THE DEMANDS AND BOUNDARIES OF CONSENT FOR MEDICAL TREATMENT IN THE NATIONAL HEALTH SERVICE

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Abstract

It is widely accepted that consent is underpinned by the principle of respect for autonomy. Accordingly, doctors are instructed to obtain consent for medical treatment through decision-making in partnership with patients. Yet, decision-making involves preceding judgments about the treatment-options that should be offered, and sometimes conflicting considerations of the doctor’s duty to care for the patient. This thesis engages Amartya Sen’s capability approach as a theoretical tool to understand the idea of consent and propose a model that responds to the broader context. Central to the capability approach is the argument that a person’s well-being is achieved through her freedom to ‘be and do’ what she has reason to value. In the context of health, this can be understood as securing a person’s capability to achieve medical treatment in line with her agency; that is, her unique health-goals. This capability has two aspects: treatments that are available to a person, as the means to her goals; and her opportunities to achieve or reject these treatments. The capability approach supplies critical conceptual clarity and distinction of these two aspects, and it enables the articulation a clear model of the wider demands and boundaries of consent. Key to attaining this model is Sen’s focus on public reason: a way of interpreting the underpinning principles that would be acceptable to a reasonable person. As per John Rawls, superior courts are fora of public reasoning. This thesis analyses significant, consent-focused case law within a capabilities framework to expose evolving ideas of justice that culminate in the Supreme Court’s decision in *Montgomery*. Traditionally, judges relied on the private reasoning of doctors for both aspects of a patient’s capability to achieve treatment; then, there is shift to public reason. Yet, reliance persists on medical professionalism, and *Montgomery* illuminates judicial strategy as well as reveals ongoing challenges.

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Abbreviations

EBM	Evidence-Based Medicine
ECT	Electro-Convulsive Therapy
GMC	General Medical Council
MDT	Multi-Disciplinary Team
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
SDM	Shared Decision-Making

Chapter 1

The Problem of Consent

1.1 Introduction

Consent for treatment has risen to remarkable prominence in medicine.[1] The medical profession's attention to consent has been instigated, in large part, by malpractice litigation. For instance, in the UK, the judgement of the Supreme Court in the case of *Montgomery*[2] has been instrumental in provoking interest in consent amongst medical professionals.[3] Although, it could be argued that medical professionals' attitudes towards, and practices of, consent have changed because of sociological evolution rather than legal developments. It is widely recognised that expectations in contemporary society have shifted away from traditional narratives of patients following the 'doctor's order',[4] and of 'a practice of silence'[5] between the doctor and the patient. Consequently, there may have been fundamental changes in medical professional practices;[6] and the law may be reflective, rather than causative, of transitions in medical approaches to consent.

It is clear that the law and medical practice are linked inextricably, but there is ongoing debate about the nature of this interaction: whether the law should shape medical professional practices; or, conversely, if the law should be

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[1] The rise in medical interest in consent is illustrated by the serial increase in the total number of publications in the PubMed database with 'consent' in the title-field: in January 1970, 22; in April 2020, 12,717.

[2] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

[3] For examples, see Robert Wheeler, 'Consent in Surgery: Is There a Montgomery Effect?' (2016) 22 Clinical Risk 21; Robert Wheeler, 'The Evolution of Informed Consent' (2017) 104 British Journal of Surgery 1119; Natalie Harrison and others, 'How Montgomery is Reconfiguring Consent in the UK' (2018) 392 The Lancet 102. For my preliminary review of consent practices, up to *Montgomery,* see Abeezar I Sarela and Michael Thomson, 'Balancing Law, Ethics And Reality in Informed Consent for Surgery' (2014) 96 Annals of the Royal College of Surgeons of England 329.

[4] Talcott Parsons, *The Social System* (first published 1951, Quid Pro Books 2012) 326.

[5] Jay Katz, *The Silent World of Doctor and Patient* (first published 1984, The Johns Hopkins University Press 2002) 3.

[6] See John C Burnham, 'Why Sociologists Abandoned the Sick Role Concept' (2014) 27 History of the Human Sciences 70. See also Gül Seçkin, 'Expansion of Parson's Sick Role into Cyberspace: Patient Information Consumerism and Subjective Health in a Representative Sample of U.S. Internet Users' (2020) 247 Social Science & Medicine 112733.

guided by medical practices.[7] This jurisprudential debate is critical, and I will contribute to it; but, this is not the starting point of my project. Instead, as a practising surgeon in the National Health Service (NHS), my question is practical: what is the modern doctor obliged to do in seeking and obtaining valid consent for treatment from his patients?

As a surgeon, I have been intrigued and perplexed by the requirements of consent for operations. The General Medical Council (GMC) sets out consent as a process in which doctors must involve patients in making decisions about their medical treatment.[8] But, the GMC's directive that doctors must supply information that patients 'want or need'[9] seems vague; and judicial demands for the provision of 'full' and 'complete'[10] information are nebulous. How is the medical professional expected to figure out a patient's 'wants and needs'? What is 'full' and 'complete' information: every single bit of knowledge about a disease and its treatment that exists in the medical universe; or, is it something less expansive? The practising doctor remains unclear about the nature and extent of information that he is obliged to provide to his patient.

Furthermore, it is plain that simply informing a patient, in the sense of just making formal disclosures of technical information, is not sufficient. Rather, the doctor has a duty to 'ensure that the patient understands'[11] the information, and he is required to 'check whether patients have understood the information they have been given'.[12] These demands create another predicament for the doctor: what is it that he is required to do, in the setting of his outpatient clinic or hospital ward, in order to ensure and check the patient's understanding? Having supplied explanations, is he simply to inquire whether the patient is satisfied? Or, is he expected to do more; and, if so, what? There does not seem to be any clear direction from the GMC or from the law. The medical profession, itself, has responded by devising 'decision aids': tools that can help patients to understand

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[7] For arguments in favour of leadership from the law, see Charles Foster and José Miola, 'Who's in Charge? The Relationship Between Medical Law, Medical Ethics, and Medical Morality?' (2015) 23 Medical Law Review 4; Iain Brassington, 'On the Relationship between Medical Ethics and the Law' (2018) 26 Medical Law Review 225. For opposing arguments, see Jonathan Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 Legal Studies 185; Jonathan Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (2017) 70 Current Legal Problems 73.

[8] General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (2008).

[9] Ibid para 9 (and at several other places in the guidance).

[10] *Thefaut v Johnston* [2017] EWHC 497 (QB), [2017] Med LR 319 [75] (Green J).

[11] *Montgomery UKSC* (n 2) [90].

[12] GMC Consent 2008 (n 8) para 11.

their medical condition and to choose treatment.[13] Such aids vary from pamphlets that set out information in easily accessible formats to sophisticated electronic applications that not only provide information in an interactive manner but also administer tests. It has been proposed that ‘certified’ decision aids could supply legally-valid vehicles for both the transfer of information as well as understanding; and there is some legislation to this effect in the USA.[14] But, in the UK, there is no statutory position on decision-aids, or any other tool, to check and ensure understanding.

Finally, even if the necessary information has been supplied and the patient’s understanding has been checked and ensured, it does not seem that a doctor should administer a treatment simply because the patient has agreed to it. For example, ‘consent’ has not been deemed sufficient for a doctor to have amputated healthy limbs in people with body integrity identity disorder (apotemnophilia), even though the amputees had not only persistently requested such operations but also were delighted with the outcomes.[15] The inference is that a person’s consent demands more than her agreement or permission for a treatment, regardless of the extent of information-provision and understanding. Rather, consent essentially requires that such agreement or permission must be obtained in certain contexts only, and not otherwise. Stated differently, consent for any medical treatment or surgical operation will be valid only if that treatment or operation is deemed to be ‘proper’;[16] if the treatment, itself, is not proper, then the consent will be invalid.

What is it, then, that defines ‘proper’ medical treatment for an individual patient with a certain health condition? A doctor might take the view that the identification of proper treatment is the unique product of applying his university education, apprentice-like training and continuing professional development to the patient’s circumstances. However, as pointed out by the Supreme Court,

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[13] For a comprehensive review, see Dawn Stacey and others, ‘Decision Aids for People Facing Health Treatment or Screening Decisions’ [2014] The Cochrane Library 1. See also Drug and Therapeutics Bulletin, ‘An Introduction to Patient Decision Aids’ (2013) 347 The British Medical Journal f4147; Ian Hargraves and Victor M Montori, ‘Decision Aids, Empowerment, and Shared Decision Making’ (2014) 349 The British Medical Journal g5811; Thomas Agoritsas and others, ‘Decision Aids that Really Promote Shared Decision Making: The Pace Quickens’ (2015) 350 The British Medical Journal g7624.

[14] Thaddeus M Pope, ‘Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law ’ (2017) 45 Journal of Law, Medicine and Ethics 12.

[15] Carl Elliott, ‘Amputees by Choice’ in Helga Kuhse and Peter Singer (eds), *Bioethics: An Anthology* (Blackwell Publishing 2006).

[16] See José Miola, ‘Moralising Medicine: 'Proper Medical Treatment' and the Role of Ethics and Law in Medical Decision-Making’ in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routlege 2016).

patients now have independent access to medical information.[17] It is not an uncommon experience for surgeons to encounter patients who come to a consultation, not for advice about treatment, but to discuss the implementation of an operation that they have already selected. I am faced with this situation frequently in my bariatric surgery practice: “Doctor, I’ve come to see you because I’m fed up of being fat and I want you to do a gastric band for me”. Less frequently, in my cancer surgery practice, I am faced by a patient with, say, gastric cancer who is insistent that I operate and remove her stomach. Often, such patients are already in possession of facts about their condition, the potential benefits and harms of their chosen operation, and alternative courses of action; or, they continue to insist on their request even after discussion.

In some such cases, the doctor’s job becomes easy because the patient’s choice corresponds to what he would have recommended anyway. But, what of the cases where the doctor sees the patient’s request as ‘improper’ or ‘wrong’? In the face of the widely publicised emphasis on ‘patient choice’ in the NHS, it can be quite difficult to justify declining treatment on the basis of insufficiency of an informed permission as consent. Reference to authority in the form of clinical guidelines from, say, the National Institute of Health and Care Excellence (NICE), can sometimes help the doctor to decline treatment. For instance, NICE’s clinical guideline on obesity could be cited in refusing a gastric band to a patient whose body mass index is below the recommended threshold of 40 kg/m^2 for such surgery.[18] Yet, tension often remains because of ambiguity, implicit value judgments, and concessions to professional discretion and patient preference in most guidelines.[19]

It is even harder to supply justification for declining treatment when there are no explicitly-stated rules; yet, decisions have to be made about the propriety, or wrongfulness, of a treatment. To exemplify: NICE’s clinical guideline on gastric cancer does not set out any criteria to select between surgery and palliative treatment for individual patients.[20] In practice, it would seem that surgeons do not operate on patients if the estimated peri-operative mortality is more than

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[17] *Montgomery UKSC* (n 2) [76].

[18] National Institute of Health and Care Excellence, *Obesity: Identification, Assessment and Management* (NICE Clinical Guideline CG149, 2014).

[19] See Alan S Brett and Lawrence B McCullough, ‘Addressing Requests by Patients for Nonbeneficial Interventions’ (2012) 307 The Journal of the American Medical Association 149. See also David M Eddy, ‘Designing a Practice Policy. Standards, Guidelines, And Options’ (1990) 263 The Journal of the American Medical Association 3077.

[20] National Institute for Health and Care Excellence, *Oesophago-Gastric Cancer: Assessment and Management in Adults* (NICE Clinical Guideline NG83, 2018).

about 5%;[21] in such cases, palliative treatment is considered to be the proper pathway. But, what if a particular patient is willing to accept a mortality-risk of 50% in return for the possibility of cure of her gastric cancer? Is her permission, backed by information and understanding, sufficient for the surgeon to undertake the operation? Would he have obtained valid consent for the gastrectomy? The practicing doctor struggles with such dilemmas.

1.2 A Doctor’s Obligations in Obtaining Consent

The GMC instructs doctors to view consent as an important part of the process of decision-making about treatment that is undertaken in partnership with patients.[22] There are two stages to the doctor’s obligation to obtain consent that are that are implicit in the GMC’s guidance: first, having assessed the patient’s condition, the doctor has to identify treatments that would be of ‘overall benefit’, that is, proper or available, for the patient, in the context of her individual situation;[23] and, then, he has to communicate information about the patient’s health and about the available treatments to the patient, in order that the patient can deliberate on this information and make a decision about the treatment that she wishes to undergo.[24]

Both stages of consent impose obligations on the doctor to make certain decisions or judgments: for the first stage, the doctor has to decide the treatments that are available to the patient; then, in the second stage, he has to make a judgment about the nature and the extent of the information that he ought to communicate to the patient, and how he ought to communicate this information. I will discuss later that these judgments are, essentially, about values; in other words, these are value judgments. These decisions, or judgments, that are required of the doctor precede any decision-making that the doctor might undertake in partnership with the patient (although, the process is dynamic and the doctor’s judgments might have to evolve and mutate during

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[21] The highest 90-day mortality following gastrectomy as reported in The Royal College of Surgeons of England Clinical Effectiveness Unit and others, *National Oesophago-Gastric Cancer Audit 2018: An Audit of the Care Received by People with Oesophago-Gastric Cancer in England and Wales 2018 Annual Report* (Version 2, 2019) 54 is 4.4%. Since the performance of individual surgeons is monitored by mortality rates, and higher than average mortality rates are criticised, it can then become a practice to regard high-mortality estimates as prohibitive, and to deem the patient as ‘unfit’ for an operation. See F Kiernan and F Rahman, ‘Measuring Surgical Performance: A Risky Game?’ (2015) 13 Surgeon 213. See also Margaret L Schwarze, Karen J Brasel and Anne C Mosenthal, ‘Beyond 30-Day Mortality: Aligning Surgical Quality with Outcomes that Patients Value’ (2014) 149 JAMA Surgery 631.

[22] GMC Consent 2008 (n 8).

[23] Ibid para 5(b).

[24] Ibid para 5(c).

the course of the decision-making); and these judgments then define the partnership-based process of decision-making.[25]

A doctor has to make some judgments in relation to the first stage of consent because simply any or all treatments that have been described to be effective for a certain health condition, in abstract, might not be suitable for a particular patient. Instead, the doctor has to decide contextually about the treatments that should be available to individual patients.[26] For example, although a gastrectomy operation can cure stomach cancer, an individual patient might not be deemed to be in a curable situation because of the combination of her cancer-stage and associated illnesses; the doctor would not, then, identify gastrectomy as a treatment that would be of overall benefit, and he would not offer it (make it available) to the patient.[27] The GMC is clear that a doctor is not obliged to make available any treatment that he does not judge to be of overall benefit to the patient.[28] But, the GMC does not offer guidance on what the doctor is obliged to do in order to identify treatments that are of overall benefit and, therefore, available to individual patients. In other words: how *ought* the doctor to identify available treatments?

Having identified available treatments, the doctor encounters the second stage of consent: how *ought* he to inform the patient about her health condition and available treatments? It would be simply infeasible for the doctor to impart all existing information to the patient;[29] instead, the doctor would have to make some decision, or judgment, about the nature and the scope of the information that he communicates to the patient, and about the mode of this communication.[30] Once again, the GMC does not offer any explicit guidance. As

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[25] For an empirical survey of the sequence of judgments in decision-making practices, see Justin T Clapp and others, ‘Surgical Consultation as Social Process: Implications for Shared Decision Making’ (2019) 269 Annals of Surgery 446.

[26] In *Montgomery UKSC* [75], the Supreme Court acknowledges that the doctor has make a ‘clinical judgment’ to identify available treatments. Such judgments are unavoidable. Advocates of self-determination of medical treatment often seem to overlook that there has to be a starting point for choice, and that this starting point, itself, cannot be self-determined. See Ingrid Whiteman, ‘The Fallacy of Choice in the Common Law and NHS Policy’ (2013) 21 Health Care Analysis 146. See also Emma C Bullock, ‘Free Choice and Patient Best Interests’ (2016) 24 Health Care Analysis 374.

[27] See Abeezar I Sarela and Shashidhar Yelluri, ‘Gastric Adenocarcinoma With Distant Metastasis: Is Gastrectomy Necessary?’ (2007) 142 Archives of Surgery 143.

[28] GMC Consent 2008 (n 8) para 5(d).

[29] Onora O'Neill, ‘Some limits of informed consent’ (2003) 29 Journal of Medical Ethics 4 discusses that disclosure of information can never be complete, over and above practical limitations, because of the infinite transitiveness of events; consequently, consent always has some ‘opaque’ components.

[30] In *Montgomery UKSC* [85], the Supreme Court admits that ‘the doctor must necessarily make a judgment as to how best to explain the risks to the patient…’.

mentioned earlier, the GMC does emphasize that the doctor should supply all the information that the patient ‘wants or needs’, and that the doctor should help the patient to understand this information; but, the GMC’s guidance does not provide clear, practical steps for the discharge of this duty.

1.3 Aims

Consent imposes various demands on the doctor. But, it also sets boundaries: consent is not simply permission, or, correlatively, unfettered choice, for any treatment. The aims of the present project are to explore and to clarify the demands and boundaries of the doctor’s obligations in making the judgments that are integral to the two stages of consent that I have outlined above. These aims reduce to two important questions. First, how *ought* a doctor to make the judgments that are necessary to identify treatments that are available to individual patients? Secondly, how *ought* a doctor to make judgments about the communication of treatment-related information to the patient?

At this point, it will be helpful to clarify the scope of the present project. This project is restricted to consent for medical treatment by adult patients with decision-making capacity in the NHS.[31] It does not deal with consent for clinical research. The project is limited to the NHS because, as a publicly-funded healthcare system, the NHS involves certain considerations of resource allocation for medical treatment that might be side-stepped in entirely privately-funded healthcare (although, it could be counter-argued that no healthcare system can be entirely free of resource considerations; and the arguments that I advance in this thesis can be extended to other healthcare systems, with appropriate adjustments).

1.4 Thesis Outline

The methodology of this project involves theoretical research and doctrinal research. I will engage with theories of political and moral philosophy, medical ethics and case law in order to address my aims. I have not conducted any empirical study. This thesis is set out in two parts. Part I covers chapters 2 to 5, and it comprises theoretical research. Part II spans chapter 6 to 8, and it encompasses doctrinal research. Chapter 9 is the concluding chapter, in which I outline some outstanding issues for future research.

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[31] I will discuss capacity for decision-making in Chapter 4 (4.4).

1.4.1 Part I: Theoretical Research

Consent is widely grounded, in bioethics and case law, in the principle of respect for the autonomy of the patient.[32] This grounding implies that a doctor's obligations in seeking and obtaining consent from patients could be clarified through the principle of respect for autonomy. In other words, if a doctor understood, and did, what he ought to do in order to respect his patient's autonomy, then he would be able to discharge the obligations of both stages of consent that I have discussed earlier, with the ingrained demands and boundaries, satisfactorily.

However, reliance on respect for autonomy has been problematic for fleshing out the obligations of consent. Neil Manson and Onora O'Neill point out that autonomy is a wide-ranging concept in political and moral philosophy; since there are different understandings of autonomy, these authors argue that the grounding of consent in respect for autonomy is theoretically vague and cannot supply practical direction.[33] From case law, John Coggon has reported that judges interpret autonomy variably, and judicial decisions on consent practices can be inconsistent because of different interpretations of the principle of respect for autonomy.[34] As such, it is not surprising that doctors face difficulties, such as the ones that I have illustrated earlier, in seeking and obtaining consent through the use of the GMC's model of decision-making that relies implicitly on the principle of respect of autonomy.[35]

1.4.1.1 The Capability Approach

In this thesis, I engage the capability approach for clarifying doctors' obligations in obtaining consent.[36] Ingrid Robeyns has described the capability approach as a 'normative framework'.[37] She explains that the capability framework is normative because it is 'prescriptive', that is, it can supply 'moral norm(s) that

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[32] See footnotes 4-10 and related text in Chapter 3.

[33] Neil C Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press 2008) 70.

[34] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235. See also John Coggon, 'Would Responsible Medical Lawyers Lose their Patients?' (2012) 20 Medical Law Review 130.

[35] See footnote 5 in Chapter 4.

[36] The capability approach has been used widely for normative and policy-setting purposes. For a prominent domestic example, see Equality and Human Rights Commission, *Measurement Framework for Equality and Human Rights* (2017). For a survey of the uses of the capability approach in healthcare, see Paul M Mitchell and others, 'Applications of the Capability Approach in the Health Field: A Literature Review' (2017) 133 Social Indicators Research 345.

[37] Ingrid Robeyns, 'The Capability Approach: A Theoretical Survey' (2005) 6 Journal of Human Development and Capabilities 93, 94.

tell us what we *ought* to do'.[38] My objective is to use this framework to answer the two questions that I have set out earlier as my aims. It seemed apt to engage this framework because it foregrounds notions of agency, freedom and opportunity that are central also to the principle of respect for autonomy. Yet, as I will discuss, the capability approach gives a particular structure to the understandings and considerations of these notions, and it provides conceptual clarity to the obligations of consent in a way that is not obtained from the principle of respect for autonomy.

I discuss the capability approach in Chapter 2. The capability approach was initiated by Amartya Sen, about four decades ago,[39] and it has been developed, over this period, by Sen and other scholars. Sen's central argument is that social justice requires attention to the opportunities that are provided to individuals to achieve the goals or ends that they have 'reason to value';[40] rather than to focus simply on the distribution of resources, which are means to valued ends, but not ends in themselves. Sen terms a person's valued ends, which he describes as 'beings and doings', as the person's agency, and he considers that all persons should be provided with equitable or fair opportunities to achieve their agency.

Sen distinguishes between opportunity and agency, and he deals with these notions separately. Sen's idea of an opportunity intertwines with his conception of freedom. He views freedom to have two dimensions or aspects: a process aspect, and an opportunity aspect.[41] The process aspect of freedom pertains, essentially, to the means that should be made available to a person in order for her to pursue her agency. Robeyns describes this process aspect as 'capability inputs': the items which constitute the basis, or starting points, for a person's opportunities.[42] The opportunity aspect, on the other hand, deals with the real or effective possibilities for a person to use the available means to achieve her agency. The focus of the capability approach is on the opportunity aspect of freedom; and it is a person's opportunity to achieve agency that Sen terms as a capability. Capability theorists acknowledge the importance of the process aspect of freedom, but they do not deal with it directly.

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[38] Ingrid Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (OpenBook Publishers 2017) 28. Author's emphasis.

[39] Amartya Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (1985) 82 The Journal of Philosophy 169.

[40] Amartya Sen, 'Capability and Well-Being' in Martha Nussbaum and Amartya Sen (eds), *The Quality of Life* (first published 1993, Oxford Online 2003) 113.

[41] Amartya Sen, *Development as Freedom* (Oxford University Press 1999) 17; Amartya Sen, *The Idea of Justice* (first published 2009, Penguin Books 2010) 228.

[42] Robeyns, 'The Capability Approach: A Theoretical Survey' (n 37) 96.

Although Sen foregrounds the opportunity to agency in conceiving the fair capability that should be provided to a person for any enterprise, his claims are nuanced. He emphasizes attention to social diversity and value pluralism in recognising agency; at the same time, he points out that a person's agency may be distorted on account of her social arrangements and influences. As such, he argues that, in providing opportunities, it is not sufficient to attend merely to a person's agency; it is important, also, to consider her well-being. Sen's idea of well-being diverges from mainstream theories.[43] He conceives well-being to encompass 'beings and doings' that include certain normative considerations as opposed to simply self-determination; and he accepts that, in some cases, a person's agency might conflict with her well-being (for example, eating junk food as opposed to nutritious food).

Sen's notice of well-being, as distinct from agency, reflects a consequentialist attitude that justice cannot be oblivious to outcomes. Yet, he does not claim that well-being should invariably trump agency (or vice versa); rather, he argues that, in deciding a person's capability for any pursuit, her opportunity to agency ('agency freedom') has to be contextually weighed and balanced with the achievement of her well-being ('well-being achievement').[44] Depending on the nature of the project at hand, both agency freedom and well-being achievement may have to be accommodated, in order to preserve the centrality of agency but, simultaneously, to not ignore well-being. Sen does not set out any fixed scheme for the balancing of agency freedom and well-being achievement. Instead, he holds that evaluative judgments have to be conducted circumstantially by public reason; which is, then, key to the normative framework of the capability approach.

Health is foundational to considerations of justice in the capability approach, because health is both intrinsic to human well-being and instrumental to all opportunities.[45] Capability theorists argue that each and every person should be provided with a fair capability to be healthy, as a basic human right.[46] Since medical treatment is undisputedly an important determinant of health, a capability to achieve medical treatment can be viewed as a sub-set of a person's capability to be healthy. This capability to achieve treatment would encompass a person's opportunities to use available medical treatments to

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[43] See Dan Brock, 'Quality of Life Measures in Health Care and Medical Ethics' in Martha Nussbaum and Amartya Sen (eds), *The Quality of Life* (Oxford Online 2003).

[44] Sen, 'Capability and Well-Being' (n 40).

[45] Amartya Sen, 'Why Health Equity?' in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics and Equity* (Oxford University Press 2004).

[46] Sridhar Venkatapuram, *Health Justice* (Polity 2011).

achieve the health-goals that she has reason to value. But, these opportunities, in and of themselves, would not identify the available treatments, which are a matter for the process aspect of freedom. In this way (and for ease of further discussion), a person's capability to achieve treatment can be viewed to have two aspects: a process aspect, and an opportunity aspect.

The two aspects of the capability to achieve treatment align with the two stages of consent that I have pointed out earlier: the identification of available treatments; and the communication of information that would enable patients to accept or reject these treatments. The capability to achieve treatment provides the critical conceptual clarity that these two stages of consent involve separate and distinct judgments, about process and opportunity, respectively. I now propose that the doctor's obligation to obtain consent is reconceptualised as an obligation to provide the patient with a fair capability to achieve medical treatment. This proposal allows the use of the capabilities framework to make, and assess, the judgments that are integral to consent.

1.4.1.2 Respect for Autonomy

In proposing the reconceptualization of consent as the provision of a fair capability to achieve medical treatment, I do not suggest that the grounding of consent in the principle of respect for autonomy is jettisoned. The principle of respect for autonomy has a long-established and powerful, symbolic role in justifying consent; which would be neither easy nor helpful to discard. Instead, my objective is to use the capability approach to clarify the demands and boundaries of the principle of respect of autonomy. The capability approach is well-suited to this task because, like the principle of respect for autonomy, it foregrounds self-determination ('agency freedom'). At the same time, unlike classic theories of personal autonomy, the capability approach does not restrict itself to debates on self-legislation, authenticity and independence. Rather, the capability approach includes critical arguments that harmonize with the concept of relational autonomy that is advanced by feminist scholars, who locate a person agency in the web of her social influences and not in isolation from existential realities.[47] The capability approach particularly resonates with the feminist ethic of care, which asserts that care-providers are obliged to balance the care-recipient's articulations of self-determination with concern for her well-being.

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[47] Catriona Mackenzie and Natalie Stoljar, 'Autonomy Refigured' in Catriona Mackenzie and Natalie Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford University Press 2000).

I will discuss respect for autonomy in Chapter 3. Following exploration of theories of personal autonomy, and associated notions of dignity and liberty, I use feminist arguments to construct a four-layered model of respect for autonomy. Over and above theoretical considerations, the incorporation of feminist concerns is practically vital, because the primary duty that is assigned to doctors by the GMC is one of care. In this model, each layer represents a set of medical professional obligations that are correlative to enabling different dimensions of a nuanced understanding of self-determination by patients. I then propose that each layer of this model is viewed as a domain of the capability to achieve treatment. In this way, the principle of respect for autonomy can be seen to link to, and enrich, the conception of a fair capability to achieve treatment; and, correspondingly, the final understanding of a fair capability to achieve treatment, which I set out in Chapter 9, can illuminate the principle of respect for autonomy.

1.4.1.3 Medical Decision-Making

In Chapter 4, I move to practical considerations. How should a doctor provide the patient with a fair capability to achieve treatment? As discussed earlier, the GMC directs doctors to view consent as process of decision-making about treatment that is undertaken in partnership with patients. This partnership model of decision-making relies implicitly on the twinned ideas of evidence-based medicine (EBM) and shared decision-making (SDM).[48] I will discuss the conception of EBM, and its focus on the generation of clinical guidelines, which increasingly form the basis of modern, Western medical decision-making. I will then discuss the idea of SDM as a variable, practical hybrid of three, theoretically-ideal styles of decision-making that can be used to evaluate EBM, in order to arrive at a treatment decision; and I will point out the views of the Supreme Court in *Montgomery* on each of these ideal styles.

The combination of EBM and SDM indicates a ‘scientific-bureaucratic’[49] process of decision-making, in which EBM supplies the treatment-options that are available to the patient, and SDM allows the patient to exercise her agency to choose amongst the available options. Ostensibly, this model is neutral to the values of the doctor: it does not require the doctor to undertake any evaluative assessment or value judgment. Yet, in reality, value judgments by doctors are unavoidable and, indeed, integral to both EBM and SDM. The problems of

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[48] Benjamin Djulbegovic and Gordon H Guyatt, ‘Progress in Evidence-Based Medicine: A Quarter Century On’ (2017) 390 The Lancet 415.

[49] S Harrison, ‘New Labour, Modernisation and the Medical Labour Process’ (2002) 31 Journal of Social Policy 465.

consent, which I discussed and illustrated earlier, can now be clearly seen as dilemmas in making such judgments. The reconceptualization of consent as a capability to achieve treatment allows the explicit acknowledgement of the centrality of value judgments by doctors to decision-making; and it supplies normative tools, which are currently lacking in the GMC's model of decision-making, that can assist doctors to make fair judgments.

1.4.1.4 Public Reason

Public reason is key to making fair judgments in the capability framework. Sen repeatedly insists on public reason for evaluative assessments; but he does not set out a structured theory of public reason. Rather, Sen's views are largely responsive to John Rawls's work on public reason. Accordingly, in Chapter 5, I will discuss Rawls's account of public reason, and I will elaborate on important areas where Sen diverges from Rawls. Notably, Rawls's conception of public reason is not discursive, that is, it does not require actual debate or discourse amongst the public. Instead, Rawlsian public reason relies on justificatory arguments that would be acceptable to a certain constituency, which is termed as a reasonable person.[50] Critically, this constituency is not one of actual people; rather, it is a philosophical ideal, which Rawls discusses in some detail. Public reason is, then, a structure, or way, of reasoning that would be acceptable to this ideal reasonable person; regardless of whether, or not, the reasoning is accepted actually by real persons. In contrast, non-public or private reason is a way of reasoning that supplies justifications to only a restricted audience of actual persons; for example, a group of doctors.

The reconceptualization of the doctor's obligation to obtain consent to an obligation to provide a fair capability to achieve treatment requires the doctor to use public reason to conceive, and supply, the patient's opportunity to use available medical treatments as the means to achieve her valued ends. For this practical application of public reason, certain important specifications, such as the characteristics of the idealized reasonable person, become necessary. Rawls acknowledges that his theory cannot supply such specifications, which will vary between different societies; and he submits that these specifications should be sought in the judgments of relevant Supreme Courts. In this way, theory leads to case law, which I will analyse in Part II of this thesis, in order to uncover judicial ideas of public reason in the UK.

However, public reason cannot address the entirety of a person's capability to achieve treatment. I explained earlier that this capability has two aspects: a

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[50] John Rawls, *Political Liberalism* (first published 1993, Columbia University Press 2005).

process aspect and an opportunity aspect. Public reason applies to the opportunity aspect only. Capability theorists admit that another theory of justice requires to be engaged for the process aspect, but they do not pinpoint this theory; it is to be selected in consistence with the project at hand.[51] For the present project, I rely on Norman Daniels's argument for procedural justice.[52] Daniels argues that a certain, fair procedure has to be agreed for determining the treatments that are to be made available to a person; whatever the treatments that are identified by this procedure, are then fair options. Accordingly, in Part II, I will also explore the fair procedure for identifying available treatments that emerges from case law.

1.4.2 Part II: Doctrinal Research

In Chapter 6, I deal with the case law on consent for medical treatment prior to the Supreme Court's decision in *Montgomery.* In a common law tradition, legal precedents set the background to *Montgomery* and enable a sociologically-enriched understanding of this case. I will use the framework of the capability approach to analyse three landmark cases that are cited by the Supreme Court in *Montgomery*: *Bolam,*[53] *Sidaway*[54] and *Pearce.*[55] I also discuss the USA case of *Canterbury*,[56] because of its heavy influence on the debate in *Sidaway*. In brief, up to *Montgomery*, judicial focus was largely on the patient's opportunity to reject the treatment that was proposed by the doctor; although, crucially, the justificatory basis for a fair opportunity to reject treatment shifted from the private reason of medical professionals in *Bolam* to public reason in *Sidaway* (per Lord Scarman and Lord Templeman). Yet, the process aspect of a person's capability to achieve treatment remained assigned entirely to the private reason of the doctor who was treating the patient. In *Pearce*, there was an attempt to expand the reasoning on the process aspect, but it seemed only allusive.

In Chapter 7 and Chapter 8, I analyse *Montgomery.* The Supreme Court can be seen to make two important, inter-related moves in *Montgomery*. It seeks, first, to re-vitalise the traditional opportunity to reject treatment into an enlarged opportunity to achieve an option from amongst a range of available treatments (including the option of rejecting all treatments). This enlarged opportunity to

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[51] Ingrid Robeyns, 'Capabilitarianism' (2016) 17 Journal of Human Development and Capabilities 397.

[52] Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008).

[53] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB).

[54] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL).

[55] *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167 (CA).

[56] *Canterbury v Spence* (1972) 464 F2d 772 Court of Appeals, District of Columbia.

achieve treatments, then, entwines with the expanded reasoning on the process aspect that had surfaced in *Pearce.* I will discuss the enlarged opportunity aspect in Chapter 7, and I will draw on the Supreme Court's observations to build a picture of a reasonable patient in 21st century, and the opportunities that would be acceptable to this patient. The narrative runs largely that a patient's agency is determinative of her well-being, regardless of normative considerations; and that opportunities to achieve treatment should be provided accordingly. In Chapter 8, I explore the Supreme Court's approach to the process aspect of the patient's capability to achieve treatment. The Court retains reliance on the private reasons of the medical profession, but it adopts a certain strategy that aspires to supply a fair procedure. In this way, *Montgomery* permits insightful inferences about both aspects of a fair capability to achieve treatment.

In Chapter 9, I draw in the theoretical and doctrinal strands that address my aims. I outline some practical challenges to the implementation of the *Montgomery* procedure for identifying available treatments; and I highlight the undercurrent of tension between agency freedom and well-being achievement in the opportunity aspect. I point to some avenues for further work to operationalize the capability to achieve treatment as a vehicle for consent.

