the principle at least requires that an apparently irrational decision be challenged.¹⁰⁶⁰

Autonomy is not the sole value to guide our interactions and in chapter two I explored some of the other values, principles and moral approaches that define the contours of autonomy. I argued that beneficence is best understood as being shaped by the individual's autonomy. The duty of beneficence requires that the beneficiary's autonomy is supported and enhanced. Although irrational decisions may not be overridden, they do not reflect the individual's autonomy and beneficence requires the HCP's intervention to persuade the patient to reconsider his or her decision.

In chapter two I also considered the relevance of justice and virtue to the principle of respect for autonomy. Justice is relevant in three ways. First, it requires that if respect for autonomy is required then that respect should be given equally to all moral agents unless there is some morally relevant reason why any particular agent or group of agents should be treated differently. Second, because respect for autonomy requires the use of scarce resources, justice is relevant to ensuring that those resources are fairly distributed. Third, the distribution of outcome responsibility should also be justly determined. Attention to virtue is important because the indeterminacy of rules generated from the even more abstract principles necessitates interpretation. A virtuous individual is more likely to interpret the rules within the spirit of the principle giving due accord to the values protected by the rule.

¹⁰⁵⁹ Henry Ford famously said that the customer can have any colour of car as long as it was black.

¹⁰⁶⁰ *Op cit* n.49, 84.

In chapter three I examined the professional-patient relationship as the context for the application for these moral approaches. Rather than draw analogy to other relationship models, as other authors have done, I discussed the interaction between HCP and patient as a unique relationship characterised by specific needs and obligations. While both parties are autonomous persons, that autonomy is constrained by the other's autonomy and also by the obligations that arise from the relationship. The HCP's autonomy is also constrained by the professional obligations that justify the social mandate to practise the profession.

The professional-patient relationship should be one of mutual trust and respect, which requires that both parties are trustworthy. Because the power within the relationship lies mostly, although by no means exclusively, with the professional, and because of the professional's role-specific obligations, HCPs should foster and support the patient's autonomy. Thus, the relationship context of the various healthcare interactions, exemplified by consent, requires the HCP to sensitively inform patients of any relevant information, assist them in understanding the information, advise them and if necessary persuade them to reconsider any apparently irrational decisions.

In chapter four, taking the prior discussions into account, I analysed the concept of consent. I argued that consent should not be restricted to being just an actively permissive state of mind. Communication to the HCP is crucial to justify any interaction. Although consent as permission justifies an action, it is necessary but insufficient to determine outcome responsibility for any action performed as a consequence of that consent. Rather, as I discussed in chapter two, outcome responsibility is a matter of distributive justice with agency simply being one factor to be taken into account.

Relying on a theory-based approach to concepts,¹⁰⁶¹ I argued that the basic theory is satisfied by consent as permission. However, a context sensitive conception of consent, situated in the professional-patient relationship as discussed in chapter three, also engages with consent as agreement. Consent as agreement requires a process of negotiation and shared-decision making that precedes and culminates in the final consent decision.

Consent as agreement also forms the basis of the professional's obligation to discuss reasonable alternatives with the patient and to engage the patient in any non-treatment decisions. However, neither consent as permission nor consent as agreement actually requires the HCP to offer or provide any particular treatment. Any such obligation arises from the professional's duty of care rather than from the duty to respect the patient's autonomy.

As an addendum to chapter four I described a model of consent that I subsequently used as a basis for critiquing the current legal regulation of consent to medical treatment. In that model, consent as permission was a secondary right derivative on the underlying right to bodily integrity. Once consent has been given an intervention becomes a justified breach of bodily integrity. Thus, consent is the act of communicating to the HCP the patient's permissive propositional attitude towards the proposed procedure. It lasts until it is either withdrawn or circumstances change to mean that the permission no longer applies. Consent as agreement is a process of negotiation and persuasion, which requires mutual trust and the virtuous engagement of both parties. It allows the professional to advise and persuade the patient to consent to a particular course of action. However, it also crucially requires the professional to be open to persuasion.

This approach relies on the assumption that both parties come to the relationship with a common goal, which is to determine the best course of action for the patient, within the

¹⁰⁶¹ Medin, D.L. 'Concepts and Conceptual Structure' (1989) 44 *American Psychologist* 1469; Murphy, G.L., Medin, D.L. 'The role of theories in conceptual coherence' (1985) 92 *Psychological Review* 289;

constraints of available resources. Thus, it allows the professional to challenge apparently irrational decisions. The HCP's duty of beneficence and respect for autonomy makes the power to persuade (and be open to persuasion) an obligation, but one that must be exercised with sensitivity to the patient's condition. However, because patients should retain their right to be wrong, which is an essential aspect of autonomy, any attempts to persuade should be limited to rational argument. Bullying and coercion are unacceptable and are not permitted in this model.

Because consent is predicated on autonomy, the patient must be competent, the decision must be made voluntarily and the patient should have sufficient knowledge to enable a rational decision. This requires that the professional both makes adequate disclosure and takes reasonable steps to help the patient to understand the information enough to use it to make a reasonable decision. Ordinarily this will involve disclosing information that relates to the implications of the proposed course of action, which includes the implications of rejecting any alternatives. However, patients may waive their right to this information, either in full or in part. In this regard, it is one of the patient's obligations to assist the HCP in determining what information should be disclosed. Where all treatment related information is refused, this does not end the HCP's obligation. Where all information is waived, the HCP must ensure that the patient understands the legal implications of that waiver.

Just as patients may waive their right to information, so they may waive their right to consent. As with the informational waiver, they should be informed of the legal consequences of the waiver. Because patients must actively waive their right, they must exercise their autonomy. In this minimal sense autonomy is mandatory, but consent to medical treatment is not an inalienable right.

The model recognises that the competent patient should have a *prima facie* right to consent or refuse consent to any proffered treatment. The right is not absolute because other justifications, such as where non-treatment poses a risk of serious harm to others, may permit non-consensual treatment. There may also be occasions, where an act harms the community, when consent is ineffective to justify intervention. Barring these exceptions, a refusal of consent should ultimately be accepted. However, as I noted above, where the refusal is irrational, temporary infringement of the right to refuse is justified, and indeed required, while the HCP attempts to persuade the patient to reconsider the decision. This allows HCPs to fulfil their obligations to the patient (see earlier). The patient, in entering into a relationship with the professional, should accept the obligation to allow the professional to fulfil those duties. Thus, patients should be willing to explain their decision and be reasonably open to persuasion.

Finally, the model recognises a distinction between responsibility for the treatment decision and responsibility for the outcome of treatment. Because consent is based on autonomy and is seen as a right, the patient is harmed by any unjustified failure to obtain an effective consent. The model allows this harm to be recognised independently of the outcome of treatment. Whether or not a risk materialises is irrelevant to the wrong. How far the damage caused by a materialised risk should be compensated for may be dependent on the interaction between the HCP and the patient in making the treatment decision, but responsibility for outcome should be a distinct judgment that takes into account, but is not determined by, the adequacy of any consent.

In chapter five I explored the legal regulation of consent to medical treatment. I noted that the courts had distinguished certain elements of the duty to disclose, most notably information about risks and alternative options. The primary reason for this was to avoid the associations of criminality inherent to battery liability. It also allows the judges much greater control over liability than would have been possible in battery law. However, in

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