1.5 Notes on Terminology

It will be helpful to clarify some terminology that I follow in this thesis:

First, I refer to patients in the feminine gender, by the use of 'she' or 'her'. Such usage seems quite uncontroversial and in keeping with contemporary practice to shift the emphasis away from the masculine context that was previously ubiquitous. On the other hand, I refer to medical professionals as 'he' or 'him'. In doing so, I do not imply any privilege to either gender. The gender distinction simply serves as a useful linguistic tool to avoid confusion and repetition.

Secondly, I have tried to avoid the use of the term 'informed consent', for two reasons. First, as explained by Manson and O'Neill: 'the notion of *informed consent* is a pleoplasm: *uninformed consent* is not really a type of consent'[57] (although, these authors continue to use the term 'informed consent' in their book). Secondly, as pointed out by Sheila McLean, informed consent refers specifically to the legal doctrine of consent that was developed in the USA, and it focuses on the liability of doctors with respect to disclosure of information.[58]

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[57] Manson and O'Neill (n 33) 89. Authors' emphases.

[58] Sheila AM McLean, *Autonomy, Consent and the Law* (Routledge 2010) ch 2. The term 'informed consent' first appears in case law in *Salgo v Leland Stanford Jr University Board of Trustees* (1957) 154 CalApp 2d 560 District Court of Appeals

Yet, as acknowledged by McLean, it seems impossible to entirely avoid this term because of its general usage. In this thesis, I will limit the mention of ‘informed consent’ to situations in which I am quoting authors who use this term.

Thirdly, I use the terms ‘medical professional’ and ‘doctor’ interchangeably throughout this thesis.

California 181 (Bray J). For discussion of the origin of this term, see Alasdair Maclean, ‘The Doctrine of Informed Consent: Does It Exist and Has It Crossed the Atlantic’ (2004) 24 Legal Studies 386.

Chapter 2

The Capability Approach

2.1 Introduction

In Chapter 1, I discussed that in seeking and obtaining consent for medical treatment from a patient a doctor is required to make two types of judgments. First, a judgment about the range of treatments that is available to the patient; and, secondly, a judgment about the communication of treatment-related information to the patient. The fundamental question that I address in the present thesis is the following: how ought a doctor to make these judgments?

I have engaged the capability approach to answer this question. Ingrid Robeyns describes the capability approach as a 'normative framework'.[1] She explains that the capability approach is 'primarily and mainly a framework of thought, a mode of thinking about normative issues; hence a paradigm—loosely defined—that can be used for a wide range of evaluative purposes'.[2] The capability approach is a framework because it provides an analytical scheme that can be used to identify different, potentially competing considerations that underpin a judgment; and it is normative because it can tell us how we ought to deal with these various considerations and make appropriate judgments. The objective of the present project is to use the capability approach to identify and evaluate the considerations that underpin the judgments in consent. Used in this way, the capability approach can tell doctors how they ought to make appropriate judgments.

In the present chapter, I will explicate the capability approach and its application to consent for medical treatment. The capability approach was pioneered by Amartya Sen. In setting out the capability approach, Sen repeatedly acknowledges his philosophical debt to John Rawls: it was in response to Rawls's theory of justice that Sen first proposed the idea of capabilities. In section 2 of this chapter, I will provide a brief overview of Rawls's theory of justice that is immediately pertinent to the capability approach. In section 3, I will discuss Sen's objections to Rawls's theory, and the fundamental propositions of the capability approach. In endeavouring to understand the capability approach, Séverine Deneulin's view of the capability approach 'as a new normative

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[1] Ingrid Robeyns, 'Capabilitarianism' (2016) 17 Journal of Human Development and Capabilities 397, 403.

[2] Ingrid Robeyns, 'The Capability Approach: A Theoretical Survey' (2005) 6 Journal of Human Development and Capabilities 93, 96.

language' is useful. She explains that 'It is a language because it possesses some basic words and a grammar structure that define it. It is a *normative language* because words are used to construct moral narratives and moral judgments'.[3] I will set out this language so that it is readily accessible for application to consent for medical treatment in the succeeding sections of this chapter and later in this thesis. In section 4, I deal with the place of health in the capability approach. The capability approach makes a claim that health is central to social justice, and it asserts that every person has a right to a certain capability, or opportunities, to be healthy. Yet, it is difficult to flesh out this right because of differences in the understanding of health, itself. I will discuss various notions of health in the capability language and the interplay of these notions in judgments about consent for medical treatment. In section 5, I propose a novel concept: each person's capability to achieve medical treatment as a subset of her capability to be healthy. I then propose that the doctor's obligation to obtain consent is reconceptualised as an obligation to provide the patient with a fair capability to achieve treatment. The capabilities approach now equips the doctor with a normative tool for making fair judgments. Section 6 is the conclusion to this chapter.

2.2 John Rawls's Theory of Justice

Rawls's theory of justice, which he called *Justice as Fairness*, is explicated in a series of his works.[4] Rawls was a political philosopher, and his aim was to formulate the most appropriate conception of justice for the basic institutions of society.[5] His work is set in the social contract tradition. He starts with the assumption that liberty and equality are fundamental, free-standing values, and he then considers how these values can be realised in the distribution of 'primary social goods' to all members of society.[6] His list of primary goods is broad, and it includes rights and liberties, income and wealth, and social bases of self-respect.[7] He explains that primary social goods serve as an index for inter-personal comparisons. Rawls proposes that, in order for the distribution of primary goods amongst members of society to be fair, these primary goods

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[3] Séverine Deneulin, 'Constructing New Policy Narratives: The Capability Approach as Normative Language' in Giovanni Andrea Cornia and Frances Stewart (eds), *Towards Human Development: New Approaches to Macroeconomics and Inequality* (Oxford University Press 2014) 47. Author's emphases.

[4] John Rawls, *A Theory of Justice* (first published 1971, Harvard University Press 1999) sets out the first, comprehensive statement of the theory.

[5] The aims are re-stated in John Rawls, *Political Liberalism* (first published 1993, Columbia University Press 2005).

[6] Rawls, *A Theory of Justice* (n 4) 79.

[7] Rawls, *Political Liberalism* (n 5) 181.

should be distributed according to his two principles of justice.[8] In this way, Rawls seeks to address the problems of distributive justice in society.

Rawls's work has been the subject of an enormous body of scholarship.[9] In-depth discussion of Rawls's theory is outside the remit of my thesis. Essentially, Rawls rejects utilitarianism,[10] and his conception of justice is egalitarian, but his egalitarianism is not simple.[11] In brief, Rawls distinguishes notions of formal equality and fair equality. Formal equality demands that primary goods are available to all members of society, and that distributions of these goods are decided on merits only. However, deep inequalities can remain, despite formal equality, since access to primary goods can be contingent on social differences that are pervasive in society; for example, the historically underprivileged status of black people as compared to white people. As such, he insists that principles of social justice must apply, in the first instance, to these inequalities that are embedded in society and are arbitrary from a moral viewpoint.[12]

In order to mitigate the influence of pervasive social inequalities, Rawls advances the notion of fair equality of opportunity, so that primary goods are not only available to all in the formal sense but also everyone has a fair chance to attain these primary goods. Fair equality attempts to level the playing field: it entitles a person to assistance by others whenever she suffers a relative disadvantage in her prospects for success through no fault or choice of her own. Even with fair equality, Rawls accepts that certain inequalities will persist in society; and this is not simply a concession to reality, but an assertion that values other than equality, such as merit and labour, too, are important, and should influence distributive shares. He proposes that such persisting inequalities should be guided by his 'difference principle': the inequalities are

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[8] Rawls, *A Theory of Justice* (n 4) 52. The first principle states that each person has an equal claim to a fully adequate scheme of equal basic rights and liberties. The second principle states that remaining social and economic inequalities are to satisfy two conditions: firstly, they are to be attached to positions open to all under conditions of fair equality of opportunity; and secondly, inequalities are to be to the greatest benefit of the least advantaged members of society.

[9] For example, Samuel Freeman (ed) *The Cambridge Companion to Rawls* (Cambridge University Press 2003).

[10] Rawls, *A Theory of Justice* (n 4) 24 asserts: 'Each member of society is thought to have an inviolability founded on justice or, as some say, on natural right, which even the welfare of every one else cannot override'.

[11] Ibid 63. For discussion, see Norman Daniels, 'Democratic Equality: Rawls's Complex Egalitarianism' in Samuel Freeman (ed), The Cambridge Companion to Rawls (Cambridge University Press 2003).

[12] Rawls, *A Theory of Justice* (n 4) 7.

acceptable provided that these result in some absolute benefit to the least well-off in society.[13]

Pertinently, Rawls's theory does not cover justice in matters concerning health. A fundamental assumption in Rawls's theory is that all members of society have normal health over their lifetime.[14] In addition, Rawls did not view health as a primary social good; instead, he saw it as a 'natural good' that was influenced by the basic structure of society, but 'not so directly under its control'.[15] As such, as acknowledged by Rawls himself, *Justice as Fairness* excludes considerations of health in social justice.[16]

2.3 Amartya Sen's Capability Approach

In contrast to Rawls, Sen asserts that:

> In any discussion of social equity and justice, illness and health must figure as a major concern. I take that as my point of departure—the ubiquity of health as a social consideration—and begin by noting that health equity cannot but be a central feature of the justice of social arrangements in general.[17]

Sen does not dispute the centrality of liberty and equality in Rawls's theory of justice.[18] However, he challenges Rawls's focus on 'primary social goods' as the index for inter-personal comparisons in the assessment of equality. Sen points out that Rawls's primary social goods are the means to valued goals or ends, but primary goods are not ends in themselves. The means-ends distinction is critical in Sen's work. He argues that social justice should focus on a person's ends, because it is ends that are constitutive of human flourishing,

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[13] Ibid 63. Rawls's idea is to secure more attractive prospects for the better off only if doing so is to the advantage of those who are less fortunate. The difference principle allows inequalities provided that these inequalities work to make those who are worst-off better than alternative arrangements.

[14] Ibid 83: 'Now I shall assume that everyone has physical needs and psychological capacities within the normal range, so that the questions of special health care and of how to treat the mentally defective do not arise.' Erin I Kelly, 'Public Reason as a Collective Capability' (2012) 43 Rutgers Law Journal 295 argues that Rawls's exclusion of health was a simplifying assumption rather than an assertion that health was not an important matter for justice.

[15] Rawls, *A Theory of Justice* (n 4) 54.

[16] Rawls, *Political Liberalism* (n 5) 20, 184.

[17] Amartya Sen, 'Why Health Equity?' in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics and Equity* (Oxford University Press 2004) 21.

[18] Amartya Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (1985) 82 The Journal of Philosophy 169. Although, Amartya Sen, *Inequality Reexamined* (first published 1995, Oxford Scholarship Online 2003) deals with equality differently than Rawls.

and not simply on the means that are available to the person.[19] Sen considers that a person’s ends are the ‘beings and doings’ that the person has ‘reason to value’.[20] He terms these ‘beings and doings’ as ‘functionings’. Accordingly, he argues that social justice should focus on a person’s functionings, and not on primary goods. Sen accepts that fair distribution of primary goods is important and cannot be ignored; notwithstanding, the thrust of his argument is that primary goods cannot be the measure of assessing equality.

Sen does not claim that justice requires that all people actually achieve their valued functionings or that there should be equality of functionings amongst all members of society. Rather, he regards that justice demands attention to a person’s opportunities to achieve her valued functionings. Sen views a person’s opportunities as her effective or real freedoms. It is these opportunities to achieve valued functionings that Sen terms as a ‘capability’: ‘the substantive freedoms he or she enjoys to lead the kind of life that he or she has reason to value’.[21] Sen argues that it only through attention to people’s capabilities for any enterprise that human diversity and inter-personal differences in ideas of advantage, flourishing and the good life can be accommodated.

In discussing human diversity, Sen highlights the distinction between what people may want to be or do and what they are able to be or do. He points out that there can be significant inter-personal differences in the use of the same set of primary goods, which he illustrates through the concept of ‘conversion factors’: the different degrees to which different persons can use the same primary good to achieve a valuable goal.[22] For example, if there was a right to recreation, and a town council decided to implement this right through free membership of sports clubs, Sen would argue that it was not sufficient to simply assess whether all citizens had been provided with club-membership. Instead, he would insist that it was essential to examine the opportunities that people had to ‘convert’ their sport-club-membership into the valuable end, that is,

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[19] John Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (Harvard University Press 1999) 13 fn 3 accepts that ‘His (Sen’s) idea is essential because it is needed to explain the propriety of the use of primary goods’. Parentheses added.

[20] At several places in Sen, ‘Well-being, agency and freedom: the Dewey Lectures 1984’ (n 18); Amartya Sen, ‘Capability and Well-Being’ in Martha Nussbaum and Amartya Sen (eds), *The Quality of Life* (first published 1993, Oxford Online 2003).

[21] Amartya Sen, *Development as Freedom* (Oxford University Press 1999) 87.

[22] Amartya Sen, *Commodities and Capabilities* (Oxford India Paperbacks 1999). Robeyns, ‘The Capability Approach: A Theoretical Survey’ (n 2) compartmentalizes these conversion factors into three groups: personal (e.g. health, intelligence, reading skills), social (e.g. social norms, discriminating practises, gender roles, social hierarchies, power relations), and environmental (e.g. climate, geographic location).

recreation. These opportunities might be quite different for an able-bodied man, versus a single mother with young children, versus a disabled person who was unable to leave her home without assistance. As such, attending only to the primary goods that are available to a person is not sufficient; it is necessary to attend, also, to her personal and social circumstances in order that she has fair opportunities to achieve her valued functionings.

In short, Sen shifts the focus of justice from primary goods, such as rights and resources, to the opportunities that are available to a person to use these goods to achieve functionings that she has reason to value. He conceptualizes the things that a person would have reason to value in terms of her agency and her well-being.[23] Agency and well-being, along with functionings, opportunities, freedoms and capabilities, are the important words of the capability language. I will expand on ideas that are expressed by these words in the sub-sections that follow.

2.3.1 Agency and Well-Being

Sen conceives a person's agency to encompass all the functionings that she has reason to value.[24] Des Gasper defines Sen's idea of agency as:

> [A] picture of persons as agents who have their own goals (including not only for themselves), make their own choices, and are not mere receptacles for resource-inputs and satisfactions; who, in Aristotelian language, live through the exercise of practical reason.[25]

However, this idea of agency, on its own, does not mean that the person necessarily has the ability to exercise these choices or attain these goals. For example, if a person determines that is valuable to exercise in a gym and to be in state of physical fitness, then this functioning—this 'doing' exercise and 'being' fit—is her agency; but, she may or may not have the opportunity to actually exercise. Sen deals with these two aspects of agency separately, in terms of 'agency freedom' and 'agency achievement', which I will discuss further in the next sub-section.

Sen considers that each person can have a unique and idiosyncratic agency. Agency is characterized by 'open conditionality' that is entirely agent-centric.[26] However, 'open conditionality does not imply that the person's view of agency has no need for discipline, and that anything that appeals to him must, for that

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[23] Amartya Sen, *The Idea of Justice* (first published 2009, Penguin Books 2010) 233.

[24] Ibid 287.

[25] Des Gasper, 'What is the Capability Approach? Its Core, Rationale, Partners and Dangers' (2007) 36 The Journal of Socio-Economics 335, 339.

[26] Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (n 18) 204.

reason, come into the accounting of his agency freedom'.[27] Both Gasper and Robeyns highlight Sen's qualification of agency as functionings that a person has 'reason to value', and not any or all functionings that are asserted, without reason, to be valuable.[28] At the same time, Sen also emphasizes that a person's agency may be influenced profoundly by her social context and relationships, such that the person may lack the cognitive and epistemological skills to crystallize her valued ends and to select the means towards these ends. In this way, Sen's idea of agency aligns closely with feminist conceptions of relational autonomy, and it engages notions of rationality and reasonability. I will expand on the alignment between feminist theories of autonomy and the capability approach in Chapter 3 (3.6), and I will discuss Sen's ideas of rationality and of a reasonable person in Chapter 5 (5.3.2).

Sen explains that 'Various concepts of "autonomy" and "personal liberty" relate to this special role of agency in personal life, going well beyond considerations of well-being'.[29] Sen's distinction between agency and well-being is critical to his project. As opposed to the open conditionality of agency, a functioning, or set of functionings, is not deemed to constitute a person's well-being simply because the person holds that these functionings are valuable. Instead, Sen argues that well-being has normative grounding: it comprises a set of functionings that satisfy certain norms that are worthy of advancement in human life and relationships.[30] He is emphatic that 'the problem of valuing functionings cannot be avoided by concentrating instead on the observation of desires and their intensities'.[31] I will discuss later that Sen advocates that the normative exercise of evaluating and selecting functionings that are constitutive of well-being should be conducted by public reason.

Sen clarifies that a person's agency may encompass her well-being, if agency coincides with normativity. But, agency is not determinative of well-being: a person's individual conception of the good does not become her well-being simply because it is her own conception. To the contrary, a person's agency could be detrimental to her well-being because idiosyncratically-set agency goals may diverge from the normative goals of well-being. Sen highlights that:

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[27] Ibid 204.

[28] Ingrid Robeyns, 'Sen's Capability Approach and Gender Inequality: Selecting Relevant Capabilities' (2003) 9 Feminist Economics 61; Gasper (n 25).

[29] Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (n 18) 186.

[30] Sen, *The Idea of Justice* (n 23) 286. In this way, Sen departs from traditional assessments of well-being as hedonism, desire-satisfaction or ideals. For discussion, see Dan Brock, 'Quality of Life Measures in Health Care and Medical Ethics' in Martha Nussbaum and Amartya Sen (eds), *The Quality of Life* (Oxford Online 2003).

[31] Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (n 18) 200.

> Assessing well-being may take us in one direction; judging achievements in terms of a person's overall goals may take us in a somewhat different direction, since a person can have objectives other than the pursuit of his own well-being.[32]

Sen acknowledges that, in case of conflict between a person's agency and her well-being, priority would have to be given to one or the other of these two dimensions, especially when society has to decide upon which aspect to protect or promote in regard to the person's capability for the related enterprise. For example, in deciding a person's capability for recreation, her agency to indulge in duelling would have to be balanced with her well-being of physical safety.

Sen does not set out any general, or universal, scheme of prioritization of agency versus well-being. Instead, he holds that prioritization has to be organized contextually, according to the situation at hand:

> Depending on the context, the agency aspect or the well-being aspect might achieve prominence. It would be a mistake to expect that one of these aspects would be uniformly more relevant than the other as a basis of interpersonal comparison for every interesting exercise.[33]

At the same time, Sen argues that 'Insofar as each person's advantage commands attention and respect in moral accounting, the well-being aspect of the person has to be directly considered. This role cannot be taken over by agency information'.[34] Sen's meaning of 'moral accounting' is not entirely clear. The implication is that well-being may be more relevant than agency in certain matters that demand special attention from society, such as public health and security, in order to advance normative views on advantage. In other matters, for example, higher education or recreation, agency might take precedence. Yet, the prioritization need not be absolute; it could be partial or incomplete, leading to ranking, rather than outright promotion or rejection of either well-being or agency.[35] Returning to the example of a person's agency to duel for recreation: duelling may not be forbidden entirely; rather, the person's opportunity for recreation could be restricted to duelling only with suitable protective equipment, thus achieving a balance, or partial prioritization, between agency and well-being.

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[32] Sen, 'Capability and Well-Being' (n 20) 36.

[33] Sen, *Inequality Reexamined* (n 18) 72.

[34] Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (n 18) 208.

[35] Sen, *The Idea of Justice* (n 23) 106, 342.

It is noteworthy that Sen's distinction between agency and well-being is not shared by other capability theorists. Martha Nussbaum (who, along with Sen, has figured prominently in the development of the capability approach) charges Sen with retaining utilitarianism in making this distinction.[36] In response, Sen acknowledges that agency and well-being are inter-dependent, but he insists on the distinction.[37] In his view, agency and well-being demand separate attention, and the relevance of each aspect is contingent upon the problem at hand. He explains that:

> Although agency aspect and well-being aspect both are important they are important for different reasons. In one perspective, person is seen as a doer and a judge, whereas in the other the same person is seen as a beneficiary whose interests and advantages have to be considered.[38]

2.3.2 Capabilities

Sen conceives of a person's 'capability' as her opportunities to achieve the functionings that are constitutive of a fair balance of her agency and well-being. Sen's conception of an opportunity relates to a particular understanding of liberty or freedom. Norman Daniels[39] and Sudhir Anand[40] have pointed out that Sen's idea of an opportunity is an extension of Isiah Berlin's positive sense of liberty. I will discuss in Chapter 3 (3.5) that Berlin distinguished between two senses of liberty: a negative sense that pertains to restrictions that are imposed on a person by others; and a positive sense that refers to person's sense of ownership of an action. Sen extends this positive sense of freedom to opportunities by considering the practical possibilities for a person to actually achieve the aspirations of which she has ownership. As explained by Robeyns:

> Capabilities are a person's real *freedoms* or *opportunities* to achieve functionings. Thus, while travelling is a functioning, the real opportunity to travel is the corresponding capability. A person who

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[36] Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Belknap Press 2011) appendix B.

[37] Sen, 'Capability and Well-Being' (n 20). Sen, *Inequality Reexamined* (n 18) 58 explains that separate ideas of agency and well-being involve the 'recognition of a significant distinction, not the assertion of any possibility of analyzing one independently of the other'.

[38] Sen, 'Well-being, agency and freedom: the Dewey Lectures 1984' (n 18) 208.

[39] Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) ch 2.

[40] Sudhir Anand, 'The Concern for Equity in Health' in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press 2004) 18.

> does not travel may or may not be free to travel; the notion of capability seeks to capture precisely the fact of whether the person *could* travel *if* she wanted to. The distinction between functionings and capabilities is that between the realized and the effectively possible…[41]

Sen deals with freedom, itself, as follows: he considers that freedom 'involves both the *processes* that allow freedom of actions and decisions, and the actual *opportunities* that people have, given their personal and social circumstances'.[42] Sen's focus is on the opportunity aspect of a person's freedom, which he labels as her capability. He argues that limits on a person's opportunity for the conversion of available means ('primary goods') into valued ends are potential restrictions on freedom:

> [A] denial of opportunities for transaction, through arbitrary controls, can be a source of unfreedom in itself. People are then prevented from doing what can be taken to be—in the absence of compelling reasons to the contrary—something that is within their right to do.[43]

Thus, Sen conceives opportunities as the real possibilities for a person to overcome constraints to the use of primary goods for achieving valued ends; it is such real possibilities that constitute capabilities. Returning to the earlier example (2.3), was it really possible for the single mother to call a babysitter or place her child in a crèche so that she could go to the sports club? If these possibilities did not exist, then Sen would argue that the opportunity aspect of her freedom was curtailed, and she did not have an adequate capability for recreation, irrespective of the fact that membership of the sports club was not denied to her.

In examining people's capabilities, Sen emphasizes attention to the diversity of human agency by distinguishing 'comprehensive outcomes', which take the availability of opportunities in to account, from 'culmination outcomes', which view consequences only.[44] For example, if the single mother did not go to the sports club (the culmination outcome), Sen would highlight the distinction of the situation in which she had no access to childcare and, therefore, had no option to do otherwise than stay at home, from the situation in which it was really possible for her to call a babysitter but she chose to not do so (the comprehensive outcome). Sen explains that the emphasis of the capability

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[41] Ingrid Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (OpenBook Publishers 2017) 39.

[42] Sen, *Development as Freedom* (n 21) 17; Sen, The Idea of Justice (n 23) 228.

[43] Sen, *Development as Freedom* (n 21) 25.

[44] Sen, *The Idea of Justice* (n 23) 228.

approach is on comprehensive outcomes: on what a person is able to do, regardless of whether or not she chooses to do it. Similarly, Nussbaum emphasizes that it is promotion of opportunities, and not achievements, that honours a person's lifestyle choices.[45]

At the same time, Sen does not disregard achievements. His reasoning does not exclude consequentialist considerations, and he accepts that culmination outcomes—the actual accomplishment of objectives—cannot be ignored.[46] Whilst insisting on the primacy of opportunities, he acknowledges that, as members of a society, individuals may have to cede control over certain aspects of their life because 'Many of the freedoms that we exercise in society work through some process other than direct control'.[47] He justifies his concession to the priority of achievements over the freedom to achieve (or not achieve), in some situations, on the basis that individuals' preferences can be made effective in different ways: either through direct control, where a person brings about the chosen result through her own actions; or indirect power, that is, via the help of others.[48] Accordingly, in certain contexts, the achievement of an end—the actual take-up of an opportunity—might take priority over the availability of this opportunity; for example, making it mandatory for everyone to wear seatbelts, rather than simply providing seatbelts in all cars as an opportunity for road-safety.

Thus, Sen distinguishes between 'well-being freedom' (for example, the opportunity to wear a seatbelt to achieve safety) and 'well-being achievement' (the actual attainment of the safety that is afforded by a seatbelt); and he points out the distinction between well-being freedom and 'agency freedom' (the opportunity to not wear a seatbelt in order to achieve, say, comfort), as well as that between well-being achievement and 'agency achievement' (actually not wearing the seatbelt). Sen explains that the obligation on society to provide a person with the capability for any enterprise has to be considered from the perspectives of each of these four dimensions: well-being freedom, well-being achievement, agency freedom and agency achievement. In deciding the person's capability, these dimensions require to be selected, quantified and aggregated in the context of the enterprise at hand.[49] These dimensions may

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[45] Nussbaum (n 36) 25.

[46] Sen, *The Idea of Justice* (n 23) 228.

[47] Ibid 302. This point is discussed also in Sen, 'Capability and Well-Being' (n 20) 35; Sen, *Inequality Reexamined* (n 18) ch 4.

[48] Sen, *The Idea of Justice* (n 23) 302. Sen, *Inequality Reexamined* (n 18) ch 4 discusses that loss of control over certain types of decisions is inevitable in complex societies and is not an infringement of freedom.

[49] Sen, 'Capability and Well-Being' (n 20). See also Robeyns, 'The Capability Approach: A Theoretical Survey' (n 2) 102.

overlap and the boundaries may be blurred, such that the four dimensions collapse into fewer. For instance, in case of the capability to achieve medical treatment that I will propose later, the critical dimensions reduce to well-being achievement and agency freedom. I will discuss later that Sen insists that judgments about selecting and ranking the dimensions of a person's capability should be made by public reason.

2.3.3 Deciding Capabilities

As discussed earlier, Sen conceived of capabilities as replacements for Rawlsian primary social goods in the assessment of social justice.[50] But, unlike Rawls, Sen does not set out principles for the fair distribution of capabilities amongst all members of society.[51] Rather, his attention is directed to the capabilities that should be made available to individuals, and not to the distribution of a fixed set of goods amongst all members of society. As explained by Nussbaum, 'Capabilities belong first and foremost to individual persons, and only derivatively to groups. The approach espouses a principle of *each person as an end.*'[52] In justifying his approach, Sen discusses that Rawls's quest was for principles of perfect justice and institutions that could deliver such principles (Sen calls this quest as 'transcendental institutionalism', which he traces to the social contract theory that grounds Rawls's work); in contrast, Sen describes his own project as 'realization-focussed comparison' (which he grounds in the social choice theory) that seeks social justice through the reduction of existing inequalities in the capabilities of individuals in society.[53]

A feature of the pragmatism in Sen's project is that the capability approach 'is *not* a fully specified theory that gives us complete answers to all our normative questions.'[54] In other words, the capability approach does not amount to a theory of justice that seeks to provide solutions for all problems; rather, it is a 'partial' theory that gives an account of some aspects of justice, but it does not

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[50] Sen, *The Idea of Justice* (n 23) 66 states that the move from primary goods to capabilities was not a 'foundational departure from Rawls's own programme, but mainly an adjustment of the strategy of practical reason'.

[51] Ibid 299 explains that the contest between primary goods and capabilities is limited to assessment of overall advantages of individuals, and it does not extend to the distribution of these advantages. Ibid 232 discusses that the capabilities approach points to an informational focus in judging and comparing overall individual advantages; it does not, unlike Rawls, propose any specific formula about how that information may be used.

[52] Nussbaum (n 36) 35. Author's emphases.

[53] Sen, *The Idea of Justice* (n 23) 5. Ibid 295 does not argue for equality of capabilities amongst all persons; to the contrary, Sen explicitly rejects any such claim.

[54] Robeyns, 'The Capability Approach: A Theoretical Survey' (n 2) 63.

enlighten on what justice requires in other areas.[55] In the capability approach, the focus is on opportunities for individuals. A complete theory of justice, on the other hand, would include distributive considerations, such as the fair division of a limited resource amongst many persons. The capability approach's drawbacks, and criticisms that are levelled against it, stem from its partial and underspecified character.[56]

To better appreciate the underspecified nature of the capability approach as a theory of justice, it is helpful to return to Sen's idea of freedom that I discussed in the previous section. Sen sets out two aspects of freedom: process and opportunity. He uses the 'capability' label for the opportunity aspect of freedom. Yet, complete attention to freedom would extend to the process aspect; as such, the capability approach does not cover freedom entirely.[57] Sen concedes this limitation of the capability approach:

> While the idea of capability has considerable merit in the assessment of the opportunity aspect of freedom, it cannot possibly deal adequately with the process aspect of freedom, since capabilities are characteristics of individual advantages, and they fall short of telling us enough about the fairness or equity of the processes involved, or about the freedom of citizens to invoke and utilise procedures that are equitable.[58]

The process aspect of freedom concerns what Robeyns terms as 'capability inputs': the means that the capabilities approach seeks to convert into valued ends. Her conception of these inputs is close to Rawls's list of 'primary goods':

> For some of these capabilities, the main input will be financial resources and economic production, but for others it can also be political practices and institutions, such as the effective guaranteeing and protection of freedom of thought, political participation, social

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[55] Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (n 41) 24.

[56] Des Gasper, 'Is Sen's Capability Approach an Adequate Basis for Considering Human Development?' (2002) 14 Review of Political Economy 435; Thomas W Pogge, 'Can the Capability Approach Be Justified?' (2002) 30 Philosophical Topics 167.

[57] Gasper, 'What is the Capability Approach? Its Core, Rationale, Partners and Dangers' (n 25) 339 points out that Sen occasionally switches to 'freedom language' but then reverts to 'capability language'.

[58] Amartya Sen, 'Human Rights and Capabilities' (2005) 6 Journal of Human Development 151, 155.

> and cultural practices, social structures, social institutions, public goods, social norms, traditions and habits.[59]

The capabilities approach does not deal directly with the identification of these inputs; its remit is restricted to the opportunities to use these inputs to achieve valued goals. Consequently, in order to deal with freedom in its entirety, the capabilities approach has to engage with other theories or 'elements of ultimate value, such as procedural fairness' for the identification of the capability inputs.[60] Accordingly, an important part of the task in applying the capabilities approach to a project could be the identification of these other elements that define the process aspect of freedom. In the example that I used earlier, the right to recreation and associated provision of sports club-membership are the capability inputs. The capability approach would not deal directly with the assessment of whether membership of a sports club was an appropriate means to satisfy this right; other theories would have to be engaged in this regard. The capability approach would admit these additional theories; but would itself focus on individuals' opportunities to use the use the sports club for the recreational ends that they had reason to value.

On the other hand, decisions about the opportunity aspect of freedom, that is, an individual's capability for any pursuit, require value judgments about functionings that are worthy of social protection and promotion. Sen asserts that 'There is no escape from the problem of evaluation in selecting a class of functionings in the description and appraisal of capabilities'.[61] He conceives of an 'evaluative space', or range, of functionings and associated capabilities that are judged to merit advancement in social enterprises.[62] Not dissimilarly, Nussbaum explains that:

> Any use of the idea of capabilities for the purposes of normative law and public policy must ultimately take a stand on substance, saying that some capabilities are important and others are less important, some good, and some (even) bad.[63]

It is such value judgments that go to the core of the capability approach. These value judgments pertain to the weighing and balancing of the various dimensions of a person's capability that I discussed earlier and conceptualizing corresponding opportunities. For instance, in deciding people's capability to

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[59] Robeyns, 'The Capability Approach: A Theoretical Survey' (n 2) 96.

[60] Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (n 41) 53.

[61] Sen, 'Capability and Well-Being' (n 24) 32.

[62] Sen, *Inequality Reexamined* (n 18) 21; Sen, 'Capability and Well-Being' (n 24) 36.

[63] Nussbaum (n 36) 28.

duel for recreation, value judgments would have to be exercised in balancing their well-being achievement versus their agency freedom, and in deciding how duelling should be promoted in sports clubs.

I have discussed previously that Robeyns has described the capability approach as a normative framework: an analytical scheme 'that tells us what we *ought* to do'.[64] She explains that normative analyses are closely linked to evaluative analyses that entail judgments on values in terms of good or bad, better or worse, desirable or undesirable, and so on. A particular strength, and appeal, of the capability approach is that it enables a way of thought for making appropriate value judgments. But, as discussed earlier, Sen does not set out any principles for making these value judgments. The question, then, is about how these judgments should be made in a fair or equitable manner.

2.3.4 Social Justice and Public Reason

Sen and Nussbaum deal differently with the evaluative conundrum; that is, how should value judgments be made fairly? Nussbaum's approach is grounded in human dignity, which she traces to ancient Greece, particularly to the Stoics and to Cicero.[65] She explains that:

> [T]he basic idea is that some living conditions deliver to people a life that is worthy of the human dignity that they possess, and others do not. In the latter circumstances, they retain dignity, but it is like a promissory note whose claims have not been met.[66]

She proposes that a minimum, or threshold, level of a list of ten capabilities, which she terms the 'Central Human Capabilities', is essential for a life that is worthy of human dignity.[67] Nussbaum acknowledges that a society may not have the resources to provide the threshold amount of the ten Central Capabilities to everyone. In such a situation, Nussbaum rejects a distributive strategy that involves trade-offs. Instead, she views that 'when capabilities have intrinsic value and importance (as do the ten in my list), the situation produced when two of them collide is tragic; any course we select involves doing wrong to

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[64] Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (n 41) 28.

[65] Nussbaum (n 36) 130.

[66] Ibid 30.

[67] Martha Nussbaum, 'Capabilities as Fundamental Entitlements: Sen and Social Justice' (2003) 9 Feminist Economics 33; Nussbaum, *Creating Capabilities: The Human Development Approach* (n 36) 33. Although, ibid 42 admits that capabilities in her list are abstract and that the ordinary political processes of a well-functioning democracy play an inalienable role for setting thresholds for the ten Central Capabilities.

someone'.[68] She advocates a response of working towards a resolution of the tragic situation by modifying social processes, but she does not provide a solution to the immediate allocative problem.

In setting out a list of central capabilities, Nussbaum diverges from Sen, who has repeatedly and firmly rejected fixed and universal lists of capabilities. Sen argues that universal lists are incompatible with the plurality of social evaluations:

> The search for given, pre-determined weights is not only conceptually unfounded, but it also overlooks the fact that valuations and weights to be used may reasonably be influenced by our own continued scrutiny and by the reach of public discussion. It would be hard to accommodate this understanding with inflexible use of some pre-determined weights in a non-contingent form.[69]

Notably, Sen does not reject capability lists for purposes of practical applications of the capability approach. To the contrary, he argues that it is essential to select and list capabilities that can, then, be the target of social arrangements. But, 'a list of capabilities must be context dependent, where the context is both the geographical area to which it applied, and the sort of evaluation that is to be done'.[70] In other words, each application of the capability approach will require its own list. Thus, Sen's objection is to a universal list, such as Nussbaum's, that is applicable to all contexts. He explains that:

> The problem is not with listing important capabilities, but with insisting on one pre-determined canonical list of capabilities, chosen by theorists without any general social discussion or public reasoning. To have such a fixed list, emanating entirely from pure theory, is to deny the possibility of fruitful public participation on what should be included and why.[71]

Furthermore, unlike Nussbaum, Sen accepts that trade-offs have to be made in advancing peoples' capabilities, because it is inescapable that social resources will be finite and not unlimited.[72] Decisions about social support should also recognise the inescapable plurality of valuable goals and competing choices,

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[68] Nussbaum, *Creating Capabilities: The Human Development Approach* (n 36) 37.

[69] Sen, *The Idea of Justice* (n 23) 242.

[70] Robeyns, 'Sen's Capability Approach and Gender Inequality: Selecting Relevant Capabilities' (n 28) 68.

[71] Sen, 'Human Rights and Capabilities' (n 58) 158.

[72] Sen, *The Idea of Justice* (n 23) 295.

moral heterogeneity and non-commensurability.[73] Moreover, as discussed earlier, resolutions of conflicts between a person's agency and her well-being might be only partial and not complete, and involve rankings rather than absolute priorities.[74] Sen proposes that the evaluative assessments, which are essential for dealing with these various problems and are fundamental to decision-making, should be conducted by public reason.

Sen argues that only public reason can supply justification for conceptualizing capabilities fairly.[75] In his view, public reason is essential, and irreplaceable, for paying heed to situational particularities, social values, and the unique goals of different exercises. He admits that theoretically-determined lists can be useful to provide general direction and to establish certain baselines; but, public reason is essential for the practical determination of relevant capabilities. Moreover, public reason is an essential component of the social role of citizens in a democracy, and the role-based obligations that are owed to fellow citizens.[76]

In the present thesis, I have adopted Sen's evaluative approach, that is, the use of public reason for making value judgments regarding capabilities. I will deal with public reason in Chapter 5. Here, I will move on to discuss the connection between the capability approach and health, which is central to my project.

2.4 The Capability Approach and Health

2.4.1 The Capability to be Healthy

I have highlighted earlier that Sen, unlike Rawls, asserts that health is central to social justice.[77] There are two justifications—instrumental and intrinsic—for including health within the remit of social justice. Sridhar Venkatapuram discusses both justifications in detail.[78] Essentially, the instrumental justification is that health is a matter for justice because it is foundational to the range of

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[73] Ibid 240. Non-commensurability refers to competing choices that are measured in different units—for example, apples and oranges—that cannot be compared directly.

[74] Ibid 107, 243.

[75] Amartya Sen, 'Capabilities, Lists, and Public Reason: Continuing the Conversation' (2004) 10 Feminist Economics 77; Sen, *The Idea of Justice* (n 23) 242.

[76] See also Charles Larmore, 'The Moral Basis of Political Liberalism' (1999) 96 The Journal of Philosophy 599; James W Boettcher, 'The Moral Status of Public Reason' (2012) 20 Journal of Political Philosophy 156.

[77] Sen, 'Why Health Equity?' (n 17).

[78] Sridhar Venkatapuram, *Health Justice* (Polity 2011). See also Norman Daniels, Bruce Kennedy and Ichiro Kawachi, 'Health and Inequality, or, Why Justice is Good for Our Health' in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics and Equity* (Cambridge University Press 2004); Daniels, *Just Health: Meeting Health Needs Fairly* (n 39) ch 2: What is the Special Moral Importance of Health?; Anand (n 40) 16.

opportunities that is open to people; if a person is not healthy, then several opportunities will not be available to her. As such, if justice requires society to protect and promote opportunity, then justice has to give special importance to health; because health is an essential instrument for a range of other opportunities, such as education and employment, that are indisputable items for social justice. On the other hand, the intrinsic justification holds that health is a matter for social justice because it is essential to liberty; without health, a person cannot be free.

Within the intrinsic justification, Venkatapuram links health to human dignity. He argues that ‘every human being has a moral entitlement to a capability to be healthy, and to a level that is commensurate with equal human dignity in the contemporary world’.[79] In doing so, he asserts ‘a human right to be healthy’ as a matter of social justice.[80] Sen has explained that the capability approach aligns closely with the assertion of human rights;[81] and Venkatapuram foregrounds a right to be healthy in the assessment of justice in social arrangements. Importantly, and in keeping with the central tenets of the capability approach, Venkatapuram does not claim that a right to be healthy translates into a demand for equality in the health of all members of society; rather, his argument is for equity or fairness in the opportunities to be healthy that are available to people. It is then up to individuals whether they choose to accept or reject these opportunities, thus accommodating the plurality and diversity of human agency. As emphasised by Venkatapuram, ‘The moral claim is to the *capability* and not directly to certain “health outcomes” or particular biological and mental functionings’.[82] He concludes that everyone should be provided with a capability to be healthy to ‘a level that is commensurate with equal human dignity in the contemporary world’.[83]

Opportunities for healthcare, and its subset of medical treatment, form an important part of the capability to be healthy.[84] In the next section, I will develop the idea of a capability to achieve medical treatment as an important subset of the capability to be healthy. But, first, it is necessary to clarify the idea of health, because disputes in evaluative judgments about opportunities for medical

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[79] Venkatapuram (n 78) 19.

[80] Ibid 3.

[81] Sen, ‘Human Rights and Capabilities’ (n 58).

[82] Venkatapuram (n 78) 19.

[83] Ibid 19.

[84] Although, it is now well recognised that there are various social determinants of health, for example, nutrition, housing, and environment, over and above healthcare and medical treatment. See Michael Marmot, ‘Social Causes of Inequalities in Health’ in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics and Equity* (Oxford University Press 2004).

treatment may stem from differences in the understanding of the ultimate target or end of the capability, that is, health, itself. As pointed out by Roy Porter:

> What is considered normal health and what constitutes sickness and impairment are negotiable, and the conventions vary from community to community and within sub-divisions of society, dependent upon class, gender and other factors.[85]

I will discuss different understandings of health in the three sub-sections that follow, and then move on to the capability to achieve medical treatment.

2.4.2 'Internal' and 'External' Views of Health

Sen contrasts the 'internal' view of a person's health, as seen by the person herself, with 'external' views that others might take of her health.[86] For example, a person's internal view might be that a body weight of 30 kg is good or 'healthy'; whereas, the external view would be that an adult weighing 30 kg is seriously malnourished. In the capability language, the internal view may be regarded as an expression of the person's agency, whereas the external view considers her well-being. Such differences between agency and well-being may lead to conflicts between the ends or goals of healthcare that are set by the person herself and by healthcare professionals. In the example that I have given above, the person, herself, may consider that she requires nutrition that is sufficient only to maintain her weight at 30 kg; whereas, a doctor might formulate her nutritional requirements in line with a target weight of, say, 50 kg.

Sen acknowledges that a person's internal view can be illuminative of her ideas of advantage and flourishing, but he cautions that it has serious epistemological limitations because of its dependence on contingent social experience. He points out that 'The internal view of the patient is not only *informed* by knowledge to which others do not have access, but it is also *limited* by the social experience of the person interpreting what is happening and why'.[87] He discusses that self-reported health can be very misleading because social conditions, such as poor education, can be associated with misperception of health conditions, which would otherwise be of grave concern, as 'normal'. On

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[85] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (Harper Collins 1997) 37.

[86] Amartya Sen, 'Health Achievement and Equity: External and Internal Perspectives' in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press 2004).

[87] Ibid 266. Author's emphases.

the other hand, external views provide a normative conception of health, as a well-being, that might not have been available to the individual.

Sen advocates that both views—internal and external—should be accommodated in the assessment of a person's health. He insists that 'What has to be avoided above all is the narrowness and limitation of choosing *either* the internal *or* the external perspective on its own, and rejecting the other'.[88] However, if an individual's health is to be conceived as a combination of her internal view and an external view, then two problems arise. One problem is to assign weightage to each view, in case of conflict between internal and external views, in the overall or aggregate conception of the person's health. Another problem is to agree on a normative external view, itself. There is debate on whether health is a 'negative' property, that is, is it defined by the absence of disease or illness; or, is it a 'positive' entity, which requires the presence of something?[89] A conclusion is elusive; for the present, it would seem that both sides of the debate on the external view require to be admitted, and I will briefly discuss each side.

2.4.3 'Negative' Views of Health

'Negative' views hold that health is the absence of disease. The issue, then, is to identify disease. Christopher Boorse's 'biostatistical' theory is the pre-eminent negative account of health.[90] Boorse defines a 'pathological condition' (his term for disease) as 'a state of statistically species-subnormal biological part-function, relative to sex and age'.[91] For example, by Boorse's theory, the diagnosis of obesity in a twenty-six year old Asian woman would be by reference to the statistical distribution of body weight in a reference population of such women; obesity would be diagnosed if this woman's weight was higher than a pre-determined point in the range of body weights in that population. Conversely, health, as the absence of disease, is identified by the statistical normality of biological function.

According to Boorse, the diagnosis of disease is value-neutral: it does not involve judgments about the undesirability, or otherwise, of the pathological

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[88] Ibid 268. Author's emphases.

[89] See Lennart Nordenfelt, 'On the Goals of Medicine, Health Enhancement and Social Welfare' (2001) 9 Health Care Analysis 15; Bengt Brülde, 'The Goals of Medicine. Towards a Unified Theory' (2001) 9 Health Care Analysis 1; Christopher Boorse, 'Goals of Medicine' in Elodie Giroux (ed), *Naturalism in the Philosophy of Health* (Springer 2016).

[90] Christopher Boorse, 'Health as a Theoretical Concept' (1977) 44 Philosophy of Science 542; Christopher Boorse, 'A Second Rebuttal on Health' (2014) 39 Journal of Medicine and Philosophy 683.

[91] Boorse, 'A Second Rebuttal on Health' (n 90) 684.

condition. To exemplify, the biostatistical theory would identify a person as severely obese if her body mass index was more than 40 kg/m^2, but it would not make the evaluative assertion that severe obesity was undesirable. Boorse does not reject the relevance of evaluative considerations or value judgments; he simply holds that the two exercises—the identification of disease and the evaluation of the resultant events and states—are separate matters. Common perceptions of health are largely revisions of Boorse's theory that combine empirical and evaluative considerations.[92]

2.4.4 'Positive' Views of Health

In contrast to Boorse, the World Health Organization (WHO) has set out a 'positive' definition of health: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[93] The WHO's definition of health has attracted criticism for being vague and difficult to operationalize.[94] A more theoretically-appealing positive conception—the holistic theory of health—has been proposed by Lennart Nordenfelt.[95] His ideas are grounded in Aristotelian notions of human welfare, and he views human beings as active creatures living in a network of social relations. He proposes that:

> P is healthy if, and only if P has the ability, given standard circumstances, to realize all his or her vital goals. P is unhealthy (or ill) to some degree, if and only if P, given standard circumstances, cannot realize all his vital goals or can only partly realize them.[96]

In this way, Nordenfelt sets out that certain requirements, or positive elements, namely, 'vital goals' under 'standard circumstances', are necessary for the identification of health. A person would be deemed to be healthy if her vital goals were satisfied in standard circumstances. But, Nordenfelt does not define these vital goals and standard circumstances.

Venkatapuram has proposed the use of Nussbaum's list of the ten Central Capabilities to populate the goals and circumstances that are missing in

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[92] See Thomas Schramme, 'Christopher Boorse and the Philosophy of Medicine' (2014) 39 Journal of Medicine and Philosophy 565.

[93] World Health Organisation, *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946* (Constitution of the World Health Organization, 1948).

[94] See Machteld Huber and others, 'How Should We Define Health?' (2011) 343 The British Medical Journal d4163.

[95] Lennart Nordenfelt, 'Concepts of Health and their Consequences for Health-Care' (1993) 14 Theoretical Medicine 277; Lennart Nordenfelt, 'The Concepts of Health and Illness Revisited' (2007) 10 Medicine, Health Care and Philosophy 5.

[96] Nordenfelt, 'Concepts of Health and their Consequences for Health-Care' (n 95) 279.

Nordenfelt's theory.[97] Venkatapuram argues that Nussbaum's list supplies the minimum requirements because the ten Central Capabilities are, themselves, justified by regard for human dignity. Venkatapuram's proposal is to conceive health as a capability to achieve the ten Central Capabilities, and not as a set of functionings. He employs the somewhat difficult-to-grasp notion of the capability to a capability.[98] Accordingly, he defines health as a meta-capability, or overarching capability, to attain the ten Central Capabilities.[99] In other words, a person has good health if she has the second order capabilities to achieve the set of basic, or first-order, capabilities that are captured in Nussbaum's list.

In conclusion, the notion of health is multi-faceted and mutable: it involves ideas of different functionings and capabilities related to both a person's agency (her 'internal' view of health) and to different concepts of her well-being (the 'external' view). On this backdrop, the capability approach becomes a particularly valuable tool to deal with opportunities to be healthy; because, as explained by Sen:

> [O]ne of the uses of the capability perspective is to bring out the need for transparent valuational scrutiny of individual advantages and adversities, since the different *functionings* have to be assessed and weighed in relation to each other, and the opportunities of having different *combinations* of functionings also have to be evaluated.[100]

2.5 The Capability to Achieve Medical Treatment

I have explained earlier that a capability to achieve medical treatment can be conceived as a subset of a person's capability to be healthy (2.4.1). Practically, this capability to achieve treatment would have to be provided to a patient by her doctor. Health, which is the implicit goal or end of medical treatment, can be conceived variously, in terms of a patient's agency and her well-being (2.4.2). These agency-led and well-being-led health goals can be several, and these might be in harmony or in conflict. In providing a capability to achieve treatment to a patient, the doctor would have to conduct a balancing exercise to select some combination of health goals, and he would then have to conceive the

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[97] Venkatapuram (n 78) 57; Sridhar Venkatapuram, 'Health, Vital Goals, and Central Human Capabilities' (2013) 27 Bioethics 271. For a response, see Lennart Nordenfelt, 'Standard Circumstances and Vital Goals: Comments On Venkatapuram's Critique' (2013) 27 Bioethics 280.

[98] For discussion of the ordering of capabilities in Venkatapuram's theory, see Michael J Selgelid, 'Capabilities and Incapabilities of the Capabilities Approach to Health Justice' (2016) 30 Bioethics 25; Per-Anders Tengland, 'Venkatapuram's Capability Theory of Health: A Critical Discussion' (2016) 30 Bioethics 8.

[99] Venkatapuram, *Health Justice* (n 78).

[100] Sen, 'Human Rights and Capabilities' (n 58) 157.

opportunities for the patient to attain the medical treatment that could supply this combination of health goals. In the capabilities paradigm, the doctor would have to make and apply value judgments for selecting the combination of health goals and for conceiving the corresponding opportunities (2.3.3).

In Chapter 1, I had pointed out that a doctor has to make certain judgments in seeking and obtaining consent for treatment from patients (1.2). I now propose that consent is reconceptualised as a patient's capability to achieve medical treatment. Through this reconceptualization, the doctor's obligation to seek and obtain the patient's consent becomes synonymous with an obligation to supply the patient with a fair capability to achieve treatment. The capabilities paradigm then provides the doctor with a robust normative tool for making the judgments that shape consent. The reconceptualization also provides a critical conceptual clarity, which I will explain below, that is otherwise usually missing from discussions of consent.

Sen insists that the evaluative assessments or value judgments for deciding capabilities should be made by public reason (2.3.4), which I will discuss in Chapter 5. However, the capabilities approach and public reason do not cover the entirety of a patient's *freedom* to achieve treatment. I have explained earlier that freedom has two aspects—process and opportunity—and that the capability approach focuses on the opportunity aspect (2.3.2). The process aspect, on the other hand, is concerned with the 'capability inputs'—the means or basis—for the opportunities to achieve valued goals. For the capability to achieve treatment, the capability inputs would be the range of treatments that is available to the patient; the opportunity aspect would, then, cover the real or effective possibilities for the patient to use these available treatments to achieve her valued health goals. The capabilities framework and public reason apply only to judgments about the opportunity aspect of a patient's freedom to achieve treatment.

In considering the entirety of a person's capability to achieve treatment, the capability inputs cannot be ignored. Attention would have to be given to both the capability-input aspect and the opportunity aspect of a patient's capability to achieve treatment. For ease of discussion, I will henceforth refer to these two aspects as the process aspect (which pertains to capability inputs) and the opportunity aspect of the capability to achieve treatment. The distinctiveness of these two aspects provides a conceptual clarity that is often missing from debates on consent: that consent involves, first, the identification of a fair range of available treatments (process); followed by fair opportunities to achieve these treatments. Thus, the opportunity aspect follows and is contingent on the process aspect; and, critically, the opportunity aspect does not influence the process aspect. The capability approach does not directly deal with judgments about the process aspect; rather, it seeks engagement with other theories, such as procedural justice, in order to identify fair capability inputs (2.3.3). I will discuss the additional theory of justice that can be engaged for the process aspect of the capability to achieve treatment in Chapter 5 (5.6).

2.6 Conclusion

The capability approach enables the articulation of a capability to achieve medical treatment, in the sense of every person’s entitlement to certain opportunities for medical treatment. Correlatively, a doctor is obliged to supply a fair capability to achieve treatment to every patient. In its entirety, this capability has two aspects: a fair range of treatment options that should be made available to the patient (the process aspect); followed by real or effective possibilities for the patient to use one or other of these options as the means towards her valued health goals (the opportunity aspect). I have proposed that consent for treatment is reconceptualised as a patient’s capability to achieve treatment, and that the doctor’s obligation to obtain consent is viewed as the obligation to provide the patient with a fair capability to achieve treatment. The distinctiveness of the two aspects of the capability to achieve treatment now supplies conceptual clarity and theoretical justification for the two stages of consent that I had inferred earlier; and normative framework of the capability approach supplies the tools that the doctor can use to make the judgments that are essential in consent (1.2).

The present proposal that consent practices are now viewed as the vehicle by which the doctor supplies the patient with a fair capability to achieve treatment entails a ‘re’-conceptualization because consent has established and strong bioethical and legal groundings in the principle of respect of autonomy. Yet, these venerable groundings have not overcome the practical problems of consent that I pointed out in Chapter 1 (1.1). Notwithstanding, in proposing the reconceptualization of consent as a capability to achieve treatment, I am not suggesting that the groundings of consent in the principle of respect for autonomy should be abandoned. Respect for autonomy has a powerful and entrenched symbolism in justifying consent. My proposal includes the use of the capability framework to clarify the demands and boundaries of the principle of respect for autonomy as the justification for consent practices. In the next chapter, I will discuss notions of autonomy and the principle of respect for autonomy, and I will place these ideas within the perspectives of the capability approach.

Chapter 3

Respect for Autonomy

3.1 Introduction

The requirement for a doctor to obtain the patient's consent prior to undertaking medical treatment is justified widely on the basis of respect for the autonomy of the patient, where autonomy is commonly understood as a person's fundamental right to make self-regarding decisions.[1] The grounding of consent in respect for the autonomy of the patient is often traced to the ruling of Cardozo J in the USA case of *Schloendorff*: 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body'.[2] In British law, this idea was echoed by Lord Scarman in *Sidaway*: he explained that a patient's 'right of self-determination'—to decide for herself whether or not to accept the doctor's advice—was a basic human right that was protected by common law, and that this right underpinned the requirement for consent.[3]

Notably, neither Cardozo J nor Lord Scarman used the word 'autonomy'. In British law, this term first appears in *Bland* (although, this case did not deal specifically with consent). Here, Hoffmann LJ explained that the law enshrined 'respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination'.[4] Subsequently, in *Chester*, Lord Steyn made explicit the connection between autonomy and consent: he declared that informed consent 'ensures that due respect is given to the autonomy and dignity of each patient'.[5] More recently, in *Montgomery,* Lady Hale JSC has reiterated the patient's 'right

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[1] For example, 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* (US Government Printing Office, 1982) 44 explains that 'Self-determination (sometimes termed "autonomy") is an individual's exercise of the capacity to from, revise, and pursue personal plans for life'.

[2] *Schloendorff v Society of New York Hospital* (1914) 211NY125 Court of Appeals of New York [5].

[3] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL) 882D.

[4] *Airedale NHS Trust v Bland* [1993] AC 789 (CA) 826G.

[5] *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [18]. See also ibid [92] (Lord Walker); ibid [77] (Lord Hope).

to act as a genuinely autonomous human being'[6] in providing consent for medical treatment.

The temporal appearance of 'autonomy' in case law is in keeping generally with the development of emphasis on this notion in bioethical theory. Tom Beauchamp and James Childress discuss that 'since the mid-1970s the primary justification advanced for requirements of informed consent has been to protect autonomous choice'.[7] These authors have set out an influential theory of bioethics, in which respect for autonomy is one of four fundamental principles.[8] They discuss that a critical requirement of informed consent is that the doctor must have respected the autonomy of the patient in obtaining her agreement to implement a treatment-decision.[9] Beauchamp and Childress define that 'An informed consent is an individual's *autonomous authorization* of a medical intervention or of participation in research'.[10]

In proposing respect for autonomy as the justification for consent, Beauchamp and Childress acknowledge the objections of Onora O'Neill.[11] She argues that autonomy, as a right to self-determination, is a nebulous idea because there can be various understandings of this term.[12] Consequently, it is insufficient to ground consent in respect for autonomy until and unless this principle, itself, is

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[6] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [116].

[7] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (7 edn, Oxford University Press 2013) 121 discuss that, from the mid-20th century onwards, several social factors have conglomerated to precipitate the rejection of hegemony and the corresponding elevation of autonomy: civil rights movements, prominent cases of abuses of patients in medical research, widespread suspicion of authority and the search for a replacement for trust. See also Alfred I Tauber, 'Historical and Philosophical Reflections on Patient Autonomy' (2001) 9 Health Care Analysis 299; David J Rothman, 'The Origins and Consequences of Patient Autonomy: A 25-year Retrospective' (2001) 9 Health Care Analysis 255; Alfred I Tauber, 'Sick Autonomy' (2003) 46 Perspectives in Biology and Medicine 484.

[8] Beauchamp and Childress (n 7) 101 justify the four principles, themselves, by reference to the 'common morality'. For a recent challenge to reliance on common morality, see Rosamond Rhodes, 'Why Not Common Morality?' (2019) 45 Journal of Medical Ethics 770. For a rebuttal, see Tom Beauchamp, 'On Rhodes's Failure to Appreciate the Connections Between Common Morality Theory and Professional Biomedical Ethics' (2019) 45 Journal of Medical Ethics 790.

[9] Beauchamp and Childress (n 7) 122. This argument first appeared in Ruth R Faden and Tom L Beauchamp, *A History and Theory of Informed Consent* (Oxford University Press 1986) 278. Rebecca Kukla, 'Conscientious Autonomy: Displacing Decisions in Health Care' (2005) 35 The Hastings Center Report 34 points out that Beauchamp has admitted that the connection between autonomy and consent is un-theorized and was simply taken as 'self-evident'.

[10] Beauchamp and Childress (n 7) 122. Authors' emphases.

[11] Ibid (n 7) 121.

[12] Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002) 47; Onora O'Neill, 'Some limits of informed consent' (2003) 29 Journal of Medical Ethics 4.

clarified. What, exactly, is it that patients are entitled to self-determine, and in what contexts, as correlative to respect for their autonomy? Neil Manson and O'Neill point out that relying on consent for securing some minimal conception of autonomy, as 'mere choice', can be 'a shaky and questionable justification for invasive treatment'.[13] Not dissimilarly, John Coggon has highlighted that judicial interpretations of patients' autonomy have been varied and inconsistent.[14] As such, it is of limited meaning to ground consent in respect for autonomy unless there is agreement on the understanding of autonomy itself, and on the corresponding requirements of respect for autonomy.

In order to address the problems of consent that arise from simply relying on a principle of respect of autonomy, I have proposed in Chapter 2 that a doctor's obligation to obtain the patient's consent for medical treatment should be reconceptualised as an obligation to provide the patient with a fair capability to achieve treatment. This reconceptualization of consent does not entail abandoning the traditional grounding of consent in the principle of respect for autonomy; rather, it seeks to understand this principle from the perspective of a theory of justice. In the present chapter, I will explore theories of autonomy as self-determination, and then expose the difficulties that arise when this 'self' is considered within the contingencies of her social milieu. In this way, I will present a nuanced understanding of respect for autonomy that aligns with and enriches the conceptualization of consent as a capability to achieve treatment.

This chapter is organised in the following sections. In section 2, I deal with autonomy as an 'ideal desire',[15] which draws upon Immanuel Kant's conception of autonomy as a form of morality. In section 3, I discuss the distinction of a person's 'current desire' from her 'best desire',[16] which is qualified by authenticity and independence. I will point out how Sen's conceptions of agency and well-being in the capability approach draw upon notions of both 'best desire' and 'ideal desire' without entirely adopting either idea. In section 4, I explain the overlap between autonomy and human dignity, which features importantly in the capability approach and has been also relied upon to justify consent. In section 5, I review liberty, which is integral to the notions of a capability and of autonomy. In section 6, I discuss the objections of feminist scholars to the traditional focus of autonomy theorists on a person as an

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[13] Neil C Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press 2008) 70.

[14] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235.

[15] Ibid 240.

[16] Ibid 240.

individual, in isolation from her relations and social influences. I will point out the similarities between feminist arguments and the capability approach. In section 7, I use feminist critiques, particularly the ethic of care, to construct a model of respect for autonomy that lends structure to the capability to achieve treatment. Section 8 is the conclusion to this chapter.

3.2 Autonomy as Morality

3.2.1 Immanuel Kant

Jerome Schneewind explains that an important notion of autonomy is morality, that is, a claim that an autonomous action is a morally correct action. He traces the origin of the concept of personal autonomy—autonomy as a property of individual persons—as morality to classical Greece.[17] Here, morality was conceived as obedience to the codes—the distinctions between right and wrong—of a community: an autonomous person was one who followed the codes, or social rules, of his community. Later, with the arrival of Christianity, the view of morality shifted to obedience to the will of God or divine authority; and emphasis on personal autonomy diminished. Later still, during the European Enlightenment, Kant made the radical move of rejecting the idea of morality as compliance with divine fiat. Instead, he proposed the conception of morality as a person’s obligations to herself, and to others, according to reasons that she had legislated for herself. In this way, Kant’s account of morality is one of self-legislation or self-governance, and Kant equated such self-legislation with autonomy.

Kant’s idea of autonomy is grounded in practical reason. He proposes that, in order to be autonomous, a person has to ask herself the following question: what should I do? Or, how ought I to conduct my life, or myself, in any and all situations? In order to supply the answers to herself, the person has to reason according to certain rules, which Kant calls maxims. The maxim that governs a person’s action, in any given situation, should follow a central principle called the Categorical Imperative.[18] There are different formulations of the Categorical

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[17] Jerome B Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge University Press 1998).

[18] Ibid. These maxims have to be decided *a priori*, that is, by theoretically-derived principles and not by reference to experience or to observations of human behaviour. Kant argued that *a posteriori* methods are inadequate because these would inform what people actually do rather than what they ought to do. *A posteriori* considerations would render obligations prima facie, that is, contingent on circumstances, and not absolute. Since Kant insists on the absolute necessity of obligations (‘perfect’ obligations), his formulations can be satisfied only by *a*

Imperative in Kant’s philosophy. One important formulation that is especially relevant to Kant’s conception of autonomy is the Universal Law: ‘Act only according to the maxim by which you can at the same time will that it should become a universal law’.[19]

O’Neill explains that the Universal Law places two requirements: first, any maxim has to be impartial, that is, it can be applied equally to everyone; and secondly, the maxim can be made applicable logically to a plurality of individuals.[20] Hence, the Universal Law is not simply a re-statement of the venerable Biblical injunction to ‘do unto others as you would have them do unto you’.[21] The Universal Law does partly entail this injunction, that is, the person should be able to accept that the maxim by which she behaves towards others is then the maxim by which others will behave towards her; but, there is more. O’Neill uses the example of a person who contemplates whether, or not, she should make a false promise. By the Universal Law, she would have to consider whether she could accept that others would, in return, make false promises to her. But, even if she did accept the return of false promises, she would, in addition, have to justify plurality, that is, everyone should make false promises to each other.[22] To exemplify in the health care context, if a patient desires to ‘jump the queue’ in a waiting list for an operation, she would have to not only accept that other patients, too, may jump the queue but also be able to justify that the National Health Service (NHS) could function without waiting lists.

3.2.2 Rationality

Kant’s conception of autonomy as practical reasoning involves rationality: the identification by a person of her own ends or goals; and, then, the selection of means towards the attainment of those ends.[23] In the preceding example, the patient has identified that her end is to obtain treatment swiftly, and that the corresponding means is to jump the queue. As explained above, this patient

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priori methods. Accordingly, autonomy, as a perfect obligation, is determined by rules that are unconditional and hold true in all circumstances.

[19] Barbara Secker, ‘The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics’ (1999) 24 Journal of Medicine and Philosophy 43, 45.

[20] Onora O'Neill, ‘Kantian Ethics’ in Peter Singer (ed), *A Companion to Ethics* (Blackwell Reference 1991).

[21] The Golden Rule of Leviticus, quoted by Jesus of Nazareth. Matthew 7:12.

[22] O’Neill emphasizes that the unpleasant effects of false promises—the consequences—cannot be the reason for rejection because Kant’s vision of morality is non-consequentialist.

[23] Rebecca L Walker, ‘Respect for Rational Autonomy’ (2009) 19 Kennedy Institute of Ethics Journal 339.

would be regarded as autonomous (her desire would be ‘ideal’) if she accepts, or rejects, her ends and means by self-application of the Universal Law.

Kant’s philosophy involves a conviction that all persons are equally competent rational agents: each individual has the innate ability to identify her own ends and to select corresponding means.[24] In this paradigm, dilemmas arise if different persons, when presented with the same circumstances, select and self-justify different means towards the same end; or, different ends in themselves. For instance, one patient may reject queue-jumping because she could not justify a waiting list-free NHS to herself, on the basis that resource for healthcare was inescapably limited; whereas another patient might endorse it by arguing that there would be no waiting lists if action had been taken to eliminate all wastage from the NHS. The problem is, then: who is to decide what counts as rational? Stated differently, who has to be satisfied by a person’s justifications in order for the person to be regarded as autonomous?

Joseph Raz resolves the dilemma by proposing that ‘we are ourselves and lead our own life so long as we see ourselves as rational agents, so long as we conduct our life under semblance of rationality’.[25] Raz’s emphasis is on the ‘self’: does the person see herself as rational? Whether or not others view her as being rational is not, on this understanding, the basis of Kantian autonomy. By Raz’s account, one has to provide moral justification to oneself only. Through this approach, the patient who endorses queue-jumping would have to be able to provide justification to herself only that, say, all wastage can be eliminated from the NHS and that this elimination would release sufficient resource to avoid waiting lists. If she could convince herself of these justifications, then her action to jump the queue would be autonomous according to Raz.

3.2.3 Principled Autonomy

In contrast to Raz, O’Neill insists that Kantian autonomy requires the person to supply justifications to others, and not simply to herself. O’Neill has formulated an influential version of Kant’s autonomy, called ‘Principled Autonomy’, which sets out the requirement for an autonomous person to act on principles, and reasons, that others can follow.[26] According to O’Neill, ‘we do not offer reasons if we offer something that we think cannot be followed by its intended

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[24] I will discuss later that this paradigm of rationality underpins informed decision-making (4.3.2) and John Rawls’s conception of a reasonable person (5.3.1.1).

[25] Joseph Raz, *Engaging Reason: On the Theory of Value and Action* (Oxford University Press 1999) 19.

[26] O'Neill, *Autonomy and Trust in Bioethics* (n 12) ch 4. See also G M Stirrat and R Gill, ‘Autonomy in Medical Ethics after O'Neill’ (2005) 31 Journal of Medical Ethics 127.

audiences'.[27] For O'Neill, the intended audience of a person's practical reasoning is not only herself but also others.

O'Neill's expansive audience is grounded in her view that 'Kantian autonomy is manifested in a life in which duties are met, in which there is a respect for others and their rights, rather than in a life that is liberated from all bonds'.[28] Accordingly, the requirements of practical reasoning can be satisfied only when people discipline their thoughts and actions in ways that others can follow. For instance, the patient who justifies queue jumping on the basis that waiting lists were the result of wasteful practices in the NHS would have to vindicate her action to her fellow citizens. Unless she was able to reason, to the satisfaction of her compatriots, that queue-jumping was legitimate, her actions would not be autonomous. Thus, O'Neill views an autonomous person as one who is governed, or legislated, by principles that could be law for all persons.

In discussing the meaning of autonomy as self-legislation, O'Neill highlights the emphases on both self and legislation. She explains that 'Self-legislation means not *legislation by a self,* but (as Kant often puts it) *legislation that is for itself,* that is a possible "law for itself" that combines lawlike form and universal scope'.[29] In other words, 'self-legislation' does not simply mean that a person makes rules that, then, become laws for herself; rather, it means that the persons makes rules that supply their own—'self'—justification. She then argues that self-legislation is a product of public reason, which she explains as reasoning that is designed to reach the 'world at large'.[30] For O'Neill, it is only the outcome of public reason that is truly autonomous and can, then, be legislated universally to an unrestricted plurality of persons. She sees adherence to obligations that are formulated by public reason as the fundamental tenet of Kant's autonomy.[31]

In conclusion, both Raz and O'Neill rely on practical reasoning as characteristic of personal autonomy, but the audience of the reasoning is different: for Raz, it

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[27] Onora O'Neill, 'Autonomy and Public Reason in Kant' in Mark Timmons and Robert N Johnson (eds), *Reason, Value, and Respect: Kantian Themes from the Philosophy of Thomas E Hill, Jr* (Oxford University Press 2015) 27.

[28] O'Neill, *Autonomy and Trust in Bioethics* (n 12) 83.

[29] Onora O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (Cambridge University Press 2015) 149. Author's emphases.

[30] Ibid 148.

[31] Jurgen Habermas, 'Reconciliation Through the Public Use of Reason: Remarks on John Rawls's Political Liberalism' (1995) 92 Journal of Philosophy 109, 109 interprets Kant's autonomy, as reflected in the works of John Rawls, similarly: 'we act autonomously when we obey those laws which could be accepted by all concerned on the basis of a public use of their reason'.

is the person herself; for O’Neill, it is the ‘public’.[32] Notwithstanding, in both cases, the reliance on practical reason for autonomy resonates with Sen’s insistence for the inclusion of only those functionings that a person ‘has reason to value’, and not simply any functionings that she may assert to be valuable, in the person’s agency (2.3.1). Sen then seems to separate Raz’s and O’Neill’s interpretations of autonomy, by predicating agency on reasons that withstand self-scrutiny, and well-being on public reason, respectively; yet maintaining that these two aspects are inter-dependent and not necessarily distinct. Furthermore, Sen introduces relational considerations, which I will discuss later (3.6.1), into his idea of agency.

3.3 Autonomy as Authenticity and Freedom

O’Neill acknowledges that Kantian autonomy is onerous. Alternatively, autonomy could be conceived simply as a person’s ‘current desire’, that is, ‘immediate inclinations, i.e. what he thinks he wants in a given moment without further reflection’.[33] O’Neill despairs of such a version of autonomy, which she sees as ‘mere, sheer choice’, because it can reflect selfishness, self-indulgence or self-centredness.[34] Not dissimilarly, Sen clarifies that he ‘does not imply that the person’s view of agency has no need for discipline’, and he emphasizes that agency is underpinned by critical self-scrutiny of desires.[35] In this way, Sen’s notion of agency (2.3.1) harmonizes with Harry Frankfurt view that impulsive or spontaneous wishes are merely desires of the ‘first order’, that is, ‘simply desires to do or not to do one thing or another’.[36] Frankfurt argues that the expression of such a first-order desire, in and of itself, does not reflect autonomy; for this desire to be autonomous it must satisfy the demands of authenticity and freedom (and it is this latter conception of autonomy that Coggon has labelled as ‘best desire’[37]). Authenticity and freedom implicitly target ideas of rational choice, albeit by a route that is different to Kantian philosophers. I will discuss authenticity and freedom separately, in the sub-sections that follow.

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[32] I will discuss O’Neill’s ideas of public reason, and her distinction between public reason and private reason (which comes close to Raz’s argument) in Chapter 5. Through the reliance on public reason, O’Neill’s idea of an autonomous person aligns with Rawls’s conception of a reasonable person.

[33] Coggon (n 14) 240.

[34] O'Neill, ‘Autonomy and Public Reason in Kant’ (n 27) 28. See also H Tristram Engelhardt Jr, ‘The Many Faces of Autonomy’ (2001) 9 Health Care Analysis 283.

[35] Amartya Sen, ‘Well-being, agency and freedom: the Dewey Lectures 1984’ (1985) 82 The Journal of Philosophy 169, 204.

[36] Harry G Frankfurt, ‘Freedom of the Will and the Concept of a Person’ (1971) 68 The Journal of Philosophy 5, 7.

[37] Coggon (n 14) 240.

3.3.1 Authenticity

Authenticity pertains to the structure of desires. Frankfurt explains that:

> [B]esides wanting and choosing and being moved to do this or that, men may also want to have (or not to have) certain desires and motives. They are capable of wanting to be different, in their preferences and purposes from what they are.[38]

Accordingly, authenticity is not simply to follow one's first order desire, but to critically reflect on the first order desire in order to determine whether, or not, this first order desire is endorsed by a higher, 'second order desire'. Gerald Dworkin clarifies that a second order desire is:

> [T]he attitude a person takes towards the influences motivating him which determines whether or not they are considered to be "his". Does he identify with them, assimilate them to himself, view himself as the kind of person who wishes to be motivated in these particular ways?[39]

Frankfurt discusses that there can be many, conflicting first order and second order desires. Through a process of critical self-reflection and endorsement, a single second-order desire is selected, and this selected desire then moves the person to action. This unique second order desire, which becomes effective*,* is termed the 'second order volition'.[40] According to Frankfurt, an individual's second order volition is her will. Authenticity prevails when a person acts in accordance with her will.

Frankfurt and Dworkin's conception of authenticity aligns closely with Sen's idea of agency (2.3.1): desires that are underpinned by critical self-scrutiny. For example, the instinctive reaction—the first order desire—of a patient to jump the queue in the NHS waiting list may, or may not, be endorsed by her critical self-reflection about other patients in situations similar to her own. Her impulse to

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[38] Frankfurt (n 36) 7.

[39] Gerald Dworkin, 'Autonomy and Behavior Control' (1976) 6 The Hastings Center Report 23, 25.

[40] Frankfurt (n 36) 16. A difficulty with such modelling of desires, as pointed out by John Christman, 'Constructing the Inner Citadel: Recent Work on the Concept of Autonomy' (1988) 99 Ethics 109, is that the hierarchy of desires can be subject to infinite regress; consequently, at some level, all desires will have no foundation, which Christman calls the 'ab initio' problem. Moreover, the notion that higher order judgments are more authentic than first order desires can be disputed. Beauchamp and Childress (n 7) 103 argue that 'nothing prevents a reflective acceptance, preference, or volition at the second level from being caused by and assured by a strong first-order desire. The individual's second-level acceptance of, or identification with, the first-order desire would then be the causal result of an already formed structure of preferences'.

jump the queue would become her agency—her second order volition or will—only if she reflects critically upon it and continues to hold it after reflection.

3.3.2 Freedom and Independence

In addition to authenticity, a second condition must be satisfied in order for a desire to autonomous: this is articulated by Frankfurt as freedom of the will, and by Dworkin as independence. In this way, Frankfurt and Dworkin combine ideas of agency and freedom in the conception of autonomy. In contrast, in the capabilities approach, Sen combines agency and freedom into the notion of a capability, as an opportunity to achieve agency (balanced with well-being) (2.3.2). Thus, it is Sen's idea of a capability, and not simply agency, that corresponds broadly to autonomy in the theories of Frankfurt and Dworkin.

Frankfurt's idea of freedom of the will parallels Sen's notion of an opportunity as an aspect of freedom (2.3.2). Frankfurt explains that freedom of the will is dependent on whether the second order desire is driven by 'necessitation': is it the only option that is available to the person; or, is it open to alternatives, that is, is more than one course of action really possible? He explains that 'Whatever his will, then, the will of a person whose will is free could have been otherwise; he could have done otherwise than to constitute his will as he did'.[41] Similar to Frankfurt, Dworkin's requirement for independence seeks to ensure that a person's motivational structure is truly her own, but he formulates the requirement differently.[42] Dworkin sets out two categories of independence—procedural and substantive—that I will discuss in the sub-sections that follow.

3.3.2.1 Procedural Independence

Procedural independence has two requirements. First, it demands that a person's identification with her motivation should not have been produced by external, controlling influences, such as manipulation, deception or coercion; because, if so, the identification would not be her own. Dworkin concedes that 'every interference with the voluntary character of an agent's actions does not interfere with her ability to choose her mode of life. In certain cases, limitations on action may, in fact, enhance efforts to define the contours of life'.[43] Nonetheless, the defining characteristic of procedural independence is the

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[41] Frankfurt (n 36) 19. See also Sabine Muller and Henrik Walter, 'Reviewing Autonomy: Implications of the Neurosciences and the Free Will Debate for the Principle of Respect for the Patient's Autonomy' (2010) 19 Cambridge Quarterly of Healthcare Ethics 205.

[42] Dworkin (n 39) 24.

[43] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1988) 15.

absence of constraining external influences, rather than the availability of favourable influences.

Secondly, in addition to the absence of external influences, Dworkin imposes a more demanding, higher, ‘internal’ level to procedural independence: there should not be ‘false consciousness’, whereby a person may fail to identify with her motivational structure because of an inability to be critical.[44] His idea of such an internal level of independence corresponds to Frankfurt’s illustration of the will of a drug addict. Frankfurt discusses that a ‘willing’ drug addict may not have concern for his actions due to either his lack of capacity for reflection or ‘to his mindless indifference to the enterprise of evaluating his own desires and motives’.[45] Although there is no external influence, the ‘willing’ addict’s desire is not internally procedurally-independent; and, therefore, it is not autonomous. A desire may also fail to satisfy internal independence if, despite critical reflection, a person is unable to align her first order desires to those of a higher order. Frankfurt exemplifies this latter situation by an ‘unwilling’ drug addict, who has a single second order desire to abstain from drugs, but is simply unable to follow this second order desire.

3.3.2.2 Substantive Independence

Apart from procedural independence, Dworkin requires that there must be substantive independence: the person should have ownership of the substance, or content, of her decision. Substantive independence is lost if a person relinquishes her independent judgment and abides by another’s desire or command; because, by doing so, she is becoming committed to the will of another. A ‘happy slave’ is the archetypical example of the loss of substantive independence. In healthcare, if a patient relinquishes all decisions about her treatment to, say, a family-member, then her consent to treatment would not be viewed as a substantively-independent action; therefore, by this account, her consent would not be an autonomous action (although, feminist scholars would object to such an argument about autonomy; and I will discuss feminist critiques later; 3.6).

In conclusion, formal theories of autonomy, based on either morality or individuality, have areas of overlap, and distinction, with Sen’s concept of

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[44] Ibid 15. Dworkin acknowledges that second order identifications can fluctuate, or shift, to fit in with the first order desire; a second order identification does not have to be permanent or settled. Change in circumstances, such as illness, can lead to new goals and desires. The process of reconciliation to the realities of life is not incompatible with autonomy. Such changes are legitimate, provided that there is no breach of procedural independence.

[45] Frankfurt (n 36) 13.

agency in the capability approach. Sen’s emphasis is on agency. Yet, he admits a separate, albeit intertwined, notion of well-being (2.3.1) that does not figure explicitly in theories of autonomy; although, it would seem that autonomy theorists implicitly prioritise one or the other idea. In O’Neill’s principled autonomy, the attention appears to be on well-being: functionings that are endorsed by public reason. In contrast, Frankfurt and Dworkin seem to focus on agency in the form of authentic functionings. Moreover, ideas of agency and well-being are combined with those of freedom and opportunity in theories of autonomy, whereas Sen separates out these ideas. In this way, the capability approach provides a structure that is missing in classic theories of autonomy. In addition, the capability approach incorporates feminist critiques of autonomy that I will discuss later (3.6).

3.4 Dignity

I have discussed earlier that consent has been justified widely in common law, including in the judgment of Lady Hale JSC in *Montgomery,* by respect for autonomy. Yet, the decision of the majority in this case, delivered by Lord Kerr and Lord Reed JJSC, does not mention autonomy. Instead, their lordships declare that ‘The more fundamental response to such points (objections to requirements for consent), however, is that respect for the dignity of patients requires no less’.[46] Thus, the majority of the Supreme Court justifies consent by reference to dignity and not to autonomy. The Supreme Court’s reliance on dignity resonates with the centrality of human dignity to a person’s capability to be healthy (2.4.1), and it emphasizes the importance of this notion to the conception of a person’s capability to achieve medical treatment as a cognate of consent.

The concept of human dignity is a seminal idea in post-World War 2 declarations, bills, and treaties that lay a foundation for the culture of human rights.[47] Yet, there is considerable confusion about the meaning of dignity, and its distinction from autonomy.[48] An influential view is that dignity is a distinctive kind of intrinsic and incomparable moral worth of each human being.[49] This view distinguishes firmly between dignity and notions of preference-satisfaction

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[46] *Montgomery UKSC* [93]. Parentheses added. Notably, Lady Hale did not mention dignity, and the Supreme Court’s majority did not refer to autonomy.

[47] See Charles Foster, *Human Dignity in Bioethics and Law* (Hart Publishing 2011) ch 7.

[48] Richard E Ashcroft, ‘Making Sense of Dignity’ (2005) 31 Journal of Medical Ethics 679.

[49] Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Belknap Press 2011) 35.

that relate to autonomy. For instance, in her discussion of the ten Central Human Capabilities, Martha Nussbaum explains that dignity demands that one ‘should not give people an option to be treated with respect and non-humiliation’.[50] Such a distinction between autonomy and dignity is captured by Hoffmann LJ in *Bland*, in drawing attention to:

> [R]espect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person.[51]

Deryck Beyleveld and Roger Brownsword discuss the overlap and the distinction between autonomy and dignity, and they set out two distinct conceptualizations of human dignity: empowerment and constraint.[52] Dignity as empowerment invokes rights to the conditions in which autonomy can be exercised. These rights can then be grounded in either one of two dimensions of empowerment: ‘negative’ rights against unwilled interventions by others; and ‘positive’ rights to secure, from others, the support and assistance that are essential for the appropriate exercise of autonomy.[53] The interpretation of dignity as empowerment can then vary according to the dimension that is given priority. Neomi Rao discusses that the ‘negative’ dimension is pre-eminent in the USA, which follows a classical, liberal understanding of freedom.[54] In contrast, the welfare states in Europe and the UK appear to give preference to the ‘positive’ dimension, with associated emphases on certain, minimum social standards of living.

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[50] Ibid 26.

[51] *Bland* (n 3) 826G.

[52] Deryck Beyleveld and Roger Brownsword, *Human Dignity in Bioethics and Biolaw* (Oxford University Press 2001).

[53] The distinction of these two dimensions of empowerment draws upon Berlin’s two senses of freedom, which I discuss in the next section (3.5).

[54] Neomi Rao, ‘American Dignity and Healthcare Reform’ (2012) 35 Harvard Journal of Law and Public Policy 171. The ‘classical’ American understanding of freedom relies upon John Mill’s philosophy, which I discuss in the next section (3.5).

On the other hand, dignity as constraint implies a capacity for moral restraint, involving a duty to the self and a duty to conform to the norms of society. The constraining aspect of dignity can generate substantial tension with the empowering elements, because the former invokes moral perfectionism (a claim that some activities or values are normatively held to be incompatible with human well-being and flourishing). Beyleveld and Brownsword illustrate the tension vividly through the case of the French Dwarves. When dwarf-throwing, as a bar-room sport, was prohibited, the dwarves protested that the ban violated their right to pursue an occupation of their choice. In dismissing the dwarves' appeal, the French Conseil d'Etat explained that 'if a form of conduct compromises human dignity it simply is not legitimate irrespective of autonomous authorization of the conduct'.[55] As explained by Beyleveld and Brownsword:

> [H]uman dignity represents an "objective value" or good (reaching beyond the individual) such that, if an act violates this value, human dignity is compromised irrespective of whether the party so acting freely agrees to perform the act in question…where human dignity so conceived is at stake, free choice is irrelevant.[56]

In conclusion, dignity encompasses somewhat amorphous yet foundational ideas that, notwithstanding overlap, distinguish it from agency and authenticity and bring it close to the idea of well-being in the capability approach.[57] I will point out later that the concept of dignity as constraint is critical to the principle of respect for autonomy.

3.5 Liberty

Autonomy is aligned closely to political notions of liberty and freedom. This alignment is not surprising, because the roots of autonomy are in political philosophy.[58] In justifying consent, liberty is sometimes relied upon instead of autonomy. For instance, in the case of *S v S,* which is cited approvingly in *Montgomery,*[59] Lord Reid decided that a blood test could not be performed without a person's consent because:

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[55] Quoted in Beyleveld and Brownsword (n 52) 26.

[56] Ibid 34.

[57] I had pointed out earlier (2.3.1) that Nussbaum disagrees with Sen about the distinction between agency and well-being. Instead, Nussbaum conceives a unified idea of well-being that is predicated on dignity.

[58] See Schneewind (n 17).

[59] *Montgomery UKSC* (n 6) [80].

> 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. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions.[60]

An influential view on freedom is that of Isiah Berlin, who famously described two central senses of liberty: negative and positive.[61] Berlin explains that negative liberty 'is the area within which the subject—a person or group of persons—is or should be left to do or be what he is or able to do or be, without inference by other persons'.[62] In other words, negative liberty is the minimum area, or space, of personal freedom that should, on no account, be violated. The critical issue, here, is to identify the restrictions that can be imposed legitimately by others; and the space of negative liberty can then vary according to the theoretical justification, from political philosophy, of these restrictions.[63] For instance, in the celebrated view of John Stuart Mill, we are free to do 'as we like, subject to such consequences as may follow: without impediment from our fellow-creatures, so long as what we do does not harm them, even though they should think our conduct foolish, perverse or wrong'.[64] Thus, Millian liberty holds that restrictive influences or restraints can be justified only by the 'harm' principle; people are free to do whatever they choose, provided that they do not harm others. Other philosophers take different views.[65] In practical terms, the boundaries of a person's negative liberty will be determined by the political institutions of the country in which she is living.

The positive sense of liberty, on the other hand, derives from an intrinsic desire of each human being to be her own master. In explaining positive liberty, Berlin writes that:

> I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibilities for my choices and able to explain them by reference to my own ideas and purposes. I feel free

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[60] *S (An Infant) v S* [1972] AC 24 (HL) 43E.

[61] Isiah Berlin, *Two Concepts of Liberty* (Oxford University Press 1969).

[62] Ibid 2.

[63] John Rawls, *Justice as Fairness. A Restatement* (Erin Kelly ed, Harvard University Press 2001) 21 explains that 'The relevant meaning of free persons is to be drawn from the political culture of such a society and may have little or no connection, for example, with freedom of the will as discussed in the philosophy of the mind'.

[64] John Stuart Mill, *On Liberty and Other Writings* (Stefan Collini ed, first published 1859, Cambridge University Press 1989) 15.

[65] For example, Joel Feinberg, *The Moral Limits of the Criminal Law: Harm to Others*, vol 1 (Oxford University Press 1984) 8.

> to the degree that I believe this to be true, and enslaved to the degree that I am made to realize that it is not.[66]

In other words, positive liberty is a person's freedom to assume ownership of her own actions: to self-determine what she should, or should not, do. Positive liberty, then, is subject only to internal constraints, that is, constraints that are imposed by a person on herself; as opposed to the external constraints that shape negative liberty. I have explained earlier that Sen uses Berlin's positive sense of liberty to conceive capabilities (2.3.2). Through the positive sense of liberty, Berlin has pointed out that a person's freedom might be subject to constraints other than those imposed explicitly by others; Sen has then considered the person's opportunities, in the sense of real or effective possibilities, to overcome these constraints. Thus, a capability can be viewed as an extension of Berlin's positive sense of liberty.

The two senses of liberty clarify the boundaries on autonomy as self-determination. In Berlin's scheme, this self-determination can be exercised only within the sphere of negative liberty. For example, if a Millian view of negative liberty has been adopted by the political institutions of a state, then a person cannot 'self-determine' actions that would harm others. But, if a state has adopted a more restrictive view of negative liberty, then self-determination cannot rely simply on the absence of harm to others. As explained by John Coggon and José Miola, negative liberty marks the outer limits of the space to act autonomously.[67] A person can self-determine her actions only to the extent that is permissible by negative liberty; accordingly, a right to personal autonomy does not allow unlimited self-determination, because liberty is legitimately subject to political restrictions.

3.6 Feminist Critiques of Autonomy

3.6.1 Relational Autonomy

Both conceptions of autonomy that I have discussed earlier—'ideal' desire and 'best' desire—emphasize the individuality, or 'self', of persons. Feminist scholars challenge such focuses on individuality. The essential feminist objection is that people are embedded in society; consequently, their autonomy cannot be abstracted from their social context and relations. Susan Sherwin explains that 'we define ourselves *in* relationship to others and *through* relationships with others', and that our 'values and deliberations are, by

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[66] Berlin (n 61) 8.

[67] John Coggon and José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70 The Cambridge Law Journal 523, 525.

necessity, pursued in a social environment that is always larger than an individual in isolation'.[68] Feminist scholars argue that theories of personal autonomy that consider individuals as atomistic, in isolation from social influences, are incomplete because they fail to recognise the inherently social nature of human beings.[69]

Feminist scholars do not reject the notion of personal autonomy; but, they advocate the reconceptualization of theoretically 'perfect', or ideal, notions of autonomy to incorporate imperfections that reflect existential realities in human lives. Such feminist reconceptualizations are termed as 'relational autonomy', as an 'umbrella term' that encompasses all views of autonomy that share the assumption that people are socially embedded, and that people's identities are formed within the context of social relationships, and shaped by a complex of intersecting social determinants, such as race, class, gender, culture and ethnicity.[70] In dealing with relational autonomy, Barbara Secker quotes the description of 'the self in community': a notion of autonomy that is grounded not in independence or self-sufficiency but in interactions with others.[71] Fundamentally, the feminist position is that a person's autonomy, as self-determination, must be interpreted in the context of her relationships and other social influences.[72]

Feminist arguments align closely with a foundational proposition of the capability approach that people will have diverse viewpoints and abilities, or 'conversion factors', as a consequence of their social arrangements; and, corresponding, people should be treated differently (2.3). As explained by Séverine Deneulin and Allister McGregor:

> Sen's formulation of the CA holds the expansion of individual freedoms as the central objective of societal development, but a social conception of human wellbeing reinforces the view that these are always defined and realized through our relationships to

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[68] Susan Sherwin, 'Relational Autonomy and Global Threats' in Jennifer J Llewellyn and Jocelyn Downie (eds), *Being Relational: Reflections on Relational Theory and Health Law* (UBC Press 2012) 16. Author's emphases.

[69] Catriona Mackenzie and Natalie Stoljar, 'Autonomy Refigured' in Catriona Mackenzie and Natalie Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford University Press 2000).

[70] Ibid.

[71] Secker (n 19) 57.

[72] Jennifer Nedelsky, 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 1 Yale Journal of Law and Feminism 7.

> others…the "freedoms that people have reason to value"—is built from the meanings that we share with others.[73]

In the subsections that follow, I will, first, expand on how a person's social context can influence her autonomy; and, then, I will discuss feminist responses to the associated problems.

3.6.2 Social Influences on Autonomy

A person's social context may shape her autonomy in two different senses, which can be termed as causative and constitutive.[74] In keeping with the roots of the feminist movement, these two senses are drawn by reference to women in disadvantageous positions, but are applicable in a non-gendered way to a variety of situations, including medical encounters.

The causative sense of a person's autonomy refers to social factors that are the source of her values, goals, characteristics and commitments. For example, a woman who is oppressed by her husband may shape her preferences to fit her husband's desires; the oppression is, then, the source—it is causative of—her particular expression of autonomy. Some women in such situations may recognize, and be able to articulate, their own unfortunate plight; here, procedural as well as substantive breaches of independence (as discussed by Dworkin; 3.3.2) may be recognizable. But, other oppressed women may develop 'adaptive preferences': an unconscious process in which a person turns away from a particular preference to another preference, in order to avoid the unpleasant cognitive dissonance that is associated with holding on to the first preference.[75] The identification of distorted autonomy is now problematic because it requires distinguishing the unconscious process of adaptive preference-formation from reflective endorsement of the substance of the actually-held preference and rejection of competing alternatives. It may never be possible to separate such adaptive preferences from truly autonomous preferences.

Apart from being causative of preferences, oppressive influences may lead to characteristics and commitments becoming constitutive of a person's identity, such that this identity then becomes normative.[76] For example, if a woman has been brought up in a social context wherein primacy is given to subservience to

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[73] Séverine Deneulin and J Allister McGregor, 'The Capability Approach and the Politics of a Social Conception of Wellbeing' (2010) 13 European Journal of Social Theory 501, 503. CA, capability approach.

[74] Mackenzie and Stoljar (n 69).

[75] Ibid. See also Deneulin and McGregor (n 73).

[76] Catriona Mackenzie, 'Relational Autonomy, Normative Authority and Perfectionism' (2008) 39 Journal of Social Philosophy 512.

men, then self-abnegation and conformity to her husband's desires may be a part of her innermost nature, which incorporates negative attitudes towards herself, such as lack of self-respect or mistrust of her own judgments. Herein, the woman does not even perceive that she is oppressed (even though she may be deemed as such by others) and cannot conceive an alternative situation. The constitutive sense of social context is related closely to adaptive preferences in the causative sense; yet, there is a fine theoretical distinction. In any case, the identification of both causative and constitutive influences requires reference to some normative paradigm; and it is agreement on this normative paradigm that, then, becomes the contentious issue.

Feminist scholars accept that an individual's social context is not necessarily or exclusively oppressive. To the contrary, in some cases a person's social situation may contingently enhance her autonomy; and her relationships may promote the expression of her individuality.[77] Similarly, the capabilities scholar, Ingrid Robeyns, points out that 'This does not mean that constraints always have to be negative or unjust; on the contrary, some people might find them very enabling and supporting'.[78] For example, in case of providing consent for medical treatment, the involvement of family members might be detrimental to the exercise of autonomy for some patients but empowering for others.[79] Consequently, relational reconceptualization of a person's autonomy requires careful selection of the normative paradigm that is used to distinguish disadvantageous social influences, which breach this paradigm, from those influences that are integral to the paradigm. As acknowledged by Jennifer Nedelsky, the challenge of relational autonomy is to 'develop and sustain the capacity for finding our own law, and the task is to understand what social forms, relationships, and personal practices foster that capacity',[80] in addition to those that impair the capacity. Thus, the selection of a normative paradigm is a central concern for scholars in both feminist and capabilities traditions.

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[77] Marina A L Oshana, 'The Autonomy Bogeyman' (2001) 35 Journal of Value Inquiry 209 explains that feminist literature focuses on disadvantageous social situations because the basic premise is that autonomy accrues only when social conditions surrounding an individual satisfy minimum standards. According to Oshana, the main aim of the feminist movement is to seek such minimum standards of autonomy; enhancement of social conditions, over and above the minimum, is not unimportant, but it is secondary.

[78] Ingrid Robeyns, 'The Capability Approach: A Theoretical Survey' (2005) 6 Journal of Human Development and Capabilities 93, 102.

[79] See Roy Gilbar and José Miola, 'One Size Fits All? On Patient Autonomy, Medical Decision-Making, and the Impact of Culture' (2015) 23 Medical Law Review 375.

[80] Nedelsky (n 72) 10.

3.6.3 Modelling Feminist Challenges to Autonomy

Catriona Mackenzie and Natalie Stojlar display the relational challenges to autonomy by separating ideas of autonomy, and associated feminist objections as well as responses, into models of procedural autonomy and substantive autonomy.[81] Procedural models of autonomy are neutral to content, and provoke debate on whether there are at least some values and preferences that are intrinsic to human life and must be shared by all persons. Procedural models are subdivided into Structural Procedural and Historical Critical Reflection. In contrast, substantive models hold that values and preferences have to be congruent with some normative paradigm, and can become open to charges of moral perfectionism. Substantive models can be sub-categorised into Weakly Substantive and Strongly Substantive. I will now discuss each of these models, in turn.

3.6.3.1 Procedural Models

3.6.3.1.1 Structural Procedural

A structural procedural account of autonomy is exemplified by the theories of Frankfurt and Dworkin (3.3). Here, the requirements of autonomy are satisfied if a certain procedure is followed, irrespective of the content of the desire. For example, if a patient requests a particular treatment, then her request is autonomous provided that it is authentic and independent; the nature of the treatment, itself, is immaterial. At an extreme, a request for the amputation of a normal limb would be regarded as autonomous if it satisfied the conditions of authenticity and procedural as well as substantive independence.

The feminist criticism of the example that is used above would be that the procedural requirements do not inquire whether the person’s treatment-request—her desire for amputation of her normal limb—might arise from her social circumstances. If the person is oppressed, uneducated, or otherwise disadvantaged, her desire may reflect resignation or ignorance, rather than her true and settled character. The problem, then, is to distinguish whether the person has been rendered non-autonomous by her social context, in which case her treatment-request is not truly an expression of her autonomy; or whether she has authentically and independently embraced what might be normatively judged as a poor or wrong desire.

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[81] Mackenzie and Stoljar (n 69).

3.6.3.1.2 Historical Critical Reflection

Historical Critical Reflection grapples with the problem of distinguishing a person who has chosen truly to relinquish normative or mainstream desires from one who asserts a certain desire but has not authentically and independently acquired that desire. As a solution, John Christman proposes attention to the historical basis of preference-formation: inquiry into the history, or process, of the formation of that preference or desire.[82] He argues that it is the process through which a person forms a preference and makes a choice that determines whether, or not, this choice is autonomous. For Christman, the test of whether, or not, a person's decision is autonomous is 'if she is able to realistically imagine choosing otherwise were she in a position to value sincerely that alternative position'.[83] In other words, the autonomy-defining question is whether the person could realistically envision choosing, or doing, otherwise than she chooses or does actually.

According to Christman, the requirements of autonomy are satisfied only if the person is able to reflect on the historical basis of formation of her desire and identify with it; or, at least, not repudiate and feel alienated from it. Christman explains that his test differs from that for authenticity (3.3.1), because it accepts that there may be certain facets of her personality that a person does not wholeheartedly approve; yet, at the same time, she continues to accept and does not entirely reject these facets. In addition, Christman's test examines whether the person has the option to review and revise beliefs, values or commitments from which she feels alienated.

3.6.3.2 Substantive Models

The problem that persists, despite Christman's proposal, is that a person may never be able to repudiate her social context entirely: certain values and preferences, however repugnant to others, may be so ingrained and embedded in a person's character that she may never be able to imagine choosing contrarily. In response to this problem, substantive accounts attempt to set out some normative requirements for the content of autonomous desires. As mentioned earlier, Mackenzie and Stojlar divide substantive theories into Weakly Substantive and Strongly Substantive.

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[82] John Christman, 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves' (2004) 117 Philosophical Studies 143, 154.

[83] Ibid 154.

3.6.3.2.1 Weakly Substantive

Mackenzie proposes that normative authority should be based on a person's attitudes towards herself.[84] The person must regard herself as competent or worthy to act: she should see herself as a legitimate source of authority, and it is this self-conception of legitimacy that confers normativity. Such self-conception of legitimacy requires that the person should have certain competencies. Mackenzie sets out these competencies as three attitudes that the person should have towards herself: self-respect, self-trust and self-esteem.[85] This formulation overcomes causative and constitutive influences (3.6.2) on autonomy because it stipulates that an agent can claim normative authority only if she has an appropriate conception of herself. Such an account is compatible with value pluralism because it does not specify the content of an autonomous action or decision; at the same time, it does not support ways of life that unjustly limit the range of valuable options that is open to a person.

In short, weakly substantive autonomy is based on 'normative competence',[86] that is, grounding normativity in the exercise of certain competencies by the individual that are essential for her autonomy. Yet, this model remains centred on the individual in the sense that it does not explicitly address the question of common societal values.

3.6.3.2.2 Strongly Substantive

Strongly substantive theories require that all autonomous persons, living together in a society, must have certain shared values that lead them to distinguish right from wrong in particular ways. For instance, O'Neill's proposal of 'principled autonomy' (3.2.3) is strongly substantive. Other philosophers, too, make similar arguments. Joel Feinberg discusses that 'It is impossible to think of human beings except as part of ongoing communities, defined by reciprocal

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[84] Mackenzie (n 76). See also Bruce N Waller, 'The Psychological Structure of Patient Autonomy' (2002) 11 Cambridge Quarterly of Healthcare Ethics 257.

[85] Mackenzie (n 76) 525 explains that to regard oneself with appropriate self-respect is to think of oneself as the moral equal of others; as having equal standing to have one's views taken seriously. If self-respect is eroded, then the person may doubt her own capacity for normative authority in legitimate reasons for action. Self-trust, or self-confidence, is the capacity to trust one's own convictions, emotional responses, and judgments; working out which desires should constitute reasons; and reconciliation of inner conflicts arising from obligations in different social roles. The lack of self-trust impairs one's capacity to understand oneself and to respond flexibly to life-changes. Self-esteem, or self-worth, is a fundamentally evaluative stance towards oneself; lack undermines autonomy if one does not think of one's own life and activities as worthwhile.

[86] Mackenzie and Stoljar (n 69) 19.

bonds of obligation, common traditions and institutions'.[87] Fabian Freyenhagen points out that content-neutral theories of autonomy ignore the dimension of dignity as a restraint on self-determination; in order to impose restraints, certain content has to be specified.[88]

Objections to strongly substantive accounts centre on charges of promoting perfectionism—one, true and objective ideal of the good life—and restricting value pluralism. Strongly substantive autonomy can result in a person becoming subject to certain values and moral principles, regardless of whether or not she authentically accepts those values and principles. People who choose to be maverick, ethnic minority-communities and socially marginalized groups may become disenfranchised when the majority sets normative requirements.[89]

The solution, then, is to agree upon a common set of values and norms that would be acceptable to all members of society. Drawing upon John Rawls's work, Freyenhagen argues that the task is to exclude normative accounts that are incompatible with 'reasonable' pluralism.[90] The call on Rawls's account of reasonability engages public reason; which, as discussed earlier, is central to the normative framework of the capability approach (2.3.4). Notably, O'Neill, too, has relied on public reason for principled autonomy (3.2.3). I will discuss Rawls's theory of public reason, and the application of public reason to a person's capability to achieve treatment, as a reflection of her autonomy, in Chapter 5. Here, I will move on to respect for autonomy: what does it mean for a doctor to respect the autonomy of the patient?

3.7 Respect for Autonomy

Beauchamp and Childress have emphasized that it is crucial to separate notions of personal autonomy from the principle of respect for autonomy: the former define certain characteristics of a person, whereas the latter refers to actions that are required from others in response to those characteristics.[91] These authors highlight that it is the latter—the doctor's obligation to act in a certain way towards the patient—that underpins consent.

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[87] Joel Feinberg, *Harm to Self: The Moral Limits of the Criminal Law* (Oxford University Press 1989) ch 19: Personal Sovereignty and its Boundaries.

[88] Fabian Freyenhagen, 'Autonomy's Substance' (2015) 34 Journal of Applied Philosophy 114.

[89] See Coggon and Miola (n 67).

[90] Freyenhagen (n 88) 115.

[91] Beauchamp and Childress (n 7) 106. See also James F Childress, 'The Place of Autonomy in Bioethics' (1990) 20 Hastings Center Report 12; James F Childress and John C Fletcher, 'Respect for Autonomy' (1994) 24 Hastings Center Report 34.

The principle of respect for autonomy can be viewed as a principle that guides the relationship between the doctor and the patient. As a relationship-guiding principle, respect for autonomy cannot ignore the ethic of care, which is an important strand within feminist scholarship and central to ideas of relational autonomy.[92] Care is, fundamentally, 'an activity of relationship',[93] such as that between a doctor and a patient. Notably, the General Medical Council (GMC) has declared that 'Good doctors make the care of their patients their first concern'.[94] In other words, the primary duty that is assigned to doctors by the GMC is that of care.

In this section, I will, first, discuss the ethic of care in order to clarify the demands that are placed by this ethic on the doctor-patient relationship. I will, then, propose a model of respect for autonomy in the light of the ethic of care.

3.7.1 The Ethic of Care

The seminal articulation of care, as a distinct ethic, can be traced to Carol Gilligan's *In a Different Voice.*[95] The ethics of a caring relationship conflict in several ways with the ethics of a relationship that is based on respect for autonomy as individuality. Gertrude Nonner-Winkler discusses that the ethics of autonomy-based relationships rely on 'masculine' or deontological premises that are stated as fixed rules.[96] Such rules impose negative duties in the form of obligations to omit or not perform certain acts. Such rules are 'perfect' because

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[92] Mackenzie and Stoljar (n 69). Carol Gilligan, 'Moral Injury and the Ethic of Care: Reframing the Conversation about Differences' (2014) 45 Journal of Social Philosophy 89, 101 situates care within the feminist tradition as follows: 'Care is a feminist, not a "feminine" ethic, and feminism, guided by an ethic of care, is arguably the most radical, in the sense of going to the roots, liberation movement in human history. Released from the gender binary and hierarchy, feminism is neither a women's issue nor a battle between women and men. It is the movement to free democracy from patriarchy'. Gilligan's seminal work involved empirical research, which indicated that care ethics was a moral perspective that was voiced mainly by women, and not by men; on this basis, she assumed a correlation between care ethics and female moral reasoning. Subsequent empirical research showed only weak gender correlation; as such, care is identified properly as a feminist, and not feminine, ethic.

[93] Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Harvard University Press 1982) 63.

[94] General Medical Council, *Good Medical Practice* (2013) para 1.

[95] Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (n 93).

[96] Gertrude Nonner-Winkler, 'Two Moralities? A Critical Discussion of an Ethic of Care and Responsiblity Versus an Ethic of Rights and Justice' in Mary Jeanne Larrabee (ed), *An Ethic of Care: Feminist and Interdisciplinary Perspectives (Thinking Gender)* (Routledge 1993). Beauchamp and Childress (n 7) 36 agree that 'a rights-based or obligation-based account may neglect appropriate forms of empathy because of its focus on protecting persons from wrong-doing by others'.

these are context-less, that is, regardless of situational contingency; and can be followed impartially by all, with respect to all. For instance, when there is a rule that everyone should refrain from coercing any or all others, the rejection of coercion is not contingent upon the relationship between the involved parties.[97]

In contrast, care subscribes to imperfect duties—positive duties or duties of commission—that require context-orientation and situation-specific knowledge, and can never be observed completely. Gilligan emphasizes that care is a 'bond of attachment rather than a contract of agreement'.[98] Not dissimilarly, Nel Noddings explains that:

> [A]ctions of the one-caring will be varied rather than rule bound; that is, her actions, while predictable in a global sense, will be unpredictable in detail. Variation is to be expected of the one claiming to really care in the particular other, in a particular set of circumstances. Rule bound responses in the name of caring lead us to suspect that the claimant wants most to be credited with caring.[99]

In the context-oriented paradigm of care, actions are guided by the strength and nature of the relationship at hand, and not in abstract with reference to any or all other persons. In contrast to the impartiality of deontological approaches, care demands partiality. Care-providers must respond adequately to those in their 'inner circles', and care for distant others is subordinate; the obligation to care grows or diminishes in proportion to the response that is, or can be, received from the care-recipient.[100] According to Joan Tronto, the ethic of care holds that it is 'more morally reprehensible to ignore wilfully that which is close to one's own actions than to fail to be aware of a distant consequence of one's actions'.[101]

The central feature of care is empathy. Tronto explains that, in showing empathy, a care-provider will 'consider the other's position as that other expresses it. Thus, one is engaged from the standpoint of the other, but not simply by presuming that the other is exactly like the self'.[102] In other words, empathy requires the care-provider to not only put herself in the care-recipient's position but also to shift her frame of reference and reasoning so that she

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[97] See Beauchamp and Childress (n 7) 138.

[98] Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (n 95) 57.

[99] Nel Noddings, *Caring: A Relational Approach to Ethics & Moral Education* (2 edn, University of California Press 2013) 24.

[100] Ibid.

[101] Joan C Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (Routledge 1993) 129.

[102] Ibid 136.

engages rationality from the perspective of the care-recipient. It is through empathy that the care provider recognises the needs of the care-recipient, and care theorists are unanimous that the focus of care is on the needs of the care-recipient.[103]

Care scholars accept that the identification of a need is an evaluative task: it requires judgments about values. Virginia Held states explicitly that care ‘requires evaluations and judgments, not only empirical findings’.[104] Noddings implies value judgments in discussing that care does not involve the satisfaction of each and every need. She explains that:

> Attempts to care are continually challenged by a tension between expressed needs (those that arise within the one who needs) and inferred needs (those defined externally and imposed on the one said to have them). As carers, we cannot ignore expressed needs, but neither should we always indulge them.[105]

In the capability language, the ethic of care suggests that a person’s agency freedom cannot always be prioritized over her well-being achievement (2.3.2); rather, these two dimensions have to be balanced contextually and contingently, and value judgments are essential to this balancing exercise. The requirement for value judgments in care resonates with observations that the doctor has to make such judgments in seeking and obtaining consent from patients (1.2); because, after all, the doctor’s obligations in consent are part of the overall duty of care that is set out by the GMC. On this background, the present proposal to reconceptualise consent as a capability to achieve treatment, so that the

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[103] Nel Noddings, *Starting at Home: Caring and Social Policy* (University of California Press 2002); Tronto (n 101) 103; Virginia Held, ‘Morality, Care, and International Law’ (2011) 4 Ethics & Global Politics 173.

[104] Virginia Held, ‘The Ethics of Care as Normative Guidance: Comment on Gilligan’ (2014) 45 Journal of Social Philosophy 107, 114.

[105] Nel Noddings, ‘Caring, Social Policy, and Homelessness’ (2002) 23 Theoretical Medicine and Bioethics 441, 443. The approach to needs in care theory chimes with that in case law. In *R v Gloucestershire County Council, Ex p Barry* [1997] AC 584 (HL) 598E, Lord Lloyd explained that ‘To need is not the same as to want. “Need” is the lack of what is essential for the ordinary business of living’; and he assigned the assessment of needs to the ‘professional judgment’ of the care-provider. Ibid 598G. Lord Nicholls, too, set out that the care-provider ‘will judge the needs for assistance against some standard, some criteria, whether spoken or unspoken. Ibid 604G. Lord Clyde conceded that ‘it will be possible to allege that in one sense there will be an unmet need; but an unmet need will be lawfully within what is contemplated by statute’. Ibid 611C. The ratio of the majority in Barry was affirmed by the Supreme Court (Lady Hale JSC dissenting) in *R (on the application of McDonald) v Kensington and Chelsea RLBC* [2011] UKSC 33, [2011] 4 All ER 881.

normative framework of the capability approach can be employed to make these value judgements, harmonizes with Daniel Engster's conclusion that care is 'best characterized as a minimal capability theory'.[106]

3.7.2 A Model of Respect for Autonomy

In a caring relationship, what does it mean for one person (the doctor) to have respect for the autonomy of another person (the patient)? Kim Atkins considers that:

> Respect for autonomy is an acknowledgement of other people and a willingness to incorporate that understanding into our worldviews. When we respect autonomy we don't simply observe another's freedom from a distance, as it were; we accede to our fundamental fallibility and epistemological humility.[107]

Atkins proceeds to explain that respect for autonomy requires an empathetic attitude, which is central to the ethic of care. However, such an attitude, whilst necessary, does not suffice as respect for autonomy; because, as highlighted by Sherwin, autonomy involves 'a set of skills that need to be learned and practiced. A person cannot simply assert autonomy; she needs to learn how to make important decisions in ways that respect her own values and convictions'.[108] Accordingly, in order to respect a person's autonomy sufficiently, her 'social scaffolding'[109]—the favourability of circumstances that surround the exercise of her autonomy—requires to promoted and enhanced. Such a requirement for action, in addition to an empathetic attitude, is widely emphasised by care scholars.[110] Similarly, Beauchamp and Childress acknowledge that respect for autonomy 'involves respectful *action,* not merely a respectful *attitude*'.[111]

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[106] Daniel Engster, *The Heart of Justice: Care Ethics and Political Theory* (Oxford University Press 2007) 29. Engster relies on three important areas of similarity between theories of care and the capability approach: firstly, both focus primarily on the well-being of individuals, such that the aggregate well-being of society is derivative from, rather than determinative of, individual well-being; secondly, both are pluralist about values, with emphasis on the appreciation of diversity and contextual interpretation of circumstances; and thirdly, both are founded on moral analyses that are consequentialist, yet not utilitarian.

[107] Kim Atkins, 'Autonomy and the Subjective Character of Experience' (2000) 17 Journal of Applied Philosophy 71, 75.

[108] Sherwin (n 68) 17.

[109] Ibid 17.

[110] For instances, Tronto (n 101) 102, 133; Held, 'Morality, Care, and International Law' (n 103).

[111] Beauchamp and Childress (n 7) 107. Authors' emphases. See also Childress and Fletcher (n 91).

I now propose a model for the actions that should be undertaken by a doctor in order to adequately respect the autonomy of the patient. I conceive these actions as activities that are undertaken within a doctor-patient relationship that is guided by the ethic of care; particularly because, as mentioned earlier, the GMC allots a duty of care to doctors. Since the obligations of care are admittedly 'imperfect', and, consequently, somewhat vague and amorphous, I use the scheme of dealing with relational challenges to autonomy that is set out by Stojlar and Mackenzie (3.6.3) to give structure to the proposed model of respect for autonomy.

The model of respect for autonomy has four layers. Each layer of the model attends to the requirements of one of the four models of relational autonomy that are proposed by Stojlar and Mackenzie. Thus, each layer of the proposed model deals with a set of actions that should be undertaken by a doctor in order to advance a particular aspect of the patient's autonomy. The actions that I propose in each layer are loose, and convey ideas rather than well-developed arguments, at this stage. Yet, it is important to set out these ideas, because it is the variability in the appreciation and interpretation of this combination of ideas than results in inconsistencies in the application of the principle of respect for autonomy. The capability approach, then, provides a normative framework into which these layers of ideas about respect for autonomy can be fitted and crystallised.

I conceive that the four layers of respect for autonomy are set out in the form of a pyramid (I will refer to this model, henceforth, as the pyramidal model), with sequential (albeit overlapping) progress of actions from the first or basal layer to the fourth or apical layer:

I. The first, or basal layer of the model, represents respect for strongly substantive autonomy. From a strongly substantive viewpoint, all members of a single society ought to hold some views in common, as starting points for choice. Correspondingly, doctors must take some actions, in order to respect autonomy, that are common to all patients. By this argument, the range of medical treatments (and the waiting times for the implementation of these treatments) that is available for a certain health condition, must be the same for all persons with that health condition; the range must not be extended for those who are, say, assertive and articulate as compared to the meek and underprivileged.

II. The second layer represents respect for the historical critical reflection aspect of procedural autonomy. A person's autonomy is contingent upon her being placed in a counterfactual epistemic situation: what is it that she would have done, or decided, if she knew otherwise than what she knows in her present situation? Accordingly, doctors must take action to inform the patient so that she is placed in that counterfactual position; that is, she now knows of matters about her health, and the treatment that is available to her, that she did not know earlier. In this way, the second layer of the model encompasses the provision of information by the doctor to the patient.

III. The third layer reflects respect for weakly substantive autonomy. From the weakly substantive viewpoint, autonomy is contingent upon a person's normative competence. Although the person has been provided the necessary information to move into a counterfactual position in the second layer, she might not have the cognitive and analytical abilities to use this information competently. In order to respect her autonomy, the doctor has to act to enhance and promote her competency, over and above providing information. Commonly-stated requirements for a doctor to ensure and to check a patient's 'understanding' of the information would seem to allude to this third layer of respect for autonomy.

IV. The fourth layer—the apex of the pyramid—represents respect for structural procedural autonomy. This layer guarantees certain freedom of desires to the patient; and the doctor must accept such desires, regardless of the consequences.

In order for a doctor to have adequately respected the autonomy of the patient, the doctor should have taken adequate actions in each of the four layers of the pyramidal model of respect for autonomy.

3.8 Conclusions

Feminist scholars argue that peoples' autonomy is shaped by social influences; and respect for a person's autonomy, as a correlate of her right to self-determination, requires attention to her individual, social circumstances. In this way, the feminist position resonates with a foundational argument of the capability approach (2.3): that peoples' abilities to convert resources into valued goals are contingent upon prevailing social arrangements; as such, justice demands attention to each person's opportunities to attain her goals in the light of these social arrangements. Thus, adequate respect for a person's relational autonomy aligns with the provision of a fair capability to that person. The pyramidal model for respect of autonomy that I proposed in the previous section encompasses relational challenges and it provides some ideas about the obligations of doctors; although, practical clarification of these obligations is outstanding.

Value judgments are central to both feminist scholarship, particularly the ethic of care, and to the capability approach. I discussed in Chapter 2 that the capability approach provides a normative framework that can be used to make fair value judgments. Feminist theories, on the other hand, are short of a robust normative structure, and the feminist dilemmas that I have discussed in this chapter can be traced to difficulties in evaluative assessments. Given the similarity of concerns, the ‘capability approach has enormous potential for addressing feminist concerns and questions’.[112] The present thesis sought to harness this potential through the reconceptualization of consent as a capability to achieve treatment. At the same time, by recognising the harmony between the capability approach and relational autonomy, the well-established grounding of consent in the principle of respect for autonomy is maintained.

I have discussed earlier that the capability to achieve treatment engages two aspects of freedom, as conceived by Sen: a process aspect that pertains to the identification of available treatments; and an opportunity aspect that pertains to a person’s effective freedoms to attain, or reject, the available treatments (2.5). The layers of the pyramidal model of respect for autonomy that I have proposed in the present chapter can now be viewed as domains of the capability to achieve treatment. The first layer of the pyramidal model is the domain that corresponds to the process aspect; whereas, the second, third and fourth layers correspond to the opportunity aspect. In this way, the pyramidal model of respect for autonomy adds structure to the capability to achieve treatment, and this structure will facilitate the analysis and specification of judgments that are required from the doctor, in subsequent chapters of this thesis.[113]

I will now move from theory to practice. I have, so far, discussed the theoretical foundations of the capability to achieve treatment and the principle of respect for autonomy, as grounds for the doctor’s obligation to seek and obtain consent from patients. However, notwithstanding theoretical debates, doctors are, in practice, obliged to follow the instructions of the GMC for obtaining consent.[114] As observed earlier (1.1; 1.2), the GMC instructs doctors to view consent as a process of decision-making that is undertaken in partnership with their patients. I will discuss medical decision-making in the next chapter, and I will show that

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[112] Ingrid Robeyns, ‘Sen's Capability Approach and Gender Inequality: Selecting Relevant Capabilities’ (2003) 9 Feminist Economics 61, 62.

[113] A synthesis is presented in Chapter 9.

[114] This move from theory to practice reflects the critical distinction, which is highlighted by Charles Foster and José Miola, ‘Who's in Charge? The Relationship Between Medical Law, Medical Ethics, and Medical Morality?’ (2015) 23 Medical Law Review 4, between philosophical medical ethics, such as my pyramidal model of respect for autonomy, and professional medical ethics. Whilst philosophical ethics are basis of normative claims about the obligations of medical professionals, these professionals are not bound to obey these claims. Instead, medical professionals are bound to obey the instructions of their professional regulatory body, which, in the UK, is the GMC.

theoretical dilemmas about value judgments are reflected in decision-making practices. In doing so, I will identify the places in decision-making where the normative framework of the capabilities approach becomes applicable.

Chapter 4

Medical Decision-Making

4.1 Introduction

The General Medical Council (GMC) has issued guidance to doctors about obtaining patients' consent for medical treatment. The GMC instructs doctors to view 'consent as an important part of the process of discussion and decision-making, rather than something that happens in isolation'.[1] Further, in conducting decision-making, doctors are instructed to work in 'partnership' with their patients.[2] This partnership process of decision-making that is advocated by the GMC is commonly equated with shared decision-making (SDM);[3] and SDM is widely regarded as synonymous with consent.[4] In this way, the implication of the GMC's guidance is that the theoretical principle of respect for autonomy, which grounds consent, is practised through SDM.[5]

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[1] General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (2008) 5.

[2] Ibid 6 para 2.

[3] See Cathy Charles, Tim Whelan and Amiram Gafni, 'What do we Mean by Partnership in Making Decisions About Treatment?' (1999) 319 The British Medical Journal 780. The GMC does not use the term 'shared decision-making', but this term is widely prevalent in public policy. For instance, the Department of Health, *Equity and Excellence: Liberating the NHS* (2010) 13 asserts that an important goal is to make the NHS a patient-led organization; and, in order to do so, the first item on the agenda is for 'the principle of "shared-decision-making" to become the norm: no decision about me without me'. Similarly, NHS England states that SDM applies to 'most decisions in healthcare and, more often than not, it is appropriate to use shared decision-making'. <www.england.nhs.uk/shared-decision-making/when-and-where-is-shared-decision-making-appropriate/>. Accessed on 3 June 2019.

[4] The role of SDM as the practice of consent seems to have gained prominence through the recommendations of 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* (US Government Printing Office, 1982) 16: 'Ethically valid consent is a process of shared decisionmaking based upon mutual respect and participation'. Erica S Spatz, Harlan M Krumholz and Benjamin W Moulton, 'Prime Time for Shared Decision Making' (2017) 317 The Journal of the American Medical Association 1309 report that the proposed equivalence between SDM and consent has been made explicit in legislation in the USA.

[5] The GMC does not use the word 'autonomy'. It is noteworthy that there is no robust theory that links SDM with consent or respect for autonomy. See Simon N Whitney, Amy L McGuire and Lawrence B McCullough, 'A Typology of Shared Decision Making, Informed Consent, and Simple Consent' (2004) 140 Annals of Internal Medicine 54. See also Lars Sandman and Christian Munthe, 'Shared

Decision-making about medical treatment can be viewed to have two domains: a basis and a style.[6] The basis deals with the identification of treatments that are suitable or available for the patient. It is widely accepted that the basis of modern, Western medicine is a certain paradigm that is called evidence-based medicine (EBM). On the other hand, the style involves evaluating the pros and cons of the available treatments and placing preferences, leading to a decision in favour of one or another treatment or rejection of all treatments. SDM refers to a certain style of decision-making, in which the doctor and patient work in partnership with each other in order to make a treatment-choice from amongst the available options. Thus, SDM, on its own, does not represent the entirety of medical decision-making. In considering SDM as a synonym of consent, the other domain of decision-making—the basis—has received limited attention by bioethical or legal theorists.[7]

The combination of EBM and SDM might suggest that medical decision-making is a ‘scientific bureaucratic’ process, that is, working according to a set of scientifically-determined rules.[8] Ostensibly, such a process would be neutral to the values of the doctor: it would imply that the doctor employs EBM as a scientific tool to identify available treatments; and that the rules of SDM enable the patient to apply her preferences to these available treatments and to make a choice. Yet, in reality, as pointed out earlier (1.2), evaluative judgments by doctors are unavoidable in both these aspects of decision-making. In the present chapter, I will explore both EBM and SDM, and I will show how, and why, value judgments by doctors are essential in decision-making.

In Chapter 2, I proposed the reconceptualization of the doctor’s obligation to obtain consent as an obligation to provide the patient with a fair capability to achieve treatment (2.5). This reconceptualization enables the doctor to use the normative framework of the capabilities approach to make the necessary value judgments. In Chapter 3, I used feminist critiques of autonomy to assign four domains to the capability to achieve treatment (3.8). In the present chapter, I

Decision Making, Paternalism and Patient Choice’ (2010) 18 Health Care Analysis 60. Notably, Ruth R Faden and Tom L Beauchamp, *A History and Theory of Informed Consent* (Oxford University Press 1986) 279 and Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (7 edn, Oxford University Press 2013) 122 have objected to the conflation of SDM and consent.

[6] David M Eddy, ‘Clinical Decision Making: From Theory to Practice. Anatomy of a Decision’ (1990) 263 The Journal of the American Medical Association 441.

[7] For work that starts to address the basis, see José Miola, ‘Moralising Medicine: 'Proper Medical Treatment' and the Role of Ethics and Law in Medical Decision-Making’ in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (Routlege 2016).

[8] S Harrison, ‘New Labour, Modernisation and the Medical Labour Process’ (2002) 31 Journal of Social Policy 465.

will point out that these domains correspond to one or the other domain of decision-making. In this way, the requirement for evaluative judgments in decision-making can be justifiably acknowledged, and the normative framework of the capability approach can be engaged to elucidate these judgments.

This chapter is arranged in the following sections. In section 2, I deal with EBM. I will discuss the value judgements that are involved in the conception and application of clinical guidelines, which increasingly constitute modern EBM. In section 3, I will explain that, in practice, SDM is a hybrid of three ideal styles of decision-making—paternalistic, informative and deliberative—and that the doctor has to make judgments about the component of each style that he includes in his practice of SDM with an individual patient. In section 4, I consider the notion of a patient's capacity for decision-making, and role of capacity in conceiving a patient's capability to achieve treatment. Section 5 is the conclusion to this chapter.

4.2 The Basis of Decision-Making

I have explained earlier that the process of medical decision-making has two domains: the basis and the style. In this section, I will deal with the basis: the range of treatments that is available to the patient. The traditional way of identifying the basis was by reference to the teachings of authoritative figures, accompanied by attention to personal experience, intuition and pathophysiological reasoning.[9] For example, in considering the treatments that were available for a patient with gastric cancer, a surgeon might come to the conclusion that gastrectomy (an operation to remove the stomach) was the only curative treatment because it had been asserted as such by an eminent professor of surgery. The surgeon might also recall his experiences with other patients whom he had treated similarly; and he might reason theoretically, from knowledge of pathology, that, unless the cancer was excised, there could be no prospect of cure. This traditional approach is now replaced by EBM.

4.2.1 What is Evidence-Based Medicine?

Seminal proposals of EBM originated from dissatisfaction with the traditional approach to the identification of available medical treatments.[10] Initially, the

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[9] See David M Eddy, 'Clinical Decision Making: From Theory to Practice. Practice Policies: What Are They?' (1990) 263 The Journal of the American Medical Association 877; Drummond Rennie and Ian Chalmers, 'Assessing Authority' (2009) 301 The Journal of the American Medical Association 1819.

[10] Evidence-Based Medicine Working Group, 'Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine' (1992) 268 The Journal of the American Medical Association 2420. See also Gordon H Guyatt and Drummond

proponents of EBM advocated that, in order to identify proper or available treatments, a doctor should conduct a ‘critical appraisal’ of the published medical literature and synthesize the available scientific information.[11] Having synthesized the information, the doctor should then apply it to his individual patient by using the ‘traditional skills of medical training’ and ‘sensitivity to the emotional needs of patients’.[12] Later, in response to various criticisms, the EBM paradigm was restated: in order to make a treatment decision, the doctor should use his professional expertise to coherently combine the clinical condition of the patient, scientific evidence and the patient’s preferences and circumstances.[13] Yet, the restatement of EBM did not clearly separate the basis from the style of decision-making: as a paradigm for the practice of medicine, EBM included both domains of decision-making.

It soon became apparent that it was infeasible for practising doctors to individually synthesize evidence from published material. There was an explosion of complex medical information by the late 20th century, and practising doctors simply did not have the time or the analytical skills to appraise literature. Consequently, efforts were re-focussed on providing doctors with synthesized sources of evidence in the form of clinical practice guidelines, which increasingly constitute the modern form of EBM. Benjamin Djulbegovic and Gordon Guyatt explain that guideline-oriented EBM is underpinned by three principles: first, practices should be based on the best available—the most ‘trustworthy’—evidence; secondly, in ‘pursuit of truth’, the totality of the evidence should be considered, and not selected evidence that supports a particular claim; and thirdly, individual patients’ values and preferences should be critical components of decision-making.[14] These authors clarify that ‘evidence never determines decisions; it is always evidence in the context of values and preferences’.[15] Thus, modern EBM explicitly separates the basis of decision-making—the evidence, which emerges from the first and second

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Rennie, ‘Users' Guides to the Medical Literature’ (1993) 270 The Journal of the American Medical Association 2096; Richard Smith and Drummond Rennie, ‘Evidence-Based Medicine: An Oral History’ (2014) 311 The Journal of the American Medical Association 365.

[11] EBM Group (n 10) 2421.

[12] Ibid 2421.

[13] R Brian Haynes, P J Devereaux and Gordon H Guyatt, ‘Physicians' and Patients' Choices In Evidence Based Practice’ (2002) 324 The British Medical Journal 1350.

[14] Benjamin Djulbegovic and Gordon H Guyatt, ‘Progress in Evidence-Based Medicine: A Quarter Century On’ (2017) 390 The Lancet 415.

[15] Ibid 420. See also Albert G Mulley, Chris Trimble and Glyn Elwyn, ‘Stop the Silent Misdiagnosis: Patients’ Preferences Matter’ (2012) 345 The British Medical Journal e6572; Victor M Montori, Juan P Brito and M Hassan Murad, ‘The Optimal Practice Of Evidence-Based Medicine: Incorporating Patient Preferences in Practice Guidelines’ (2013) 310 The Journal of the American Medical Association 2503.

principles of guideline-based practice—from the style, which deals with the application of this evidence to individual patients.

For the practice of their first and second principles, Djulbegovic and Guyatt endorse the GRADE (Grading of Recommendations Assessment, Development and Evaluation) method, which is a comprehensive framework for assessing the quality of published clinical information and for making recommendations.[16] An implicit premise of modern EBM, which is incorporated in GRADE, is that doctors and patients are not only seeking assessments of the quality of evidence but also require recommendations that correspond to these assessments.[17] The GRADE methodology has been adopted by several guideline-development agencies, including the National Institutes of Health and Care Excellence (NICE).[18] It is GRADE-generated recommendations, which I will exemplify later, that progressively form the basis of modern medical decision-making.

For the practice of their third principle, that is, the incorporation of patients' values and preferences, Djulbegovic and Guyatt endorse SDM as the style for evaluating GRADE-generated recommendations in order to arrive at treatment decisions for individual patients. As observed by Tammy Hoffmann and colleagues, 'Without SDM, authentic EBM cannot occur'.[19] By corollary, references to SDM implicitly assume EBM as the associated basis. The EBM literature does not engage in the debate on theoretical styles of decision-making that I deal with in the next section. Instead, the emphasis is on practicality, and it is assumed that the use of decision-aids represents SDM.[20]

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[16] There is extensive literature on GRADE. For examples, see Gordon H Guyatt and others, 'GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations' (2008) 336 The British Medical Journal 924; Alfonso Iorio and others, 'Use of GRADE for Assessment of Evidence About Prognosis: Rating Confidence in Estimates of Event Rates in Broad Categories of Patients' (2015) 350 The British Medical Journal h870.

[17] Gordon H Guyatt and others, 'Going from Evidence to Recommendations' (2008) 336 The British Medical Journal 1049; Pablo Alonso-Coello and others, 'GRADE Evidence to Decision (EtD) Frameworks: A Systematic and Transparent Approach to Making Well Informed Healthcare Choices. 2: Clinical Practice Guidelines' (2016) 353 The British Medical Journal i2089.

[18] Judith Thornton and others, 'Introducing GRADE across the NICE Clinical Guideline Program' (2013) 66 Journal of Clinical Epidemiology 124.

[19] Tammy C Hoffmann, Victor M Montori and Chris Del Mar, 'The Connection Between Evidence-Based Medicine And Shared Decision Making' (2014) 312 The Journal of the American Medical Association 1295, 1295.

[20] See Thomas Agoritsas and others, 'Decision Aids that Really Promote Shared Decision Making: The Pace Quickens' (2015) 350 The British Medical Journal g7624.

4.2.2 Institutional Value Judgments in Evidence-Based Medicine

Outwardly, EBM is value-neutral; it deals with facts. Yet, in reality, value judgments are inherent to EBM.[21] The reliance on value judgments is implicit in the references to 'trustworthy' and 'pursuit of truth' in the statement of principles for the generation of clinical practice guidelines by Djulbegovic and Guyatt (4.2.1). Elsewhere, Guyatt and colleagues make it explicit that 'value judgments will always be required for each step' of the GRADE method that is used for creating guidelines.[22] These steps, and related judgments, pertain to categorising the quality of published information, selecting treatment-outcomes of interest, and setting thresholds of effect for making recommendations.[23] The values and preferences to which SDM applies are then secondary to these inherent value judgments.

Guyatt and colleagues explain that guideline developers will work according to certain institutional values, and GRADE provides a framework into which relevant institutional values can be imported.[24] These values are likely to differ amongst guideline development institutions or organisations. For instance, NICE acknowledges that certain social value judgments are integral to its process of guideline development, and it sets out a particular way of making and applying these judgments.[25] Other guideline development organisations may have different criteria for making and applying value judgments. Moreover, institutional value judgments are not necessarily explicitly articulated, but may be tacit and reflective of the underlying traditions of that organisation or institution. Consequently, recommendations in guidelines from different organisations may not only vary but also the reasons for variation may not be readily apparent.

A critical factor in making value judgments is the approach to resource-utilization: was the guideline development institution indifferent to resource, or

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[21] See Ian Kerridge, 'Ethics and EBM: Acknowledging Bias, Accepting Difference and Embracing Politics' (2010) 16 Journal of Evaluation in Clinical Practice 365; Mona Gupta, 'Improved Health or Improved Decision Making? The Ethical Goals of EBM' (2011) 17 Journal of Evaluation in Clinical Practice 957; Michael P Kelly and others, 'The Importance of Values in Evidence-Based Medicine' (2015) 16 BMC Medical Ethics 69.

[22] Gordon H Guyatt and others, 'What is "Quality of Evidence" and Why is it Important to Clinicians?' (2008) 336 The British Medical Journal 995, 998.

[23] Ibid. See also Holger J Schünemann and others, 'Grading Quality of Evidence and Strength of Recommendations for Diagnostic Tests and Strategies' (2008) 336 The British Medical Journal 1106; Guyatt and others (n 16).

[24] Gordon H Guyatt and others, 'Incorporating Considerations of Resources Use into Grading Recommendations' (2008) 336 The British Medical Journal 1170.

[25] National Institute for Health and Clinical Excellence, *Social Value Judgments: Principles for the Development of NICE Guidance* (2nd ed).

did it consider resource from the viewpoint of out-of-pocket costs for an individual patient, or from a population viewpoint for a socially-funded healthcare system such as the NHS? Social resource-allocation judgments are ultimately political, because these involve decisions about the relative value of pursuing a certain treatment versus foregoing it, and allocating the resource to something else.[26] For instance, NICE relies on cost-utility analyses, using the quality-adjusted life-year methodology for assessing expected gains in selected health outcomes in relation to treatment-cost, in order to obtain 'value for money' for the NHS.[27] Thus, problems of rationing are central to EBM, and the legitimacy of a guideline in a given clinical context could become dependent on the authority of the institution that makes the rationing decisions.[28]

4.2.3 Individual Value Judgments in Evidence-Based Medicine

Practising doctors do not directly have to make the value judgments that are involved in the generation of EBM; they are presented with published literature and guidelines, to use as the basis of their decision-making in partnership with patients. Yet, the practice of EBM, as a philosophy of medicine, continues to require doctors to make value judgments about the basis of decision-making for individual patients. The individual situations in which such requirements to make judgments arise can be separated broadly into two groups: first, situations that are covered by guidelines; and secondly, situations where guidelines do not exist or do not cover particular aspects of the situation.

4.2.3.1 Situations Covered by Clinical Guidelines

Although EBM is widely accepted as the basis of modern medicine, it is not clear whether doctors are legally entitled and bound to rely upon guidelines;[29] or whether the inherent value judgments, which underpin the recommendations in

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[26] Guyatt and others (n 24).

[27] NICE (n 25) 18. For a critique of NICE's approach, see John Appleby, 'Crossing the Line: NICE's Value for Money Threshold' (2016) 352 The British Medical Journal i1336.

[28] See S I Saarni and H A Gylling, 'Evidence Based Medicine Guidelines: A Solution to Rationing or Politics Disguised as Science?' (2004) 30 Journal of Medical Ethics 171.

[29] For discussion of the variable treatment of clinical guidelines in malpractice litigation, see Ash Samanta and others, 'The role of clinical guidelines in medical negligence litigation: a shift from the bolam standard?' (2006) 14 Medical Law Review 321. See also Brian Hurwitz, 'How does Evidence Based Guidance Influence Determinations of Medical Negligence?' (2004) 329 The British Medical Journal 1024; M J Mehlman, 'Medical Practice Guidelines as Malpractice Safe Harbors: Illusion or Deceit?' (2012) 40 The Journal of Law, Medicine & Ethics 286; Rob Heywood, 'Litigating Labour: Condoning Unreasonable Risk-Taking in Childbirth?' (2015) 44 Common Law World Review 28.

guidelines, should themselves be open to debate in the doctor-patient interaction. In other words, should the analysis and synthesis of published medical literature, itself, be a subject for SDM, notwithstanding the existence of a guideline?[30] This dilemma can arise specially in clinical situations that are covered by more than one clinical guideline with potentially conflicting recommendations, although even single guidelines can be challenged.

The *Montgomery* case illustrates the problem. Here, Dr McLellan, an obstetrician, defended her omission to offer a caesarean section, as an alternative to vaginal delivery, on grounds that a guideline from the Royal College of Obstetricians and Gynaecologists did not recommend that caesarean section should be considered for pregnant diabetic women with estimated foetal weight of less than 4.5 kg. But, the Supreme Court disregarded this guideline. Instead, in allowing *Montgomery's* appeal, the Court, particularly Lady Hale JSC, relied heavily on a clinical guideline from NICE that did not consider foetal weight.[31]

The Supreme Court's decision implies that Dr McLellan was not entitled to rely on the Royal College's guideline in order to determine the basis of decision-making. Instead, it would seem that she was obliged to exercise a judgment about the application of this guideline to Mrs Montgomery's situation; and that the appropriate judgment would have been to include both vaginal delivery and caesarean section in the basis of decision-making about Mrs Montgomery's

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[30] See Doreen M Rabi, Marleen Kunneman and Victor M Montori, 'When Guidelines Recommend Shared Decision-Making' (2020) 323 The Journal of the American Medical Association 1345.

[31] Dr McLellan predicted the baby's birth-weight to be 3.9 kg. The trial judge, Lord Bannatyne, found that all experts agreed that 'guidelines' stated that a planned caesarean section should be offered only if the predicted birth-weight was greater than 4.5 kg. *Montgomery v Lanarkshire Health Board* [2010] CSOH 104, 2010 GWD 34-707 [16], [17], [21]. The guideline is not specified. Jonathan Montgomery and Elsa Montgomery, 'Montgomery on Informed Consent: An Inexpert Decision?' (2016) 42 Journal of Medical Ethics 89, 91 assume this guideline to be the Royal College of Obstetricians and Gynaecologists Green-top Guideline No. 42 on Shoulder Dystocia, which is mentioned by Lady Hale JSC in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 (n 2) [112]. Para 5.1.2 of guideline states: 'Elective caesarean section should be considered to reduce the potential morbidity for pregnancies complicated by pre-existing or gestational diabetes, regardless of treatment, with an estimated fetal weight of greater than 4.5 kg'. This guideline was first published in 2005, so it would not have been available in 1999. But, it seems very unlikely that any earlier guideline, which would have been applicable in 1999, would have proposed a threshold lower than 4.5 kg. Yet, Lady Hale JSC ibid (n 2) [116] relied on NICE's clinical guideline on Caesarean Section (CG132, issued in 2011) para 1.2.9.5: 'For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS'.

mode of childbirth, regardless of the Royal College's recommendation. From the Supreme Court's decision, it could be inferred that the value judgment that underpinned the threshold weight of 4.5 kg in the guideline should, itself, have been a subject for discussion between Dr McLellan and Mrs Montgomery. As such, it seems that doctors remain obliged to make judgments about what should be included in the basis of decision-making, notwithstanding the existence of a clinical guideline; but, the Supreme Court does not explicitly set out a scheme for how doctors ought to make these judgments (in Chapter 8, I will induce the scheme that is implicit in the Supreme Court's decision in *Montgomery*).

4.2.3.2 Situations Not Covered by Clinical Guidelines

Although modern EBM is practised increasingly through clinical guidelines, these are not available for all health conditions or clinical situations. In the absence of a guideline, medical professionals will have to rely on alternative sources of information, such as textbooks (which, then, reflect the values of the authors), or individually evaluate published literature, as was envisaged originally by the proponents of EBM. In appraising the literature, it is unavoidable that the doctor will have to make some judgments, similar to guideline developers. For example, if there are several publications with different conclusions, the doctor will have to make some judgments about the information that should be included, and that which should be excluded, from the basis of decision-making.[32] But, it is not clear how the doctor ought to make these judgments: what information should he include, and what should he exclude, from the basis of decision-making? A normative paradigm is missing.

Even in situations that are covered generally by clinical guidelines, some specific value judgments are assigned implicitly to the professionals who will implement the guidelines. For instance, NICE's clinical guideline for oesophago-gastric cancer states: 'Provide information about possible treatment options, such as surgery, radiotherapy or chemotherapy, in all discussions with people with oesophago-gastric cancer who are going to have radical treatment'.[33] The

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[32] For examples, in *Blyth v Bloomsbury HA* [1993] 4 Med LR 151 (CA), the gynaecologist made the judgment that unpublished, research data about serious menstrual irregularities were not of sufficiently good quality to be included as the basis of SDM about Depo-Provera, a contraceptive agent, with the patient. In *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120, [2014] Med LR 122, the haematologist made the judgment that there was insufficient evidence to support the use of oxymethalone, as an alternative to ALG, for treatment of myelodysplasia; and, so, she did not include oxymethalone in her SDM with the patient.

[33] National Institute for Health and Care Excellence, *Oesophago-Gastric Cancer: Assessment and Management in Adults* (NICE Clinical Guideline NG83, 2018).

guideline then proceeds to elaborate various recommendations for investigations, extent of surgery, and types of chemotherapy. But, the guideline does not offer any direction for deciding who is ‘going to have radical treatment’, that is, treatment with the intention to cure cancer, as opposed to palliation only.

The judgment about the treatment-intent—cure or palliation—is assigned implicitly to medical professionals or, increasingly, to multi-disciplinary teams (MDTs) of healthcare professionals. The MDT will make a judgment about whether, or not, the patient is ‘fit’ for curative treatment, and then make recommendations according to the NICE guideline. Thus, the MDT’s judgments serve as an ‘eligibility checkpoint’[34] and supply the basis on which SDM can proceed. MDTs will have to apply some values, if not explicitly then tacitly, in making these judgments about treatments that are available to individual patients. Neither NICE, nor the GMC or any other body, clearly instructs medical professionals on how they ought to make these value judgments. Instead, the normativity of these judgments relies implicitly on some attribute of medical professionalism, and I will expand on this issue later (8.3.2).

4.3 Styles of Decision-Making

In this section, I will discuss the style of decision-making: the weighing and balancing of available treatment options in order to arrive at an outcome, or treatment-decision, for an individual patient. I have pointed out earlier that SDM has been widely endorsed as the appropriate style of decision-making. However, the characteristics of SDM are unclear: what, exactly, is meant by SDM? What is it that has to be shared by the doctor and the patient in order for the style to qualify as SDM?

Ezekiel Emanuel and Linda Emanuel have discussed and compared three ideal styles of medical decision-making: paternalistic, informative and deliberative.[35] These three styles remain representative of the ‘ideal’, or archetypical, alternatives that are available to a doctor. Emanuel and Emanuel emphasize that these three decision-making-styles are theoretical ‘ideal types’, and not practical models. Rather, as pointed out by Cathy Charles and colleagues:

> In the real world of everyday practice, many clinical decision-making interactions are likely to reflect some form of hybrid model. Human

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[34] Justin T Clapp and others, ‘Surgical Consultation as Social Process: Implications for Shared Decision Making’ (2019) 269 Annals of Surgery 446, 448.

[35] Ezekiel J Emanuel and Linda L Emanuel, ‘Four Models of the Physician-Patient Relationship’ (1992) 267 The Journal of the American Medical Association 2221. A fourth style of decision-making, called ‘interpretive’, is dismissed as impractical by the authors, so I have excluded this style from my discussion.

> behavior rarely conforms to ideal types. Given the often dynamic, complex, and personal nature of the doctor-patient relationship, the decision-making model adopted at the outset of a clinical encounter may not unfold according to the pattern of the ideal type but instead be modified to reflect the needs of individual patients.[36]

Charles and colleagues discuss that, in practice, SDM will comprise a dynamic hybrid of the ideal styles, and that this hybrid will be unique for each individual patient. Indeed, there is abundant empirical evidence that practices of SDM are variable hybrids.[37] In the sub-sections that follow, I will discuss each of these ideal styles separately, and I argue that doctors have to make judgments about the extent to which each one of these ideal styles is included in the hybrid model of SDM that is adopted for any individual patient.

4.3.1 Paternalistic Style

4.3.1.1 What is Paternalism?

Onora O'Neill writes that 'the whole tradition of medical paternalism centred on desires to assist patients and research subjects by mild and well intentioned deception and euphemism'.[38] However, a single, universally-accepted definition of paternalism is elusive.[39] Common descriptions suggest a range of practices. For example, Emanuel and Emanuel consider that the decision-making style is paternalistic when:

> [T]he physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best. At the extreme, the physician authoritatively informs the patient when the intervention will be initiated.[40]

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[36] Charles, Whelan and Gafni (n 3) 781.

[37] See Glyn Elwyn and others, 'Shared Decision Making Observed in Clinical Practice: Visual Displays of Communication Sequence and Patterns' (2001) 7 Journal of Evaluation in Clinical Practice 211; Orit Karnieli-Miller and Z Eisikovits, 'Physician as Partner or Salesman? Shared Decision-Making in Real-Time Encounters' (2009) 69 Social Science and Medicine 1; France Legare and others, 'Interventions for Improving the Adoption of Shared Decision Making by Healthcare Professionals' (2010) Cochrane Database of Systematic Reviews CD006732; Floyd J Fowler, Bethany S Gerstein and Michael J Barry, 'How Patient Centered are Medical Decisions? Results of a National Survey' (2013) 173 JAMA Internal Medicine 1215.

[38] Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002), 119.

[39] See Antal Szerletics, *Green Paper Technical Report: Paternalism* (Essex Autonomy Project, 2011).

[40] Emanuel and Emanuel (n 35) 2221.

Whereas, Tom Beauchamp and James Childress define paternalism as:

> [T]he intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden.[41]

Both definitions indicate externally-placed restrictions on the patient's ability to participate in decisions about her own healthcare; but, these authors do not provide a formal connection between autonomy and paternalism. Gerald Dworkin has reviewed various formulations of paternalism in healthcare, and he links paternalism with autonomy as follows:[42] he proposes that X (the doctor) acts paternalistically towards Y (the patient) by doing (or omitting) Z if: first, Z (or its omission) interferes with the liberty or autonomy of Y; secondly, X acts without the consent of Y; and thirdly, X acts because Z will improve the welfare of Y, or in some way promote the interests, values or good of Y.[43]

Dworkin's definition of paternalism, in itself, does not involve an evaluative proposition, that is, a claim of whether paternalism is good or bad. Nonetheless, the definition is clear in that paternalism involves inference with autonomy; accordingly, if the normative premise is that autonomy ought to be respected, and not interfered with, then paternalism should be rejected. Yet, the rejection of paternalism could be qualified according to the assessment of a person's autonomy: to what extent were the person's desires, on which interference was imposed, truly authentic and independent (which, as I discussed in section 3.3, are Dworkin's requirements for autonomy)? The acceptance or rejection of paternalism then becomes subject to the evaluation of the person's autonomy, and outright rejection of a paternalistic style of decision-making can become problematic.[44]

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[41] Beauchamp and Childress (n 71) 215.

[42] Gerald Dworkin, 'Defining Paternalism' in Thomas Schramme (ed), *New Perspectives on Paternalism in Healthcare* (Springer 2015).

[43] If the doctor's agenda is other than benevolence, for example, financial gain, then the doing, or omitting, of 'Z' is not paternalism. In this case, the decision-making style would be morally wrong (Emanuel and Emanuel (n 35) 2222 call it 'instrumental'), but it is wrong for reasons other than the premises of paternalism. Similarly, Erich H Loewy, 'In Defense of Paternalism' (2005) 26 Theoretical Medicine and Bioethics 445, 448 explains that 'to be paternalistic an act must be done purely for the (supposed) benefit of the patient. Forcing a patient to undergo a procedure so as to generate more income or to satisfy the physician's curiosity is not paternalism'.

[44] Gerald Dworkin, 'Paternalism' in Edward N Zalta (ed), *The Stanford Encyclopedia of Philosophy* (Spring edn, 2020) <https://plato.stanford.edu/archives/sum2020/entries/paternalism/> accessed 27

4.3.1.2 Premises of Paternalism

Paternalism has been a long-standing, normative tradition in medical decision-making. The following premises seem to underlie this tradition: first, both the patient and doctor have common conceptions of health and disease, and a common desire to promote and protect the patient's health; and secondly, the patient will not (or should not) desire other that what the doctor considers is best for the promotion or protection of her health. Therefore, the doctor can make treatment decisions without involving the patient in the process of decision-making.[45] To apply the language of the capability approach, well-being achievement trumps agency freedom (2.3.2) in this tradition, and the doctor was entitled to make this prioritization on behalf of the patient. I will discuss later that this normative argument was congruent with sociological narratives that prevailed up to around the mid-20th century, wherein patients assumed a 'sick role' and doctors served as social-control agents (6.2.1).

4.3.1.3 Judgments in the Paternalistic Style

The normative premises of paternalism are not grounded in a sociological context that prizes respect for autonomy. The normative argument of paternalism does not consider that there can be differing ideas of health (2.4.2), and those of the patient and the doctor may not coincide, such that the premise of implicitly shared conceptions of health and disease does not remain tenable. Alternatively, even if a conception of health is shared, the patient may not desire the health goal that is deemed to be 'best' by the doctor; in other words, that a patient's agency freedom may diverge from her well-being achievement. As such, it does not seem that an ideal, paternalistic style of decision-making can serve as a practical tool to provide the patient with a fair opportunity to achieve treatment. In *Montgomery*, Lord Kerr and Lord Reed JJSC arrive at such a conclusion: they hold that recent social and legal developments 'point away from a model of the relationship between the doctor and the patient based on medical paternalism'.[46]

Yet, as pointed out earlier, unqualified rejection of paternalism can be problematic. Moreover, outright rejection of paternalism creates tension with the doctor's obligation to care for the patient that is set out by the GMC;[47] because

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July 2020 discusses normative arguments for paternalism according to various conditions of authenticity and independence.

[45] O'Neill (n 38) 119.

[46] *Montgomery UKSC* (n 2) [81]. Previously, in *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [16], Lord Steyn, too, had ruled that 'In modern law, medical paternalism no longer rules…'.

[47] General Medical Council, *Good Medical Practice* (2013) para 1.

rejection would require that attention is directly only to agency freedom and that well-achievement is disregarded. As discussed earlier (3.7.1), care theorists admit that a care-provider may occasionally intentionally override the agency of the care-recipient through the application of value judgments that are central to the ethic of care. In the words of Nel Noddings, 'despite classical liberalism's fears of paternalism, a caring society must sometimes intervene in the lives of adults to prevent them from harming themselves'.[48] Not dissimilarly, within the capabilities literature, Séverine Deneulin discusses that 'Nussbaum's liberalism admits a stronger form of paternalism: interfering with someone's choice is not only legitimate if that choice harms others, but interfering is justified when the choice harms the chooser herself'.[49]

It would seem that the normativity of paternalism has to be contingent upon the level or extent of a person's autonomy; which, as discussed previously is subject to various social influences (3.6). I will discuss later that that the level of a person's autonomy merges with her decision-making capacity (4.4). As such, the Supreme Court's stricture on paternalism would have to be qualified, in practice, in line with the arguments of care and capability theorists; and, the doctor would have to make a judgment about including some component of paternalism—some balancing of well-being achievement with agency freedom—in the decision-making style that constitutes the practical hybrid of SDM for individual patients.

4.3.2 Informative Style

4.3.2.1 What is the Informative Style?

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[48] Nel Noddings, *Starting at Home: Caring and Social Policy* (University of California Press 2002) 2. See also Christina H Sinding and others, '"I Like To Be An Informed Person But ..." Negotiating Responsibility for Treatment Decisions in Cancer Care' (2010) 71 Social Science and Medicine 1094; Laurence B McCullough, 'Was Bioethics Founded on Historical and Conceptual Mistakes About Medical Paternalism?' (2011) 25 Bioethics 66; Roxanna Lynch, 'Paternalistic Care?' in Thomas Schramme (ed), *New Perspectives on Paternalism in Healthcare* (Springer 2015). Other care scholars have attempted to reject a formal link with paternalism, but their arguments are weak. For example, see Michael Slote, 'Autonomy and Empathy' (2004) 21 Social Philosophy & Policy 293. See also Laura Specker Sullivan, 'Medical Maternalism: Beyond Paternalism and Antipaternalism' (2016) 42 Journal of Medical Ethics 439; Laura Specker Sullivan and Fay Niker, 'Relational Autonomy, Paternalism, and Maternalism' (2018) 21 Ethical Theory and Moral Practice 649.

[49] Séverine Deneulin, 'Perfectionism, Paternalism and Liberalism in Sen and Nussbaum's Capability Approach' (2002) 14 Review of Political Economy 497, 510.

Emanuel and Emanuel’s outline of the informative style of decision-making is very similar to the proposal by Amiran Gafni and colleagues of ‘informed decision-making’.[50] Here, the doctor’s role is simply to supply the basis of decision-making—information about the diagnosis and EBM-recommended treatments—to the patient. The processing of this information, that is, the weighing and balancing of the pros and cons of one treatment versus another (or no treatment at all), is a matter that is exclusively for the patient. The patient independently evaluates the information and selects the treatment-option that she prefers. The patient then communicates her decision to the doctor, who implements this decision. The doctor does not participate in, or question, the values and associated judgments that underlie the patient’s decision.

The informative style is illustrated by the approach of Miss Kerslake, an obstetrician, in the case of *Al Hamwi*:

> I give them the facts…If I’m asked by a patient, what would you do? I tell them very clearly that it is not my decision but their decision and if they need further information they can have that and more time to think about the decision, which is very important…[51]

Miss Kerslake goes on to clarify: ‘I would never ask a patient to explain or justify the decision they have made. I would not do so because I would be concerned that by doing so the patient may interpret this as criticism of their choice’.[52]

4.3.2.2 Premises of the Informative Style

The informative style employs normative assumptions of the rational choice theory.[53] In this theory, people are seen to be motivated by wants or goals that manifest as their preferences; and they act, in order to satisfy these preferences, on the basis of the information that they have, or are given, about the conditions under which they are acting.[54] Individuals make choices in relation to both their preferred goals and their preferred means for attaining these goals, by estimating the outcomes of alternative courses of actions and then selecting the outcome that will best satisfy their preferences. In the rational

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[50] Amiram Gafni, Cathy Charles and Tim Whelan, ‘The Physician-Patient Encounter: The Physician as a Perfect Agent for the Patient Versus the Informed Treatment Decision-Making Model’ (1998) 47 Social Science and Medicine 347.

[51] *Al Hamwi v Johnston* [2005] EWHC 206 (QB), [2005] Lloyd's Rep Med 309 [65].

[52] Ibid [73].

[53] See Irene M L Vos, Maartje H N Schermer and Ineke L L E Bolt, ‘Recent Insights into Decision-Making and their Implications for Informed Consent’ (2018) 44 Journal of Medical Ethics 734.

[54] John Scott, ‘Rational Choice Theory’ in G Browning, A Halcli and F Webster (eds), *Understanding Contemporary Society: Theories of the Present* (Sage Publications 2000).

choice theory, the content or substance of the preferences and the reasons why a person has come to hold such preferences is irrelevant.[55] This theory focuses on the relationship between preferences and action-choices: it asks whether, or not, a person's choice is consistent with the maximization of her preferences; if it is not, then the choice is deemed to be irrational.[56] In the language of the capability approach, the focus of the informative style is on agency freedom, with the underlying assumption is that a person's agency is determinative of her well-being.

4.3.2.3 Judgments in the Informative Style

The GMC's model of partnership-based decision-making suggests an informative style: following an assessment of the patient's condition and circumstances, the doctor has to identify and explain treatments that are likely to result in overall benefit for the patient; the patient then deliberates on the proposed options and makes a decision, which she communicates to the doctor, who implements this decision.[57] In *Montgomery*, the Supreme Court approves 'this basic model of partnership between doctor and patient'.[58]

From the capabilities perspective, the informative style can be rigorously challenged on the grounds that the rational choice theory does not accommodate the complexities of social choices.[59] Amartya Sen has explained that rationality is often 'bounded', or incomplete, because of various internal and external constraints on practical reasoning.[60] A person's goals and preferences might not be clear and well-defined, or she may not have the cognitive and analytical abilities to select the means that will most efficiently deliver these preferences; and such deficiencies are important sources of the conflicts between the person's agency and her well-being that Sen discusses in the capability approach (2.3.1).

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[55] Debra Satz and John Ferejohn, 'Rational Choice and Social Theory' (1994) 91 The Journal of Philosophy 71. Unlike Kantian scholars (3.2.2), the rational choice theory does not debate the justification for the ends and means of rational choices.

[56] Amartya Sen, *The Idea of Justice* (first published 2009, Penguin Books 2010) 179.

[57] GMC Consent 2008 (n 1) 6 para 1.

[58] *Montgomery UKSC* (n 46) [78]. The style of decision-making that is reiterated by Lord Kerr and Lord Reed JJSC aligns with rational choice: the doctor provides information about 'the seriousness of her condition, and the anticipated benefits and risk of the proposed treatment and any reasonable alternatives' so that the patient 'is then in a position to make an informed decision'. Ibid [90].

[59] See also Dan W Brock, 'The Ideal of Shared Decision Making Between Physicians and Patients' (1991) 1 Kennedy Institute of Ethics Journal 28.

[60] These objections were first raised in Amartya K Sen, 'Rational Fools: A Critique of the Behavioral Foundations of Economic Theory' (1977) 6 Philosophy & Public Affairs 317.

Specifically in the context of deciding about medical treatment, Neil Levy discusses that the rational choice paradigm may fail to promote individual notions of good because various biases and heuristics can lead to treatment-choices that less than maximally satisfy actual preferences, in comparison to an alternative choice.[61] Levy points out biases from myopia (the degree to which the future is discounted), motivated reasoning (dismissal of evidence that conflicts with prior views), affective forecasting (overestimating or underestimating the effects of events or changes), base rate neglect (overlooking the frequency of an event) and saliency (over-impression by cases that come to mind easily). Such decision-making biases represent cognitive illusions: superficially, the patient is acting in accordance with her own values and associated preferences; but, in reality, she misapplies these values because the world is not what she takes it to be. Critically, such biases and heuristics may not be overcome by simply acquiring information.

Considering the limitations of rational choice, it does not seem that, notwithstanding the instructions of the GMC and the Supreme Court, doctors can practice an ideal, informative style in the real world. Rather, the doctor will have to make some judgment about the extent to which he should adopt an informative style, relative to the two other ideal styles. Moreover, even if the doctor employs an informative style in its ideal form, in the manner of Miss Kerslake in *Al Hamwi* (4.3.2.1), he will have to make some judgment about the extent or scope of information that he provides to the patient; because, as pointed out earlier (1.1), unqualified demands for ‘full’ or ‘complete’ disclosures of information are meaningless.

4.3.3 Deliberative Style

4.3.3.1 What is the Deliberative Style?

In the deliberative style, in addition to supplying information, the doctor helps the patient to crystallize her values and preferences, and he shares his own values and preferences with the patient. Emanuel and Emanuel emphasize that a doctor cannot participate meaningfully in the decision-making process unless he shares his own values and preferences.[62] Charles and colleagues, too, argue that ‘unless both patient and physician share treatment preferences, a

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[61] Neil Levy, ‘Forced to be Free? Increasing Patient Autonomy by Constraining It’ (2014) 40 Journal of Medical Ethics 293. See also Dan W Brock and Steven A Wartman, ‘When Competent Patients Make Irrational Choices’ (1990) 322 New England Journal of Medicine 1595.

[62] Emanuel and Emanuel (n 35).

shared treatment decision-making process did not occur, no matter how much information may have been exchanged by either party'.[63]

In addition to sharing his own preferences, Emanuel and Emanuel consider that the doctor should explore and evaluate the patient's preferences; and, if necessary, engage in 'deliberation about what kind of health related values the patient could and ultimately should pursue'.[64] Essentially, this style obliges the doctor to make and express his own value judgments. The doctor and patient then deliberate the importance and worthiness of different health-related values, so that the patient can develop or change her values, rather than simply following her existing values and associated preferences. The patient's understanding of the information is now dependent on the expression of the doctor's values, and the exploration and challenge of the patient's values by the doctor, including persuasion by the doctor.

4.3.3.2 Premises of the Deliberative Style

Emanuel and Emanuel conceive the deliberative style as a 'dialogue' between the doctor and the patient. They explain that:

> In the deliberative model, the physician acts a teacher or friend, engaging the patient in dialogue on what course of action would be best. Not only does the physician indicate what the patient could do, but, knowing the patient and wishing what is best, the physician indicates what the patient should do, what decision regarding medical therapy would be admirable.[65]

These authors do not expand on the characteristics of a dialogue as a distinctive genre of conversation. In the doctor-patient encounter, dialogue has been conceived theoretically as a form of inter-personal relating, with certain intrinsic demands and aims, through which the patient's experience of illness gets transformed into a narrative.[66] In the language of the capability approach, a dialogue could be conceived as a discussion about various notions of health as a well-being, and a balancing of well-being achievement versus agency

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[63] Cathy Charles, Amiram Gafni and Tim Whelan, '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, 683.

[64] Emanuel and Emanuel (n 35) 2222. See also Franking G Miller and Alan Wertheimer, 'The Fair Transaction Model of Informed Consent: An Alternative to Autonomous Authorization' (2011) 21 Kennedy Institute of Ethics Journal 201; Brock (n 59).

[65] Emanuel and Emanuel (n 35) 2222.

[66] Richard M Zaner, 'Medicine and Dialogue' (1990) 15 The Journal of Medicine and Philosophy 303. See also H Abramovitch and E Schwartz, 'Three Stages of Medical Dialogue' (1996) 17 Theoretical Medicine 175.

freedom. However, this notion of a doctor-patient dialogue has not been developed, and its contours remain vague.[67]

4.3.3.3 Judgments in the Deliberative Style

In *Montgomery*, Lord Kerr and Lord Reed JJSC conclude that 'the doctor's advisory role involves dialogue'.[68] From the engagement of 'dialogue', it could be inferred that their lordships endorse a deliberative style of decision-making, with its inherent value judgments. Earlier, in *Re T*, Lord Donaldson MR, too, had implied a deliberative style, by observing that a doctor 'can not only explore the scope of his decision with the patient, but can seek to persuade him to alter that decision'.[69] However, the Supreme Court does not expand on its notion of a notion of a 'dialogue', which has been interpreted variably by lower courts. [70]

Emanuel and Emanuel acknowledge that the deliberative style is open to charges of moral perfectionism and curtailment of value pluralism. Nonetheless, the Supreme Court does not exclude the deliberative style; to the contrary, as discussed above, some support for the deliberative style can be inferred from the *Montgomery* judgment. As such, some component of a deliberative style, with its inherent requirement for value judgments by the doctor, could be included in the hybrid style of decision-making that, in practice, constitutes SDM.

4.4 Decision-Making Capacity

The requirement to engage a patient in SDM, as a practice of the principle of respect for the patient's autonomy, raises the issue of whether the patient, in the first place, has the competence or capacity to participate in decision-making. Beauchamp and Childress explain that:

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[67] Camillia Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue and Autonomy* (Cambridge University Press 2017) has come to my attention only very recently as an important source on dialogue that I have not explored in this thesis, but requires close attention. See John Coggon, 'Mental Capacity in Relationship: Decision-Making, Dialogue, and Autonomy' (2018) 45 Journal of Law and Society 316.

[68] *Montgomery UKSC* (n 46) [90].

[69] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA) (n 75) 114C. It is not clear whether the Master of the Rolls considered that persuasion was obligatory or optional. Subsequently, in *Attwell v McPartlin* [2004] EWHC 829 (QB) 10, Playford J deemed that there was no legal duty for a doctor to persuade a patient to change her irrational decision: 'There is no scope for a duty to "push"…'

[70] For examples, *Hassell v Hillingdon Hospitals NHS Foundation Trust* [2018] EWHC 164 (QB) [67] (Dingemans J); *Britten v Tayside Health Board* 2016 GWD 37-668 (Sheriff Court) [24] (Sheriff Collins QC).

> Law, medicine, and, to some extent, philosophy presume a context in which the characteristics of the competent person are also the properties possessed by the autonomous person. Although autonomy and competence differ in meaning (autonomy meaning self-governance; competence meaning the ability to perform a range of tasks), the criteria of the autonomous person and of the competent person are strikingly similar.[71]

Theoretically, a person's decisions or choices can reflect a spectrum of autonomy: from being highly autonomous to satisfying some only minimal conception of autonomy. However, for practical purposes, a cut-off point, or threshold, is required to classify a decision as either autonomous or non-autonomous, and formal tests of capacity become required to supply and identify this threshold.[72] As observed by Beauchamp and Childress, 'Competence or capacity judgments in health care serve a gatekeeping role by distinguishing persons whose decisions should be solicited or accepted from persons whose decisions should not be solicited or accepted'.[73]

The bioethical position on capacity is similar to that adopted in case law. For instance, Arden LJ has held that mental 'capacity is an important issue because it determines whether an individual will in law have autonomy over decision-making'.[74] Earlier, Lord Donaldson MR had explained that '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 which can be rebutted'.[75] Moreover, the rebuttal of the presumption of capacity is not a general assessment of the person's mental condition, but it is specific to the decision at hand. As set out by Lord Donaldson MR:

> What matters is that the doctors should consider whether at that time he (the patient) 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 capacity required.[76]

The common law has subsequently been codified in the Mental Capacity Act 2005 (MCA 2005), which retains the fundamental premise of case law that all adult patients are presumed to have capacity until proved otherwise. The MCA

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[71] Beauchamp and Childress 116.

[72] Ibid 105.

[73] Ibid 114. See also James F Childress, 'The Place of Autonomy in Bioethics' (1990) 20 Hastings Center Report 12.

[74] *Bailey v Warren* [2006] EWCA Civ 51, [2006] CP Rep 26 [105].

[75] *Re T (Adult: Refusal of Treatment)* (n 69) 112H.

[76] Ibid 113B. Parentheses added.

2005 stipulates that the presumption of capacity in relation to any decision can be rebutted only 'if at the material time he (the patient) is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.[77] The Act requires that the doctor must 'so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate',[78] in the decision-making. If the patient continues to lack capacity, even after reasonably practicable help, then attention shifts to decision-making by the doctor, and others, in the best interests of that patient. Best interests have been explored in detail by other authors.[79] I will not expand on best interests here, because, as clarified earlier (1.3), my project focuses on patients who retain decision-making capacity.

The MCA 2005's test for the rebuttal of capacity has two stages. The first stage is the 'diagnostic test', which involves the determination that the person has an impairment or disturbance of the mind or brain. In other words, the person's inability to make a decision is not to be attributed to simply any reason, but specifically to impairment of the mind or brain. The second stage is the 'functional test', which involves the determination that the impairment of the mind or brain renders the person unable to make the decision for herself.[80] The MCA 2005 clarifies that 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'.[81] Rather, in order to establish that the person is unable to make a decision, it has to be ascertained that the person 'is unable—(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate the decision (whether by talking, using sign language or any other means'.[82]

The MCA 2005 enshrines the binary, or threshold, view of capacity that emerges in bioethics and case law: either a person has capacity or she does

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[77] Mental Capacity Act 2005 Part 1, s 2(1). Parentheses added.

[78] Ibid Part 1, s 4(4).

[79] Richard Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law' (2014) 22 Medical Law Review 459; Helen J Taylor, 'What are 'Best Interests'? A Critical Evaluation of 'Best Interests' Decision-Making in Clinical Practice' (2016) 24 Medical Law Review 176; Mary Donnelly, 'Best Interests in the Mental Capacity Act: Time to say Goodbye?' (2016) 24 Medical Law Review 318; John Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (2016) 24 Medical Law Review 396.

[80] *A Local Authority v TZ (by his litigation friend, the Official Solicitor)* [2013] EWHC 2322 (COP), [2013] All ER (D) 144 (Oct) [17] (Baker J).

[81] Mental Capacity Act 2005, Part 1 s 1(4).

[82] Ibid, Part 1 s 3(1).

not have capacity.[83] The MCA 2005 does not seem to accommodate the fact that, in reality, people will be situated along a wide spectrum of decision-making capacities, and that binary categories cannot be uniformly representative of their populations.[84] As pointed out by Lord Donaldson MR, 'It may not be the simple case of the patient having no capacity…'.[85]

Moreover, by relying on impairment or disturbance of the mind or brain, the MCA 2005 seems to overlook feminist challenges to personal autonomy (3.6). The MCA 2005 does not seem to consider that the web of social influences and relationships in which people are embedded might distort their decision-making capacity even in the absence of a formal diagnosis of impairment of the mind.[86] Instead, the MCA 2005 would appear to advance a predominantly 'structural procedural' notion of autonomy (3.6.3.1.1). The idea of autonomy in the MCA 2005 does not include consideration of 'historical' influences on a person's preference-formation (3.6.3.1.2); also, through the explicit directive to not base assessments of capacity on whether the person's decision was 'unwise', the MCA excludes substantive notions of autonomy (3.6.3.2).

Some judges have recognised the rigidity of the MCA 2005-framework, and they have responded to it by conceptualizing a 'vulnerable' person, and by asserting that the inherent jurisdiction of superior courts survives this Act. Munby J described a vulnerable person as:

> [S]omeone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity.[87]

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[83] See Jonathan Herring and Jesse Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act' (2015) 35 Legal Studies 698; Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (n 79); Beverley A Clough, 'New Legal Landscapes: (Re)Constructing the Boundaries of Mental Capacity Law' (2018) 26 Medical Law Review 246.

[84] Although, Catriona Mackenzie and Wendy Rogers, 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act' (2013) 9 International Journal of Law in Context 37 argue that the MCA 2005's accompanying Code of Practice does take a wider view.

[85] *Re T (Adult: Refusal of Treatment)* (n 69) 113B.

[86] See Natalie F Banner, 'Can Procedural and Substantive Elements of Decision-Making be Reconciled in Assessments of Mental Capacity?' (2013) 9 International Journal of Law in Context 71.

[87] *Re SA (Vulnerable Adult With Capacity: Marriage)* [2005] EWHC 2942 (Fam), [2006] 1 FLR 867 [82]. Munby J's characterization of a vulnerable person is approved in *A*

Munby J then asserted that the inherent jurisdiction of the High Court provided a ‘flexible remedy’ that was ‘adaptable to ensure the protection of a person who is under a disability’.[88] He explains that it was this inherent jurisdiction that had been exercised in earlier cases pertaining to patients without mental capacity; and Munby J extends the inherent jurisdiction to vulnerable persons, who might not have any disorder of the mind, yet were significantly disadvantaged in decision-making because of their personal limitations or social situations.[89]

Subsequently, the Court of Appeal has clarified that the MCA 2005 does not remove the inherent jurisdiction of superior courts; and McFarlane LJ explains that this jurisdiction ‘is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity’.[90] Thus, through the idea of vulnerability,[91] senior judges have attempted to move assessments of, and responses to, variable expressions of autonomy and decision-making capacity beyond the binary confines of the MCA 2005 (although, as I will discuss later, the ‘reasonable person’ that emerges from case law is largely the autonomous agent of the rational choice theory rather than a vulnerable being; 7.4, 9.3).

The MCA 2005 makes it obligatory for doctors to assess the capacity of patients in relation to every decision; and to invoke best interests decision-making if the patient is found to lack capacity. In practice, very few patients are judged to lack capacity, with formal triggering of best interests assessment.[92] Yet, even if a

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Local Authority and others v DL [2012] EWCA Civ 253, [2012] 3 All ER 1064. Notably, Munby J, and other judges, have deliberately kept the idea of vulnerability as a broad one, and they have declined to provide a definition; instead, Munby J emphasises that the idea is ‘descriptive, not definitive; indicative rather than prescriptive’.

[88] *Re SA (Vulnerable Adult With Capacity: Marriage)* [41] (n 87), quoting Butler-Sloss P in *Re Local Authority (Inquiry: Restraint on Publication)* [2003] EWHC 2746 (Fam), [2004], Fam 96 [96]. Munby J traces the ‘rediscovery’ of the inherent jurisdiction to *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL), where Lord Donaldson MR describes the common law as ‘the great safety net’ (13D).

[89] For discussion, see Michael C Dunn, Isabel CH Clare and Anthony J Holland, ‘To Empower or to Protect? Constructing the ‘Vulnerable Adult’ in English Law and Public Policy’ (2008) 28 Legal Studies 234; A Szerletics, *Vulnerable Adults and the Inherent Jurisdiction of the High Court* (Essex Autonomy Project, 2011).

[90] *A Local Authority and others v DL* [54] (n 87).

[91] The recognition of vulnerability chimes with feminist theory through the acceptance that human beings are dependent upon, and embedded within, various social relationships and influences throughout their life-course. See Martha Albertson Fineman, ‘Vulnerability and Inevitable Inequality’ (2017) 4 Oslo Law Review 133.

[92] See Vanessa Raymont and others, ‘Prevalence of Mental Incapacity in Medical Inpatients and Associated Risk Factors: Cross-Sectional Study’ (2004) 364 The Lancet 1421; Laura L Sessums, Hannah Zembrzuska and Jeffrey L Jackson, ‘Does This Patient Have Medical Decision-Making Capacity?’ (2011) 306 The Journal of the American Medical Association 420. See also Rosemary A

patient retains capacity, the common law recognises her vulnerability, as an existential reality, and attempts its accommodation. It can be argued that this strand of common law places an additional obligation on doctors, over and above the obligations of the MCA 2005.[93] This common law obligation would require doctors to make some judgments about the patient's vulnerability, and to then adjust their styles of decision-making (the 'SDM hybrid' that I discussed in the previous section) accordingly. For example, an informative style-predominant hybrid of SDM might be judged as most suitable for a patient who is 'a highly educated man of experience',[94] but not for others. In this way, assessments of capacity link closely with judgments that are required of doctors in decision-making about treatment.

Yet, the retention of formal capacity demarcates a legal space in which the patient is free to make certain choices without any restriction; that is, a space in which there is a certain, absolute priority of the patient's agency freedom, regardless of the doctor's assessment of her vulnerability. This space of absolute priority to agency freedom is subsequent to the doctor's judgments about capacity and vulnerability, and the corresponding style of decision-making. In the language of the capability approach, it is the space in which a patient can effectively exercise her agency freedom, after her agency freedom has been balanced with her well-being achievement in providing her with an opportunity to achieve treatment. I will elaborate on this absolute priority to agency freedom, and the resulting tension with well-being achievement, in later chapters (6.4.1; 8.2.1; 9.3.2).

4.5 Conclusion

Decision-making in partnership between the doctor and patient, as a practice of consent, involves the twin notions of EBM and SDM. In this chapter, I have discussed that both notions require the doctor to exercise certain value judgments. I have earlier proposed the engagement of the capability approach as a normative framework for making judgments in consent, and that the doctor's obligation to obtain consent can be reconceptualised as an obligation to provide the patient with a fair capability to achieve treatment (2.5). Thus, the capability approach supplies a normative device for making fair judgments about EBM and SDM.

Humphreys, Robert Lepper and Timothy R J Nicholson, 'When and How to Treat Patients Who Refuse Treatment' (2014) 348 The British Medical Journal g2043.

[93] See Emma Cave, 'Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships, and Risk' (2017) 25 Medical Law Review 527.

[94] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL) 895C (Lord Diplock).

In Chapter 2, I explained that the capability to achieve treatment has two aspects: the process aspect, which deals with the range of available treatments; and the opportunity aspect, which deals with the real, effective possibilities for the patient to accept or reject available treatments (2.5). In Chapter 3, I constructed a four-layered of model of respect for autonomy (3.7.2), and I argued that each layer can be construed as a domain of one or the other aspect of the capability to achieve treatment (3.8). From the perspective of decision-making, EBM corresponds to the process aspect of the capability, which is the first or basal domain: the range of available treatments. On the other hand, SDM corresponds to the opportunity aspect that is covered by the second, third and fourth domains. Decision-making capacity intertwines with SDM in the opportunity aspect, because patients will have different levels of capacity and SDM will have to be adjusted accordingly. Yet, if a patient retains formal capacity, then there are certain choices or decisions over which the patient has unrestricted sovereignty, regardless of the doctor’s judgments. The fourth domain of the capability to achieve treatment is concerned specifically with this space of unrestricted freedom of choice for the patient.

I discussed in Chapter 2 that fair judgments pertaining to the process aspect (EBM) of the capability to achieve treatment require the engagement of a theory of justice other than the capability approach (2.3.4). On the other hand, for the opportunity aspect (SDM), the capability approach is sufficient and it relies on public reason for making fair judgments. I will deal with public reason, and with the additional theory of justice for making EBM-related judgments, in the next chapter.

Chapter 5

Public Reason

5.1 Introduction

The idea of public reason is central to the capability approach (2.3.4). In relying on public reason for evaluative assessments within the capabilities framework, Amartya Sen echoes John Rawls, who declared that only public reason could supply justifications for a pluralistic society.[1] Rawls argues that once the fact of pluralism in a society is accepted, it follows that a conception of justice that is based on a restricted view cannot be engaged, as all people will not have reason to accept this view. The essential idea of public reason is that matters of justice are settled by appeal to values that everyone in society, regardless of their comprehensive or ideological views (for example, religion), has reason to endorse. Thus, public reason provides a platform on which matters of basic justice can be settled by appeal to a set of common values.

Although Sen insists on public reason, he does not explicate his idea of public reason. As pointed by Ingrid Robeyns, 'In Sen's case, it is not at all clear how these processes of public reasoning and democracy are going to take place…'.[2] As such, in the present thesis, I will follow Rawls's theory of public reason for applying the normative framework of the capability approach to consent for medical treatment. Rawls's account of public reason is acclaimed widely as the pre-eminent philosophical model of public reason.[3] Apart from recognising its philosophical strengths, I follow Rawls's approach to public reason because, as discussed earlier (2.3), Sen has drawn heavily on Rawls's theory of justice in developing the capability approach. The use of Rawls's account of public reason lends internal consistency to my project. Yet, Sen's ideas of public reason differ from Rawls in some important ways,[4] which I will discuss in the

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[1] John Rawls, *Political Liberalism* (first published 1993, Columbia University Press 2005) 222.

[2] Ingrid Robeyns, 'The Capability Approach: A Theoretical Survey' (2005) 6 Journal of Human Development and Capabilities 93, 106.

[3] See Onora O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (Cambridge University Press 2015) 59. Important, alternative theories of public reason are set out by Jurgen Habermas, 'Reconciliation Through the Public Use of Reason: Remarks on John Rawls's Political Liberalism' (1995) 92 Journal of Philosophy 109; Gerald Gaus, *The Order of Public Reason: A Theory of Freedom and Morality in a Diverse and Bounded World* (Cambridge University Press 2010).

[4] See Erin I Kelly, 'Public Reason as a Collective Capability' (2012) 43 Rutgers Law Journal 295.

course of this chapter and in later chapters; and these differences expose tensions between Sen's approach and applications of justice that follow Rawls's views.

My aim, in this chapter, is to set out Rawls's theory of public reason, and to explain how public reason applies to an individual's capability to achieve medical treatment. This chapter is divided into the following sections. In section 2, I provide an overview of Rawls's theory of public reason, and I introduce two important dimensions of public reason: the constituency and the structure of reasoning. In section 3, I deal with the constituency: the ideal audience of public reason, which Rawls terms as a reasonable person. I will discuss Rawls's philosophical ideal of a reasonable person, and Sen's emphasis on the 'position' of this reasonable person. In section 4, I discuss the structure of public reason: the way of reasoning that should be employed by decision-makers in justifying their judgments to a reasonable person. In section 5, I compare public reason with private reason; an important distinction that arises subsequently in doctrinal analysis. In section 6, I discuss the application of public reason to judgments about the opportunities that should be provided to patients by medical professionals. In addition, I draw in procedural justice for the identification of available medical treatments. Section 7 is the conclusion to this chapter.

5.2 John Rawls's Theory of Public Reason

The idea of public reason as the central facet of a liberal society rose to prominence in Rawls's *Political Liberalism*.[5] Rawls starts with the assumption that any liberal society is, inevitably and inherently, ideologically pluralistic: it will be composed of diverse persons, who will continue to have irreconcilable and intractable differences on matters of value and the good life.[6] Rawls address the problem of how such people, with conflicting belief-systems, principles, and desires, can live together harmoniously to form a stable and well-ordered society. He argues that, for the establishment and the continuing existence of a

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[5] Rawls (n 1). The emphasis on public reason in *Political Liberalism* was a marked shift from John Rawls, *A Theory of Justice* (first published 1971, Harvard University Press 1999). Onora O'Neill, 'Constructivism in Rawls and Kant' in Samuel Freeman (ed), *The Cambridge Companion to Rawls* (Cambridge University Press 2003) discusses that this shift reflects Rawls's strategy to address certain argumentative weaknesses in his earlier theory.

[6] Rawls, *Political Liberalism* (n 1) Lecture 1: Fundamental Ideas.

well-ordered liberal society, agreement has to be reached on important social issues; such agreement is obtained by public reason.[7]

Rawls sets out a two-stage strategy for public reason: in the first stage, public reason is employed to generate a set of principles of justice; then, in the second stage, public reason serves to interpret these principles.[8] For the first stage, Rawls proposes the device of the 'original position': a primordial condition of society, in which the negotiating parties are shrouded from the belief-systems (which Rawls terms as 'comprehensive doctrines') of the citizens whom they represent by a 'veil of ignorance'.[9] Here, the negotiating parties have available only the 'background culture' of that society, and they employ 'reflective equilibrium' to settle on guiding principles. In the second stage, these principles of justice, which have been generated in the first stage, are interpreted by public reason.[10]

By this two-stage method, Rawls separates the issues on which there is basic agreement—the principles of justice that have been generated in the first stage—from those issues to which pluralism applies, in the second stage.[11] The principles of justice underpin the discussions in the second stage. These principles, themselves, cannot be renegotiated in the second stage; it is only the interpretation of these principles that is now open to debate. Jonathan Quong explains that the second stage represents the 'site' of public reason, where decision-makers, such as judges and legislators, have to be able to justify their judgments or proposals to the public.[12] Thus, as explained by Jürgen Habermas, Rawls distinguishes between the public as authors of law versus the public as subjects of the law.[13]

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[7] Ibid 214 does not claim that agreement has to obtained on all issues; agreement by public reasoning is limited to important social issues, that is, to 'constitutional essentials' and 'matters of basic justice'. Kelly explains that Rawls adopted such a 'narrow' scope because he realised that his conception of public reason was morally demanding, since it required people to subordinate their comprehensive commitments to a political conception of justice. In contrast, Amartya Sen, *The Idea of Justice* (first published 2009, Penguin Books 2010) ch 15 implicitly espouses a 'broad' scope, where public reason encompasses a wide range of problems. For arguments in support of a broad scope, see Jonathan Quong, 'The Scope of Public Reason' (2004) 52 Political Studies 233; Jonathan Quong, *Liberalism Without Perfection* (Oxford University Press 2011) 274.

[8] See Habermas (n 3).

[9] Rawls, *Political Liberalism* (n 1) 223; John Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (Harvard University Press 1999) 144.

[10] See Chapter 2 (n 8) for the two principles of justice that emerge from the first stage of public reason in Rawls's theory.

[11] See Andrew Lister, 'Public Reason and Reciprocity' (2017) 25 Journal of Political Philosophy 155.

[12] Quong, *Liberalism Without Perfection* (n 7) ch 9.

[13] Habermas (n 3).

The interpretation of the principles of justice in the second stage demarcates two important dimensions of public reason: a conception of the way of reasoning; and a conception of the public to whom the resulting decisions have to be justified.[14] Quong labels the way of reasoning as the ‘structure’ of public reason, and he terms the public as the ‘constituency’ of public reason.[15] He explains that the structure refers to the manner of construction of an argument, such that its premises can logically vindicate the conclusion. The structure links closely with the constituency. The constituency is the ideal audience of reasoning: a conception of how people ought to behave in order to participate in public reason, and not simply how they may or can behave.

Rawls termed the constituency as a reasonable person, and he explained that:

> [B]eing reasonable is not an epistemological idea (though it has epistemological elements). Rather, it’s part of a political ideal of democratic citizenship that includes the idea of public reason. The content of this ideal includes what free and equal citizens as reasonable can require of each other with respect to their reasonable comprehensive views.[16]

A widely accepted view is that the idealization of a reasonable person is a normative exercise, which is to be conducted by philosophical analysis, both moral and political, and not by actual deliberation amongst people.[17] Thus, being ‘reasonable’ refers to the theoretically-required, and not actual, characteristics of the people to whom the interpretation of the principles of justice has to be justified. In other words, the characterisation of the constituency deals with the elaboration of the features that the public ought to possess in order to qualify as the justificatory audience for public reasoning.[18] The implication is that some decisions about a particular issue can rightly be imposed on a diverse set of people, who have fundamental disagreements on that issue, if these decisions are justified by appeal to arguments that those persons, at some level of idealization, ought to accept on the basis of their membership of a society.[19]

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[14] Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (n 9) 133. See also O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) 141.

[15] Quong, *Liberalism Without Perfection* (n 7) ch 9.

[16] Rawls, *Political Liberalism* (n 1) 62.

[17] See Charles Lamore, ‘Public Reason’ in Samuel Freeman (ed), *The Cambridge Companion to Rawls* (Cambridge University Press 2003); Kevin Vallier, ‘Public Reason is Not Self-Defeating’ (2016) 53 American Philosophical Quarterly 349.

[18] Quong, *Liberalism Without Perfection* (n 7) 259.

[19] For objections, that a highly idealised constituency can become excessively sectarian, see Micah Schwartzman, ‘Religion, Equality, and Public Reason’ (2014)

5.3 The Constituency of Public Reason: A Reasonable Person

In this section I will, first, discuss Rawls's ideal of a reasonable person; then, I will deal with Sen's views on the 'position' of a person in conceptualizing her reasonability.

5.3.1 John Rawls's Ideal of a Reasonable Person

Rawls's ideal of a reasonable person involves three characteristics: rationality, reciprocity and the acceptance of 'burdens of judgment'.[20]

5.3.1.1 Rationality

Rawls considers that a reasonable person is fundamentally rational, and he sets out a particular conception of rationality. According to Rawls, a rational person is one who can form and pursue her own views of a good life: she has the powers of deliberation and judgment to identify and assign priority to her own interests or ends, and to then choose effective means towards these ends.[21] Rawls acknowledges that conceptions of a good life may vary widely amongst people. Hence, the assumption of rationality does not necessarily provide any insight to the ends that a person may desire to pursue; the assumption is only that a person will have certain ends and that she will pursue these ends intelligently.[22] Rawls clarifies that a rational person is not merely self-interested or selfish: her interest is not always in benefits to herself, and she may be driven by benefit to others; regardless, the means that she adopts

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94 Boston University Law Review 1321; Cathrine Holst and Anders Molander, 'Jürgen Habermas on Public Reason and Religion: Do Religious Citizens Suffer an Asymmetrical Cognitive Burden, and Should they be Compensated?' (2015) 18 Critical Review of International Social and Political Philosophy 547; Kevin Vallier, 'On Jonathan Quong's Sectarian Political Liberalism' (2017) 11 Criminal Law and Philosophy 175; Cillian McBride, 'Religion, Respect and Public Reason' (2017) 17 Ethnicities 205.

[20] Rawls, *Political Liberalism* (n 1) 49. Ibid 82 adds further two features: self-respect and normal moral psychology. Self-respect is predicated on the assumption that reasonable people are normal and fully functioning over their entire lifetime (illness is excluded). I had referred earlier (2.2) to this assumption in Rawls work. Ibid 86 discusses normal moral psychology very briefly, and this aspect of a reasonable person has not attracted commentary.

[21] Ibid 48, 176. Rawls's idea of rationality is, essentially, that of the rational choice theory (4.3.2.2). There is a strong Kantian influence in Rawls's work. Rawls's ideal of a reasonable person aligns with O'Neill's conception of an autonomous person (3.2.3).

[22] See Gillian K Hadfield and Stephen Macedo, 'Rational Reasonableness: Toward a Positive Theory of Public Reason' (2012) 6 The Law and Ethics of Human Rights 7.

are directed to the efficient attainment of the chosen end, without any other consideration.[23]

Rawls's reasonable person is not characterised merely by rationality; rather, rationality is the initially-defining aspect of her personality. He explains that, by her rational aspect, a person conceives her own claims on society. The move from rationality to reasonability then requires the person to assess the strength of her own claims by consideration to the claims of other members of society.[24] Rawls discusses that the rational aspect of a person links to her idea of good, whereas the reasonable aspect relates to her idea of justice. He explains that 'it is by the reasonable that we enter the pubic world of others and stand ready to propose, or to accept, as the case may be, fair terms of cooperation with them'.[25] In this way, Rawls holds that the rational aspect and the reasonable aspect of a person work in tandem, because 'Merely reasonable agents would have no ends of their own they wanted to advance by fair cooperation; merely rational agents lack a sense of justice and fail to recognise the independent validity of the claims of others'.[26]

This move, from being a simply rational person to a reasonable person, requires two additional characteristics, over and above rationality: reciprocity and acceptance of the burdens of judgment.

5.3.1.2 Reciprocity

Rawls explains that reasonable persons 'are willing to govern their conduct by a principle from which they and others can reason in common; and reasonable people take into account the consequences of their actions on others' well-being'.[27] In this way, Rawls idealises that, in order to be reasonable, a rational person will interact with her fellow citizens in certain way, and he terms this way of interaction as 'reciprocity'. Rawls discusses that the idea that underpins his concept of reciprocity lies somewhere between altruism and mutual advantage. He explains that 'Reasonable persons are not moved by the general good as such but desire for its own sake a social world in which they, as free and equal, can co-operate with others on terms all can accept'.[28]

Commentators have interpreted Rawls's idea of reciprocity variously: as a quest by reasonable persons to secure justice amongst free and equal persons;[29] or,

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[23] Rawls, *Political Liberalism* (n 1) 48.
[24] Ibid 52.
[25] Ibid 53.
[26] Ibid 52.
[27] Ibid 49 fn 1.
[28] Ibid 50.
[29] Hadfield and Macedo (n 22) 19.

as a desire to cooperate with others on terms that all persons can accept.[30] Also, Rawls's requirements of reciprocity have generated considerable debate. Rawls proposes that reasonable persons display reciprocity by abiding to 'fair terms of co-operation'[31] that are proposed to them, provided that they are 'given the reassurance that others will likewise do so'.[32] Since fairness, itself, depends on the ideal of a reasonable person, it can be argued that making the conception of reciprocity contingent upon 'fair terms' results in the self-defeat of public reason.[33] Further, the 'reassurance' condition within reciprocity can make the ideal unstable, because compliance then becomes dependent on the actual or predicted actions of others.[34] As such, the exact demands that reciprocity makes, in order for a rational person to be considered as reasonable, are not entirely clear.

5.3.1.3 Burdens of Judgment

A second requirement in the move from rationality to reasonability is the reasonable person's willingness to recognize that some disagreements may persist despite reciprocity, and to accept such disagreements, and their consequences, as part of public reason. Rawls terms the sources of such disagreement amongst reasonable persons as the 'burdens of judgment'.[35] He explains that the burdens of judgment are 'the many hazards involved in the correct and conscientious exercise of our powers of reason and judgment in the ordinary course of political life'.[36] His purpose for introducing burdens of judgments is to overcome the problem of different beliefs of 'truth'; because, otherwise, there can be descent into futile battles of assertion and counter-assertion.[37]

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[30] Quong, *Liberalism Without Perfection* (n 7) 39.

[31] Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (n 9) 136.

[32] Rawls, *Political Liberalism* (n 1) 16, 49; Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (n 9) 136.

[33] See Sameer Bajaj, 'Self-Defeat and the Foundations of Public Reason' (2017) 174 Philosophical Studies 3133.

[34] Brian Kogelmann and Stephen G W Stich, 'When Public Reason Fails Us: Convergence Discourse as Blood Oath' (2016) 110 American Political Science Review 717 discuss the 'prisoner's dilemma' and the 'assurance game' as the problems of reassurance. See also John Thrasher and Kevin Vallier, 'The Fragility of Consensus: Public Reason, Diversity and Stability' (2015) 23 European Journal of Philosophy 933.

[35] Rawls, Political Liberalism (n 1) 56.

[36] Ibid 56. By 'political', Rawls refers to basic social institutions upon which claims can be made by all citizens.

[37] Ibid 216. Ibid 224 makes the recognition of burdens of judgment conditional upon appeal to only 'presently accepted' and 'non-controversial facts'. Habermas (n 3) 124 considers that Rawls introduced the predicate 'reasonable' as complementary to truth. For objections, that abstention from considerations of truth is a paradox of

Rawls sets out six burdens of judgment.[38] A unifying features of these burdens of judgment is the introduction of various uncertainties into decisions that are made by public reason. Thus, the acceptance of burden of judgments is tantamount to an acknowledgement by reasonable persons that decisions by public reason cannot provide certainty or perfection; some uncertainties and imperfections have to be accepted as part of public reason. It has been suggested that burdens of judgment are viewed as providing a 'benefit of doubt role' to decisions or proposals that originate in public reason.[39]

5.3.2 Amartya Sen's Focus on the Position of a Reasonable Person

Rawls's ideal of a reasonable person is abstract and impartial: it applies to any, and all, persons in a pluralistic, liberal society. Rawls does not regard that a person's unique circumstances should influence the ideal of her reasonability. In contrast, Sen shifts the focus to a person's 'position' in considering her reasonability. Similar to Rawls, Sen starts his idealization of a reasonable person with the contemplation of rationality. But, as discussed earlier (4.3.2.3), Sen rejects the assumptions of the rational choice theory. Instead, he views that rationality is 'primarily a matter of basing our choices—explicitly or by implication—on reasons that we can reflectively sustain if we subject them to critical scrutiny'.[40]

Sen points out that there may be systematic departures from rationality in actual choices, because rationality may be 'bounded', such that:

> [P]eople may not, in all cases, look for fully rational choices because of their inability to be sufficiently focused, or adequately steadfast or

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public reason, see Elizabeth H Wolgast, 'The Demands of Public Reason' (1994) 94 Columbia Law Review 1936; Joshua Cohen, 'Truth and Public Reason' (2009) 37 Philosophy & Public Affairs 2. See also Chad Flanders, 'The Mutability of Public Reason' (2012) 25 Ratio Juris 180.

[38] Rawls, *Political Liberalism* (n 1) 56 lists the following burdens of judgment: scientific evidence can be conflicting and complex and thus hard to assess; there may be agreement about the kinds of relevant considerations, yet disagreement about weightage; many concepts are vague and subject to hard cases, and this indeterminacy relies on judgments and interpretation within some range where reasonable persons may differ; the ways of assessing evidence and weighing moral and political values is shaped by an individual's total life experience, and in modern society total experiences will be sufficiently disparate for judgments to diverge; often there are different kinds of normative considerations of different force on both sides of an issue and it is difficult to make an overall assessment; and any system of social institutions is limited in the values it can admit so that some selection must be made from the full range of moral and political values that can be realized.

[39] Karin Jønch-Clausen and Klemens Kappel, 'Scientific Facts and Methods in Public Reason' (2016) 22 Res Publica 117, 120.

[40] Sen (n 7) 179.

> alert enough in seeking and using information that would be needed for complete pursuit of rationality.[41]

Sen discusses that there may be inability to adequately understand the nature of the uncertainty that is involved in decisions; or, there may be ‘weakness of the will’ or ‘insufficient self-command’, such that a person may know fairly well what she ought to do rationally, and yet she may fail to act in that way.[42] Consequently, a person’s actual decision or choice might be quite different from what would be rational, in theory, for her to choose.

Notwithstanding his divergence from Rawls about the nature of rationality, Sen agrees that a reasonable person is intrinsically rational, and that reasonability imposes additional demands, over and above rationality. Sen explains that:

> While survival under one’s own engaged scrutiny is central to the idea of rationality, taking serious note of critical scrutiny from the perspective of others must have a significant role in taking us beyond rationality into reasonable behaviour in relation to other people.[43]

But, unlike Rawls, Sen does not attempt to set out an ideal of a reasonable person that could, then, characterise any or all reasonable persons. Instead, the focus of Sen’s discussion of reasonability is on the unique characteristics, or the ‘position’, of the individual person. He explains that a reasonable person’s consideration of the perspective, or proposals, of others would depend on her own position, because ‘What we can see is not independent of where we stand in relation to what we are trying to see’.[44] He describes the accounting of a person’s position, in the assessment of her reasonability, as ‘positional objectivity’. Essentially, in Sen’s argument, the pertinent issue is the way that an ‘object’, say, a decision or a proposal, looks from a specified position of observation, and the way it would look to anyone with the same positional features.[45]

Yet, Sen does not rely simply on positional objectivity for the assessment of reasonability. He cautions that positional objectivity may be associated with illusions that can be very hard to dislodge; in such cases, positionality can

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[41] Ibid 176.
[42] Ibid 183.
[43] Ibid, 197.
[44] Ibid 156.
[45] Ibid 156 explains that positional objectivity is person-invariant: the variance in objectivity is relative to the position of the person but independent of her identity as an individual. Ibid 160 illustrates that non-positional and positional objectivity represent views from ‘nowhere’ versus from a ‘delineated somewhere’, respectively. For discussion, see Elizabeth Anderson, ‘Sen, Ethics, and Democracy’ (2003) 9 Feminist Economics 239.

mislead and misinform rather than illuminate a situation.[46] In order to satisfy both the demands and limitations of positional objectivity, Sen proposes the device of ‘open impartiality’.[47] He explains that ‘closed impartiality’ takes account of the views of only the ‘focal group’, that is, the persons to whom proposals are made. As such, closed impartiality admits preconceptions and biases that are common to the focal group. In contrast, open impartiality invites judgments from others, outside the focal group, and, so, overcomes parochialism.[48] Stated differently, open impartiality allows that ‘the relevant judgments can come from outside the perspectives of the negotiating protagonists; indeed, they can come from, as Smith puts it, any “fair and impartial spectator”’.[49]

Sen goes on to explain that, in open impartiality, opinions may be relevant either because these come from one of the parties who is directly involved (‘membership entitlement’) in the situation; or, because these opinions include perspectives that bring important insights into the evaluation, regardless of whether or not these opinions belong to a directly involved party (‘enlightenment relevance’).[50] Thus, the assessment of the position of a reasonable person by open impartiality does not hinge exclusively on the views of that person or of others in her situation; in addition, it invites the views of others.

5.4 The Structure of Public Reason

Quong terms the strategy of the justificatory argument by which decision-makers vindicate their proposals to their constituency as the ‘structure’ of public reason (O’Neill phrases it differently as the ‘norms of reasoning’[51]). He points out that Rawls proposed an ‘overlapping consensus’ as the structure of public reason; and he discusses that consensus, as a justificatory strategy, can be either ‘strong’ or ‘weak’.[52]

In a strong consensus, the audience of the reasoning will, or actually does, accept the justificatory argument. Hence, a strong consensus requires some form of public discourse to ascertain that the same argumentative premises are

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[46] Sen (n 7) 163. Sen gives the example of self-perceptions of health: limited education can lead to low recognition of disease by self-assessment, despite high incidence of medically-detected illness and mortality; consequently, self-perceptions cannot be taken always as accurate reflections of health.

[47] Ibid 45.

[48] Ibid 123.

[49] Ibid 131. ‘Smith’ refers to Adam Smith, *The Theory of Moral Sentiments* (1759).

[50] Ibid 131.

[51] O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) ch 3.

[52] Quong, *Liberalism Without Perfection* (n 12) 262.

actually accepted by all members of the audience. On the other hand, a weak consensus requires that some arguments should be acceptable to the constituency of public reason, regardless of whether, or not, real persons actually accept these arguments.[53] Thus, a weak consensus becomes co-extensive with the idealization of a reasonable person. If the stringency of the idealization is increased, that is, the normative demands on reasonability are raised, then it becomes increasingly possible to justify decisions by philosophical analysis only, without recourse to any actual discussion with the audience. Conversely, the less idealized the account of the constituency, the more the structure will depend on strong consensus, that is, some actual process of deliberation and agreement with the audience in the real world, and less on abstract argumentation.

There is debate about Rawls's concept of an 'overlapping consensus'. His discussions do not make it explicit whether an overlapping consensus is a strong or a weak variant of consensus.[54] Rawls's ambiguity on this issue was pointed out by Habermas,[55] and it has been discussed extensively by O'Neill in her critique of *Political Liberalism*.[56] O'Neill terms Quong's strong variant as a 'motivational' formulation of consensus, and the weak variant as a 'modal' formulation. From a Kantian perspective, she campaigns for a modal formulation on the grounds that 'Too great an emphasis on others' willingness to converge on standards or principles appears paradoxically to render this conception of reasonableness hostage to what we might otherwise see as others' unreasonableness'.[57]

O'Neill discerns that a modal formulation emerges in Rawls's later work; that is, Rawls's overlapping consensus involve proposals that others can accept—proposals that are acceptable—irrespective of whether or not others do, in fact, accept these proposals.[58] In her view, Rawlsian public reason is not discursive,

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[53] Ibid 262.

[54] Rawls, *Political Liberalism* (n 1) 139 discusses 'overlapping consensus'. Later, ibid 247; Rawls, *The Law of Peoples with The Idea of Public Reason Revisited* (n 9) 143 introduces 'exclusive' and 'inclusive' views of consensus, with some variation. Finally, John Rawls, *Justice as Fairness. A Restatement* (Erin Kelly ed, Harvard University Press 2001) 90 fn 12 modifies consensus to a 'wide' view of public reason.

[55] Habermas (n 8) 122.

[56] Onora O'Neill, 'Political Liberalism and Public Reason: A Critical Notice of John Rawls, *Political Liberalism*' (1997) 106 Philosophical Review 411. See also Alessandro Ferrara, 'Public Reason and the Normativity of the Reasonable' (2004) 30 Philosophy & Social Criticism 579.

[57] O'Neill, 'Political Liberalism and Public Reason: A Critical Notice of John Rawls, *Political Liberalism*' (n 56) 415.

[58] O'Neill admits that a modal conception invokes the objection of insincerity in public reason: people may behave in ways that they do not really endorse. See Micah

that is, it does not require actual, inclusive participation in debate; instead, it is a commitment that does not preclude the possibility of reasoning with others, and it does not rely on principles that others cannot follow. Justifications are not supplied by discourse, but through respecting norms that enable proposals to be intelligible and accessible to all.[59]

In contrast to Rawls, Sen places considerable emphasis on public debate and discourse. Nonetheless, Sen's justificatory strategy involves weak or modal consensus, too. He explains that 'thinking about right and wrong is, at the most basic level, thinking about what could be justified to others on grounds that they, if appropriately motivated, could not reasonably reject'.[60] Thus, Sen relies on non-rejectability—what others could not reasonably reject—as distinct from acceptability; whereas, O'Neill appears to use acceptability and non-rejectability interchangeably.[61] Sen explains that non-rejectability introduces more rigorous demands than acceptability; because, even when a person does have a clearly-favoured (acceptable) priority, it may be difficult for her to entirely reject well-defended reasons to which others give importance.[62] Hence, in Sen's view, arguments should turn on non-rejectability by reasonable persons, and not simply on acceptability.

5.5 Public Reason versus Private Reason

Rawls distinguishes public reason from non-public reason.[63] For public reason, the justificatory audience—the constituency—is the abstract and all-inclusive reasonable person who represents society in general. In contrast, non-public reasoning is directed to restricted constituencies, for example, religious groups, ethnic communities or professional associations. As such, there are potentially infinite non-public justificatory audiences for proposals pertaining to any one issue. Since reasoning is the provision of justification to a certain audience, if

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Schwartzman, 'The Sincerity of Public Reason' (2011) 19 Journal of Political Philosophy 375. See also Michael Baur, 'On Actualizing Public Reason' (2004) 72 Fordham Law Review 2153.

[59] O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) 144. See also Micah Lott, 'Restraint on Reasons and Reasons for Restraint: A Problem for Rawls' Ideal of Public Reason' (2006) 87 Pacific Philosophical Quarterly 75.

[60] Sen (n 7) 197, 201. In proposing non-rejectability, Sen relies on Thomas M Scanlon, 'Contractualism and Utilitarianism' in Amartya Sen and Bernard Williams (eds), *Utilitarianism and Beyond* (Cambridge University Press 1982) 110; Thomas M Scanlon, *What We Owe to Each Other* (Harvard University Press 1998) 199.

[61] Although, O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) 144 comes close to Scanlon's formulation: 'Public reasoning, on Kant's account, may not rely on principles that others cannot follow'.

[62] Sen (n 7) 201.

[63] Rawls, *Political Liberalism* (n 1) 220.

there is a plurality of audiences to whom various justificatory strategies might appeal, then there can be conflicting reasoning that leads to different outcomes for the same issue. In contrast, public reasoning appeals to a single constituency—a reasonable person—that accepts the same justifications, leading to a unitary outcome. As explained by Rawls, ‘there are many non-public reasons and but one public reason’.[64]

Rawls clarifies that the reasoning of restricted constituencies is public with respect to their members, but it is non-public by reference to society. He does not claim that non-public reason is defective in itself; but, it does not offer fundamental justifications to members of society other than the audience to whom these justifications are directed. O’Neill terms non-public reason as private reason, by reference to Immanuel Kant, and she expands on the similarities and differences between public and private reason.[65] She explains that an important difference is that private uses of reason often assume but do not justify authority; for example, magisterial assertions made by individuals in commanding positions, without any persuasive argument in support of the assertion. Whilst such assertions may be appealing to some, these can seem pointless or unreasoned to other audiences. In contrast, public uses of reason do not assume authority without justification and could, in principle, be followed by an unrestricted audience.

O’Neill concedes that private reason, too, can be ‘lawlike’,[66] that is, it can provide a structure and discipline that is necessary in order for others to follow it. Yet, simply lawlike reasoning can retreat to the norms of particular groups, and it would not supply sufficient justification to a wider audience. She explains that reasoning that relies on provincial and variable norms is ‘heteronomous’,[67] that is, subject to a law or standard that is external to itself, and does not count as fully public use of reason; although, such reasoning is public with respect to its restricted audience. On the other hand, according to O’Neill, public reasoning is autonomous reasoning: it is reasoning that can provide laws for all.[68]

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[64] Ibid 220.

[65] O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) ch 8. Although, Rawls, *Political Liberalism* (n 1) 220 fn disagrees with this terminology: ‘there is no such thing as private reason’.

[66] O'Neill, *Constructing Authorities: Reason, Politics and Interpretation in Kant's Philosophy* (n 3) 145.

[67] Ibid 148.

[68] I have discussed earlier (3.2.3) that O’Neill holds that principled autonomy is, essentially, self-legislation according to public reason.

5.6 Public Reason and Procedural Justice for Deciding a Person's Capability to Achieve Medical Treatment

In this thesis, I have proposed that consent should be reconceptualised as a patient's capability to achieve medical treatment. With this reconceptualization, doctors are obliged to provide patients with fair capabilities to achieve treatment; and, for a capability to be fair, underlying evaluative assessments, or value judgments, should be made by public reason. Accordingly, doctors become required to employ public reason in making the judgments that are inherent to obtaining consent from patients (1.2).

Doctors will engage with public reason at the second stage—the 'site'—of public reason in the Rawlsian paradigm that I have explained earlier (5.2).[69] Here, as envisaged by Jonathan Montgomery, doctors will play a 'quasi-judicial role, applying normative principles to cases that come before them in an attempt to adjudicate a dispute over the proper conclusions to be drawn on the application of the law to the facts presented'.[70] However, in employing public reason within the framework of the capability approach the rigid separation of two stages—the generation of principles of justice in the first stage, followed by the interpretation of these principles in the second stage—that is a feature of Rawls's theory is not maintained. I have discussed in Chapter 2 that, unlike Rawls, Sen does not set out any principles of justice (2.3.3). Instead, Sen proposes that justice revolves around attention to an aggregate of four perspectives of a person's capability: her agency freedom, agency achievement, well-being freedom and wellbeing-achievement (2.3.2). In this scheme, the conception of well-being and the construction of the aggregate are, themselves, contingent upon public reason; and it could be charged that Sen's idea of public reason is circular and self-defeating.[71] The counter-argument is that such use of public reason is representative of Sen's intention to avoid a rigid theory and, instead, to allow flexibility and pragmatism through a 'range of actual and imperfect social arrangements'.[72] The debate is not yet concluded.

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[69] Other authors, who have applied Rawls's theory to healthcare decision-making, have situated doctors similarly. See Jake Greenblum and Ryan K Hubbard, 'Responding to Religious Patients: Why Physicians Have No Business Doing Theology' (2019) 45 Journal of Medical Ethics 705; Zoë Fritz and Caitríona Cox, 'Conflicting Demands on a Modern Healthcare Service: Can Rawlsian Justice Provide a Guiding Philosophy for the NHS and other Socialized Health Services?' (2019) 33 Bioethics 609.

[70] Jonathan Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square' (2015) 23 Medical Law Review 200, 206.

[71] See Bajaj (n 33).

[72] Kelly (n 7) 306.

I have discussed in Chapter 2 that the capability approach is an underspecified theory of justice, and the flexibility of principles that I pointed out in the preceding paragraph reflects this ‘partial’ nature of the capability approach. Moreover, the practical applicability of the capability approach is limited to the opportunity aspect of a capability; another theory of justice has to be engaged for the process aspect (2.3.3). In case of the capability to achieve treatment, the process aspect pertains to the availability of treatments; and the opportunity aspect refers to the effective possibilities for a patient to use these treatments to achieve her valued health goals. In Chapter 4, I explained that the practical tool for the opportunity aspect of the capability to achieve treatment is shared decision-making (SDM) (4.3). Accordingly, the normative framework of the capability approach, with its reliance on public reason, is practically applicable to judgments about SDM.

I discussed in Chapter 4 that a doctor has to make various judgments in conceiving the hybrid model of SDM that he will employ in supplying the patient with a fair opportunity to achieve treatment. Public reason is central to the doctor’s use of the capability framework as the normative device for making these judgments. The engagement of public reason requires the doctor to conceptualize a certain ideal of a reasonable person and the structure of reasoning that would be acceptable to this reasonable person. For instance, is this reasonable person entirely rational (as idealized by Rawls); or, is her rationality prey to various confounding factors, as pointed out by Sen? How does she balance her agency freedom with her well-being achievement? To what extent does she demonstrate reciprocity and accept the burdens of judgement? What is the structure of reasoning that the doctor ought to employ: can it be entirely non-discursive (weak consensus); or, does actual discussion (strong consensus) have to be included? I will deal with these specifications in Part II of this thesis.

On the other hand, public reason does not apply to the process aspect of the capability to achieve treatment; which corresponds to the basis of decision-making (4.2). I have discussed earlier that another theory of justice has to be engaged for the process aspect (2.3.4). In the present thesis, I rely on Norman Daniels for this additional theory for the process aspect.[73] Daniels points out that financial resource is a critical consideration in making treatments available to individuals. He argues that resources for healthcare, however large and well-

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[73] Daniels’s arguments are set out in a series of his work, spanning from Norman Daniels, ‘Rationing Fairly: Programmatic Considerations’ (1993) 7 Bioethics 224 to Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008).

managed, will inescapably be finite. Consequently, in making judgments about the availability of treatments to individuals, egalitarian principles of justice will face various types of conflicts with utilitarianism. Daniels sets out these egalitarian-utilitarian dilemmas as the ‘priorities problem’, the ‘aggregation problem’ and the ‘best outcomes, fair chances problem’.[74] In addressing these problems, an egalitarian healthcare system cannot simply jettison utilitarian considerations.[75] Instead, resource-allocation or rationing strategies have to be employed, and these will result in setting limits on the treatments that can be made available to individuals.

In focussing on the problems that will always arise, at some level, from the unavoidable scarcity of financial resources, Daniels does not imply that resource is the only determinant of the availability of medical treatments. He does not suggest, for example, that wealthy people should have the availability of any treatment that they desire simply because they are able to pay for this treatment. Rather, Daniels’s argument for setting limits on available treatments implicitly advances a paradigm in which resource-based limits are set in the context of medical determinants of treatments that might be otherwise available to a person. Daniels does not expand on these medical determinants. Nonetheless, for the overall paradigm of determining available treatments, Daniels argues for ‘a fair *process* for setting limits’ that relies on Rawls’s idea of pure procedural justice.[76] Rawls had explained that in pure procedural justice there is no independent criterion for the correct result; instead, there is an agreed, correct or fair procedure such that the outcome of this procedure is likewise correct or fair, whatever it is, provided that the procedure has been properly followed.[77] Accordingly, Daniels proposes that the identification of medical treatments that are available to a person depends upon the correct execution of an accepted procedure. Once a procedure has been accepted as fair, then the range of treatments that is yielded by this procedure can be taken as fair. I will address this fair procedure in Chapter 8.

5.7 Conclusion

The judgments that a doctor is obliged to make in providing a patient with a fair capability to achieve treatment are guided by two separate theories of justice: the capability approach, which includes public reason, for the opportunity

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[74] Daniels, *Just Health: Meeting Health Needs Fairly* 106-107.

[75] For instance, Department of Health, *The Handbook to the NHS Constitution for England* (2015) 18 acknowledges that ‘The NHS seeks to maximise benefits with the constraints of limited resources’.

[76] Daniels, *Just Health: Meeting Health Needs Fairly* (n 73) 110. Author’s emphases.

[77] Rawls, *A Theory of Justice* (n 5) 75; Rawls, *Political Liberalism* (n 1) 184.

aspect of the capability; and procedural justice for the process aspect. In practical terms, then, what are the obligations that are imposed on doctors by public reason and by procedural justice? Rawls explains that his theory of public reason provides a structure, into which the specifications of a reasonable person, and of the ways of reasoning that would be acceptable to this reasonable person, require to imported as per the society in which public reason is being employed.[78] These specifications, which Rawls terms as ‘guidelines of inquiry’,[79] are likely to be different for different societies. Rawls proposes that, for a democratic state with judicial review, the specifications of public reason are to be found in the judgments of the supreme court of that state; because the supreme court is the branch of government that serves as the exemplar of public reason.[80] Rawls declares: ‘To check whether we are following public reason we might ask: how would our argument strike us presented in the form of a supreme court opinion? Reasonable? Outrageous?’[81] In this way, theory leads to legal doctrine, which is the subject of Part II of this thesis.

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[78] Rawls, *Political Liberalism* (n 1) 139.
[79] Ibid 253.
[80] Ibid 231.
[81] Ibid 254.

Chapter 6

From *Bolam* to *Pearce*: Consent as an Opportunity to Reject the Proposed Medical Treatment

6.1 Introduction

This is the start of Part II of my thesis, which comprises doctrinal research. To briefly recapitulate Part I, I started with the observation that a doctor requires to make judgments in obtaining consent for treatment from patients. These judgments are essentially evaluative, that is, they involve values. Relying simply on the principle of respect for autonomy is not sufficient for making these value judgments. Instead, I have proposed Amartya Sen's capability approach as a normative framework that can enable doctors to make these judgments. In other words, the capability approach can be used as a tool to tell doctors how they ought to make these judgments. Using the capabilities framework, I have reconceptualised the doctor's obligation to obtain consent as an obligation for the doctor to provide the patient with a fair capability to achieve treatment.

The capability to achieve treatment has two aspects: a process aspect and an opportunity aspect. Practically, doctors are expected to supply this capability to patients through decision-making about treatment. In the decision-making paradigm, the process aspect corresponds to the basis—the identification of treatments that should be made available to the patient; and the opportunity aspect corresponds to the style—the way of evaluating the available treatments in order to reach a treatment-decision. For the process aspect, doctors ought to rely on an agreed procedure; whereas, for the opportunity aspect, doctors ought to employ public reason within the capabilities framework. Thus, the use of the capability approach to tell doctors what they ought to do engages two different ideas of justice: procedural justice and public reason. According to John Rawls, the specifications of these ideas for any nation are to be found in the relevant judgments of its supreme court.

In *Montgomery,*[1] the UK's Supreme Court assessed the capability to achieve treatment that was provided by Dr Dina McLellan, an obstetrician, to Nadine Montgomery, a pregnant woman. I will use the framework of the capability approach to analyse the judgment of the Supreme Court in *Montgomery's* case, in order to find this Court's ideas of public reason and procedural justice. In its

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[1] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

judgment, the Supreme Court cites the cases of *Bolam*[2], *Sidaway*[3] and *Pearce*[4] as landmarks in the development of British law on consent for medical treatment. Considering the common law tradition, it would be difficult to appreciate the Supreme Court's reasoning in *Montgomery* without reference to these preceding cases. Therefore, in the present chapter, I will analyse these precedents in the framework of the capabilities approach, to show the evolution of ideas of justice that culminated with the Supreme Court's decision in *Montgomery.*

This chapter is organised in the following sections. In section 2, I commence my analysis of the common law with the *Bolam* case. Here, the achievement of the doctor's idea of the patient's well-being was prioritised over the patient's agency freedom, and the patient's opportunity to accept or reject the proposed treatment was decided by the private reason of the doctor. In section 3, I discuss the USA case of *Canterbury*.[5] Although my focus is on British law, analysis of *Canterbury* is necessary because it occupied an important part of the debate in *Sidaway*. In *Canterbury,* the prioritization of well-being achievement and agency freedom was reversed, and the patient's opportunity was decided by public reason. In section 4, I deal with the speeches in the House of Lords in *Sidaway*. I will discuss that Lord Scarman and Lord Templeman adopted the *Canterbury* paradigm; yet, their attention remained focussed on the patient's opportunity to reject the treatment that was proposed by the doctor. In section 5, I argue that *Pearce* highlighted the process aspect of the capability to achieve treatment, and that it was this dimension of *Pearce* that was perceived by the Supreme Court as an advance on *Sidaway*. Section 6 is the conclusion to this chapter.

6.2 Bolam v Friern Hospital Management Committee

John Hector Bolam was a 'voluntary patient' at the Friern Hospital, for the treatment of depression.[6] He was administered electro-convulsive therapy

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[2] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB).

[3] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL).

[4] *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167 (CA).

[5] *Canterbury v Spence* (1972) 464 F2d 772 Court of Appeals, District of Columbia.

[6] *Bolam* (n 2) is not the first English case on consent for medical treatment. It was preceded shortly by *Hatcher v Black* The Times, June 28 June 29 July 1 July 2 1954 (QB), which dealt with consent for a thyroidectomy operation, and was presided by Denning LJ (sitting as a High Court judge). Earlier English cases on consent for treatment are *Cull v Butler* 1 The British Medical Journal 1195, 1932 (KB) and *Slater v Baker & Stapleton* [1767] 2 Wils KB 359 (KB), which Ruth R Faden and Tom L Beauchamp, *A History and Theory of Informed Consent* (Oxford University Press 1986) 116 identify as the earliest recorded case on consent in common law jurisdictions.

(ECT), during which he suffered bilateral acetabular fractures. Bolam had not been warned about the risk of fractures. He alleged that the treating psychiatrist had failed in his duty in two respects: in not disclosing the risk of fractures from ECT, and in not conducting ECT properly.

For the present thesis, I will restrict attention to the first part of Bolam's claim—the disclosure of risk—which pertains to his consent for ECT. It can be assumed that Bolam's end, or health-goal, was to be relieved of depression, and that he had sought the assistance of the medical profession in order to obtain the means towards this end; the psychiatrists proposed and administered ECT as these means. In seeking Bolam's consent for ECT, the psychiatrists were obliged to provide Bolam with a fair capability to achieve treatment for depression. Was it, then, fair that the psychiatrists did not disclose the risk of fractures from ECT to Bolam? It can be inferred that the jury considered that injustice had not been done to Bolam because it dismissed his claim; in other words, it was fair that he had not been informed of the risk of fractures. I will analyse the directions that were given by presiding judge, McNair J, to the jury, in order to infer the ideas of justice in this case.

6.2.1 Prioritization of Well-Being over Agency

Dr Bastarrechea, the chief psychiatrist at Friern Hospital, admitted that there was a risk of fractures from ECT, and that this risk had not been disclosed to Bolam.[7] Dr Bastarrechea's justification for excluding this information from Bolam was that:

> [T]here was some danger in emphasizing to a patient who ex hypothesi is mentally ill, any dangers which in the doctor's view were minimal, because, if he does so, the patient may deprive himself by refusal of a remedy which is the only available hopeful remedy open to him.[8]

Dr Bastarrechea conceded that this justification was contingent upon the absence of inquiries from the patient: 'I agree that a man should be given the opportunity of deciding whether to take the risk, but I leave him to put the question'.[9] Two expert witnesses in psychiatry endorsed Dr Bastarrechea's justification, which was accepted tacitly by McNair J in his charge to the jury:

> [Y]ou may well think that when dealing with a mentally sick man and having a strong belief that his only hope of cure is E.C.T. treatment, a

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[7] *Bolam* (n 2) 589.
[8] Ibid 589.
[9] Ibid 590.

> doctor cannot be criticized if he does not stress the dangers which he believes to be minimal involved in that treatment.[10]

The justificatory argument comprises the following premises: first, risk-disclosure might have led Bolam to decline ECT;[11] and secondly, Bolam should not decline ECT, that is, he should not reject these means to be cured of depression, simply because he was averse to the risk of fractures.[12] In concluding that the omission to inform Bolam of the risk of fractures was fair ('a doctor cannot be criticised'), McNair J implicitly prioritised the achievement of the medical profession's normative conception of well-being (restoration of health through the treatment of depression with ECT) over Bolam's possibly conflicting agency goals to reject this treatment and to continue in a state of depression.

I have discussed the roles of agency and well-being in conceptualizing health, and health-related goals, in Chapter 2 (2.4). Agency represents a person's own, or internal, goals for her own health. On the other hand, well-being represents the goals that others, importantly doctors, may conceive for the person, on normative grounds. In this framework, it could be viewed that Bolam's agency was to be cured of depression provided that this cure did not entail the possibility of fractures; whereas, Bolam's well-being was conceived to be the cure of depression, regardless of the possibility of fractures.[13] If the achievement of well-being was prioritized over agency freedom, then Bolam's opportunity to achieve ECT would not include information about fractures (because this information might lead him to reject ECT). Accordingly, it would be considered as fair to not inform Bolam of the possibility of fractures from ECT; and it can be inferred that this is the view of justice that was taken by McNair J.

McNair J's view of justice seems consistent with normative expectations around health and illness in the mid-20th century. In an influential, contemporaneous sociological account, Talcott Parsons has explained that people assumed a

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[10] Ibid 590.

[11] Ibid 590: 'giving the full details may drive a patient away'.

[12] Ibid 590: 'it would be a great mistake if they refused to benefit from the treatment because of fear'.

[13] For simplicity, I am assuming that ECT was 100% effective for curing depression, and that the only conflict between agency and well-being was the possibility of fractures. In reality, the effectiveness of ECT is considerably less than 100%; and there are possible harms other than fractures. Thus, the 'risk' of ECT, or of any treatment, becomes a multifactorial notion, which I discuss later in 7.2. In order to maintain the distinctiveness of this multi-factorial idea of a risk, I have attempted, as far as is possible, to separate the idea of the possibility of a discrete harm from the 'risk' of a treatment.

‘sick role’ during ill-health or disease.[14] In the social contract tradition, all citizens had certain responsibilities; but, when sick, they could legitimately claim exemption from these responsibilities and make claims on the goodwill and resources of others. At the same time, there was a demand for the sick person to co-operate with physicians in order to get well and to resume her social obligations. Kenneth Veitch discusses that such a civic obligation—to follow the doctor’s advice—was conceived to be an integral part of citizenship during the founding of the UK’s welfare state and the NHS in the 1940s.[15] On this sociological background, Dr Bastarrechea could presume to administer the treatment that he considered would restore Bolam’s health, and Bolam was expected to acquiesce to this treatment.

Yet, in prioritizing the achievement of Bolam’s well-being (well-being achievement) over the freedom of his agency (agency freedom), McNair J did not entirely ignore agency freedom. I have discussed previously that, in Sen’s view, the prioritization of well-being versus agency does not have to be complete; it can be incomplete or partial, in that one consideration is privileged over another, but the other is not totally excluded (2.3.1). The scheme of prioritization in McNair J’s judgment was, in this sense, partial. Although well-being achievement was prioritised over agency freedom, it was not held that the patient should not be allowed any agency freedom, whatsoever, to reject the proposed treatment. There was no argument in the *Bolam* case that the patient should be coerced to have the treatment that was proposed by the doctor (any such views had been debunked in earlier cases[16]). Implicitly, it was accepted that the patient’s agency might conflict with her well-being that was the target of the proposed treatment, and that her agency might lead her to reject the proposed treatment. The crux of the debate was about the opportunity for agency-led health goals that should be provided to the patient by the doctor.

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[14] See Matthias Zick Varul, ‘Talcott Parsons, the Sick Role and Chronic Illness’ (2010) 16 Body & Society 72; Alison Pilnick and Robert Dingwall, ‘On the Remarkable Persistence of Asymmetry in Doctor/Patient Interaction: A Critical Review’ (2011) 72 Social Science and Medicine 1374.

[15] Kenneth Veitch, ‘Obligation and the Changing Nature of Publicly Funded Healthcare’ (2019) 27 Medical Law Review 267.

[16] In *Slater* (n 6) 862 the Lord Chief Justice had ruled that ‘indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation’. Later, in *Cull* (n 6) 1196 the Lord Chief Justice summed up that ‘a point had not been reached at which a surgeon, considering that sterilization was advisable in particular case, could proceed to carry it out against the desire of the patient’.

6.2.2 The Opportunity Aspect of the Capability to Achieve Treatment

McNair J considered whether Dr Bastarrechea had provided Bolam with a fair opportunity to reject ECT. McNair J formulated this question in terms of whether, or not, Dr Bastarrechea had been negligent in omitting to disclose information about the possibility of fractures from ECT.[17] By implication, Bolam was viewed as a rational being, at least to some extent, who might have health goals of his own; if he was informed about the harms that might result from a treatment, then he would be able to decide about whether, or not, to accept this treatment as the means towards his goals. Thus, Bolam's opportunity to use the proposed treatment as the means towards his agency-led health-goals was conceptualized in terms of information that had been disclosed to him about the potential harms of this treatment, so that he could reject the treatment. The debate was, then, essentially about the scope of the information that should have been disclosed, in the context of the underlying ranking of well-being achievement above agency freedom.

McNair J explained to the jury that 'negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do'.[18] He clarified that, in case of a doctor, the test of being 'reasonable' was 'the standard of the ordinary skilled man exercising and professing to have that

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[17] The claim in *Bolam* (n 2) was framed in negligence and not in battery or trespass. Subsequently, in *Chatterton v Gerson* [1981] 1 QB 432 (QB) 443A, Bristow J clarified that 'once the patient is informed 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'. Bristow J's stance was approved implicitly in *Sidaway HL* (n 3) 883E by Lord Scarman, who observed that it was 'deplorable' to base such litigation in assault or battery. Margaret Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 Legal Studies 169 discusses the English judiciary's reluctance to engage with trespass. Recently, an application to add a claim of trespass was rejected in *Border v Lewisham and Greenwich NHS Trust* [2015] EWCA Civ 8, [2015] Med LR 48 [26].

[18] *Bolam* (n 2) 586. In discussing the *Bolam* test, Lord Scarman, *Sidaway HL* (n 3) 885G, traces the 'root principles of common law negligence' to the dicta of Lord Atkins in *Donoghue v Stevenson* [1932] AC 562 (HL), which allowed an appeal that the manufacturers of a bottled drink were culpable for the presence of a dead snail in a bottle. Alasdair Maclean, 'Beyond Bolam and Bolitho' (2000) 5 Medical Law International 205 points out that McNair J's test closely follows an earlier dictum: that of Alderson B in *Blyth v The Company of Proprietors of the Birmingham Waterworks* (1856) 11 Ex 781 Court of Exchequer 1049. In reversing a jury's verdict that a waterworks company was negligent in permitting the escape of water from a fire-plug during unexpectedly severe winter conditions, Alderson B had declared that 'Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or something which a prudent and reasonable man would not do'.

special skill'.[19] In other words, the actions of a doctor should be judged to be reasonable if these actions were endorsed by his professional peers: 'he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'.[20] If Dr Bastarrechea had been reasonable, then he was not negligent; by extension, it was not unfair that he had omitted to disclose the risk of fractures.

By McNair J's formulation, the constituency—the reasonable audience—to whom Dr Bastarrechea was required to justify the scope of information-disclosure, for it to be considered as fair, was a body of his professional peers. McNair J's dicta were approved, about 25 years later, by the House of Lords in *Whitehouse*;[21] and, shortly thereafter, in *Maynard*.[22] In *Whitehouse*, Lord Edmund-Davies referred to McNair J's dicta—the *Bolam* test—as 'the true doctrine',[23] and he declared that 'If a surgeon fails to measure up to that standard in any respect ("clinical judgment" or otherwise), he has been negligent and should be so adjudged'.[24] In *Maynard*, Lord Scarman affirmed Lord Edmund-Davies's dictum as 'the nature of the duty that is owed by a doctor to his patient'.[25] Here, Lord Scarman explicitly articulates the premise that, in the *Bolam* test, the justificatory constituency for a doctor's reasoning was not the patient, but a body of the doctor's professional peers: 'it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper'.[26]

6.2.3 Private Reason

I have discussed earlier that if the reasons for an action are directed to, or can be grasped by, a restricted audience only, then the reasoning is private and not public (5.5). In *Bolam*, Dr Bastarrechea's reasons were to be assessed by an audience of his professional peers only. Accordingly, McNair J can be seen to have relied upon the private reason of medical professionals for deciding Bolam's opportunity to reject the proposed treatment. Once again, McNair J's

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[19] *Bolam* (n 2) 586. Lord Diplock, *Sidaway HL* (n 3) 892E, explains that 'The original rule can be traced to the maxim *spondet peritiam artis et imperitia culpae admuneratur*' (He is responsible for skill in his profession, and want of such skill is regarded as a fault). Similar tests have been stated in earlier USA judgments. See Allan H McCoid, 'A Reapprasial of Liability for Unauthorized Medical Treatment' (1956) 41 Minnesota Law Review 381, 382 fn 7.

[20] *Bolam* (n 2) 587.

[21] *Whitehouse v Jordan* [1981] 1 WLR 246 (HL).

[22] *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 (HL).

[23] *Whitehouse* (n 21) 258B.

[24] Ibid 258D.

[25] *Maynard* (n 22) 638A.

[26] Ibid 638F.

judgment seems consistent with contemporaneous sociological premises. In the mid-20th century there was a well-accepted sociological narrative that medicine was a social order-maintaining enterprise, where doctors were control-agents for the management of unmotivated social deviance.[27] This sociological discourse perceived political foundations for acceptance of the authority of medical professionals because of their intimate involvement, through their expertise, in the processes of normalization that are crucial to the reproduction of legitimate power in a liberal, democratic state.[28] As observed by Sir John Donaldson MR at *Sidaway's* appeal, the 'doctor's prime object…is to maintain and improve the patient's health'.[29] In this paradigm, doctors were expected to make decisions that limited the patient's opportunity to reject treatment in order to preserve and advance social integrity.

Notably, McNair J does not endorse arbitrary reasoning by medical professionals. He qualifies the justificatory constituency as 'reasonable' and 'responsible', and he cautions: 'that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion'.[30] It has been argued that McNair J intended his test to evaluate normative standards, that is, what doctors ought to do, and not what doctors actually do.[31] Later, in *Bolitho*, Lord Browne-Wilkinson emphasized the

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[27] See Pilnick and Dingwall (n 14). See also Jonathan Montgomery, 'Medicine, Accountability, and Professionalism' (1989) 16 Journal of Law and Society 319. Illness was seen as a 'deviance' from normative social responsibilities; in order for a person to establish that her deviance was 'unmotivated', that is, she was not malingering in order to be relieved of her social responsibilities, she was obliged not only to seek medical attention but also to follow the doctor's orders.

[28] Julia Evetts, 'The Sociological Analysis of Professionalism: Occupational Change in the Modern World' (2003) 18 International Sociology 395. See also Donald M Berwick, 'Politics and Health Care' (2018) 320 The Journal of the American Medical Association 1437.

[29] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1984] 1 QB 493 (CA) 511G. For discussion, see Michael A Jones, 'Doctor Knows Best' (1984) 100 Law Quarterly Review 355.

[30] *Bolam* (n 2) 587. McNair J's qualifications of his test are highlighted by Lord Woolf, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 Medical Law Review 1, in discussing the reasoning of the judiciary in relying on medical professionals' opinions.

[31] J L Montrose, 'Is Negligence an Ethical or a Sociological Concept?' (1958) 21 Modern Law Review 259 argues that negligence is a normative concept that relates to an idealized 'reasonable' doctor, and not simply to prevalent practice. Yet, as pointed out by Margaret Brazier and José Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8 Medical Law Review 85, prevalent-practice interpretations of the *Bolam* test have been dominant. Such prevalent-practice interpretations may be traced to Lord Scarman's instruction in *Maynard* (n 22) 639G that 'in the realm of diagnosis and treatment negligence is not established by preferring one responsible body of professional opinion to another'.

normative underpinning of the *Bolam* test by insisting that the justificatory audience had to be 'responsible, reasonable and respectable',[32] and that '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'.[33] From this viewpoint, McNair's J dicta were consistent with Onora O'Neill's proposition that private reason is not lawless: it, too, is 'lawlike', but for a restricted audience only (5.5).

I have explained earlier that there can be more than one non-public, or private, reason, as opposed to only one public reason, to resolve a particular issue; because, in private reasoning, different justificatory constituencies might accept different arguments (5.5). Correspondingly, McNair J's dicta accommodate differences in professional reasoning as legitimate. McNair J directed the jury to consider that a doctor had not failed to be reasonable 'merely because there is a body of opinion who would take a contrary view'.[34] Later, in *Maynard*, Lord Scarman approves this stance: 'Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment'.[35]

In *Bolam's* case, although one expert witness in psychiatry argued in favour of informing about the possibility of fractures, two other experts supported the exclusion of such information. Since Dr Bastarrechea's decision to withhold the information about the possibility of fractures satisfied the reasoning of the latter

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In *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) 241H, Lord Browne-Wilkinson infers a normative stance in Lord Scarman's dictum from the qualification 'responsible'. But, Lord Scarman, *Sidaway HL* (n 3) 881F, lends further to a prevalent-practice interpretation by explaining that, through the *Bolam* test, 'the law imposes the duty of care: but the standard of care is a matter of medical judgment'.

[32] *Bolitho* (n 31) 241H.

[33] Ibid 242A. The *Bolitho*-qualified *Bolam* test has been dubbed as 'New *Bolam'* by Harvey Teff, 'The Standard of Care in Medical Negligence: Moving on from Bolam?' (1988) 18 Oxford Journal of Legal Studies 473, 475; Maclean (n 18) 206. Yet, as pointed out by Lord Browne-Wilkinson, himself, a similar approach had been taken previously by Sachs LJ in *Hucks v Cole* [1993] 4 Med LR 393 (CA) 397. As such, the *Bolitho* qualification of the *Bolam* test was not really 'new'. For discussion, see Brazier and Miola (n 31) 98. See also Jonathan Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition' (2000) 53 Current Legal Problems 363, 374. Teff points out that Lord Browne-Wilkinson's reliance on a 'logical basis' provokes speculation that his focus was on deductive reasoning and internal consistency of an expert's argument rather than on reasonability. I will discuss a difficulty of relying on logic in Chapter 9 (9.2.2).

[34] *Bolam* (n 2) 587. McNair J applied the dictum of Lord President Clyde in *Hunter v Hanley* [1955] SLT 213, 217: 'In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge that others would have shown'.

[35] *Maynard* (n 22) 638H.

group of psychiatrists, he had not been negligent. By corollary, Dr Bastarrechea had provided Bolam with a fair opportunity to reject ECT, and injustice had not been done by not informing Bolam of the possibility of fractures. Accordingly, Bolam's claim was dismissed.

6.2.4 The Process Aspect of the Capability to Achieve Treatment

In *Bolam*, there was no argument that any treatment other than ECT, that is, treatment-options or alternatives to ECT, should have been made available. The claim focused on Bolam's opportunity to reject ECT. Implicitly, it was accepted that ECT was the single, proper treatment for Bolam; the only question, then, was whether he had been provided with a fair opportunity to decline ECT and, by default, to continue to suffer depression. Perhaps, in Bolam's case, this focus was practically unavoidable; because, in the 1950s, the medical profession had not yet devised any alternative to ECT for the treatment of severe depression. Yet, by the private reasoning that underpins McNair J's dicta, a doctor was entitled to offer only a single treatment that he favoured, even if alternatives did exist that would be chosen by other medical professionals. As observed later by Lord Scarman, the question of selection of medical treatment was 'classified as one of clinical judgment'.[36] Consent, as a matter for justice, was limited to considerations of the patient's opportunity to reject the treatment that had been selected by the doctor; and not to claim any alternatives to the proposed treatment.

6.2.5 Normative Framework of Consent

In *Bolam,* judgments about both the process aspect and the opportunity aspect of a patient's capability to achieve treatment were assigned to the private reason of the medical professional who was treating the patient. In other words, the capability to achieve treatment that was provided to a patient would be fair if the doctor could justify the treatment that he had selected, and the information that he had communicated to the patient, to a body of his professional peers.[37]

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[36] Ibid 638C.

[37] Over and above contemporaneous sociological premises, judges seem to have been concerned to protect the private reasoning of medical professionals in order to control malpractice litigation and the practice of defensive medicine. See *Hatcher v Black* (n 6) July 1 (Denning LJ); *Sidaway CA* (n 29) 523C (Browne-Wilkinson LJ); ibid 517C-D (Dunn LJ); *Sidaway HL* (n 3) 893B (Lord Diplock). Lord Scarman, too, recognised the 'danger of defensive medicine' but he deemed that 'courts are concerned with legal principles: if policy problems emerge, they are best left to the legislature'. Ibid 887C. The Supreme Court has taken a view similar to that of Lord Scarman. *Montgomery UKSC* (n 1) [93].

Clearly, the idea of justice in *Bolam* is quite different from that in the capability approach, which insists on public reasoning (5.6).[38]

6.3 Canterbury v Spence

The USA case of *Canterbury* figured prominently in the debate in the House of Lords in *Sidaway*, and the *Canterbury* propositions were adopted by Lord Scarman. Jerry Canterbury had suffered paraplegia following a laminectomy operation for the treatment of backache. The possibility of paraplegia (1-2%) following this operation was undisputed, but Canterbury had not been informed of this danger. As in *Bolam*, the surgeon, Dr Spence, appears to have prioritized Canterbury's well-being achievement over his agency freedom.[39] The justification from Dr Spence for not disclosing information about paraplegia was similar to that from Dr Bastarrechea in *Bolam*: if informed, Canterbury might have suffered psychological harm and he might have declined the operation, and that it was common surgical practice to not disclose this risk.[40]

A trial court had dismissed Canterbury's claim, and an appeal was made to District Court of Appeals of Columbia. In a judgment delivered by Robinson J, the Court of Appeals reversed the verdict of the lower court and ordered a re-trial by jury. It can be inferred that the idea of justice in *Canterbury* diverged from that in *Bolam*; and, in the sub-sections that follow, I will discuss the divergence.

6.3.1 Reversal of Priorities: Agency Trumps Well-Being

Robinson J traces the 'root premise' of his argument for reversing the lower court's judgment to a dictum of Cardozo J in *Schloendorff*.[41] Here, Mary Schloendorff had agreed for only 'examination under ether', and had expressly instructed that no operation should be undertaken; but, despite her protest, a 'tumour' was removed. In condemning the operation, Cardozo J had declared that 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body'.[42] In other words, every adult person was

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[38] As observed by Faden and Beauchamp (n 6) 59, 'the justification of practices of disclosure and consent-seeking were strictly governed by what we shall call a beneficence model rather than an autonomy model of the physician's responsibility for the patient'.

[39] Canterbury's health agency could be viewed as his goal to be cured of backache, provided that this cure did not involve the possibility of paraplegia; on the other hand, Dr Spence saw his well-being as the cure of backache regardless of the possibility of paraplegia.

[40] *Canterbury* (n 5) 778.

[41] Ibid [2], [3].

[42] *Schloendorff v Society of New York Hospital* (1914) 211NY125 Court of Appeals of New York 93.

entitled to a right of self-determination for medical treatment. Robinson J reasoned that a patient's right to self-determination could be 'effectively exercised only if the patient possesses enough information to enable an intelligent choice'.[43] Since the average patient would have little or no medical knowledge, the physician was obliged to disclose sufficient information about 'the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from a particular treatment and no treatment'.[44]

In the capabilities framework, a patient's right to 'determine what shall be done with his own body' can be viewed as his, or her, freedom to pursue her health agency, that is, her own goals of health, even if these goals conflict with the achievement of the normative health goals that a doctor may conceive as her well-being. By affirming Cardozo J's dictum, Robinson J prioritized a person's agency freedom over her well-being achievement. Robinson J then considered the patient's opportunities—what could be 'effectively exercised'—to use the proposed treatment to achieve her health agency, and he conceptualized this opportunity as 'enough information to enable an intelligent choice'. In discussing *Bolam*, I had pointed out that McNair J, too, had conceptualized a patient's opportunity to health agency in terms of information about the proposed treatment. However, in *Bolam*, the attention to information disclosure was in a context where the person's well-being achievement was prioritized over her agency freedom; whereas, in *Canterbury*, it was the reverse.

I have discussed earlier that, in *Bolam*, despite the emphasis on the well-being achievement, agency freedom was not rejected entirely. Conversely, in *Canterbury*, although agency freedom was prioritized over the well-being achievement, the latter was not ignored. Robinson J concedes that the doctor had a 'privilege not to disclose',[45] when the information itself posed a risk that the patient may 'become so ill or emotionally distraught as to foreclose a rational decision, or complicate or hinder treatment, or perhaps even pose psychological damage to the patient'.[46] In this way, Robinson J appears to reserve a place for the doctor's authority—his 'privilege'—as a social control agent (6.2.3) to attend to the patient's well-being achievement, in addition to her

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[43] *Canterbury* (n 5) [2], [3].

[44] Ibid fn 27.

[45] Ibid [26].

[46] Ibid [27]. The seminal articulation of this 'privilege' appears to be in *Natanson v Kline* (1960) 350 P2d 1093 Supreme Court of Kansas 406: 'There is probably a privilege, on therapeutic grounds, to withhold the specific diagnosis where the disclosure of cancer or some other dread disease would seriously jeopardize the recovery of an unstable, temperamental or severely depressed patient'.

agency freedom, in providing the patient with an opportunity to reject the proposed medical treatment.

It could be inferred that Robinson J apprehends the tension that arises from retaining a place for well-being achievement because he attempts to circumscribe this space. He cautions that ‘The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forgo therapy the physician feels the patient really needs’.[47] However, his stricture is weak because he has to concede that whether, or not, a physician had exercised this privilege appropriately was matter of ‘sound medical judgment’;[48] to be assessed, implicitly, by the private reason of medical professionals (the *Bolam* test). The concession is unavoidable because the therapeutic privilege, itself, admits the premises of the *Bolam* argument (whereas, in the *Bolam* paradigm, a therapeutic privilege does not arise because the justificatory basis of the privilege is incorporated within the doctor’s duty itself).

6.3.2 The Opportunity Aspect of the Capability to Achieve Treatment

With the reversal of priorities on agency freedom and well-being achievement, Robinson J rejected the idea of justice, which had been adopted in *Bolam*, that the scope of information that was disclosed was fair it had been determined by the private reason of the doctor. Robinson J remonstrated that ‘We do not agree that the patient’s cause of action is dependent upon the existence and non-performance of a relevant professional tradition’.[49] He conceded that the practice of a group of doctors was an appropriate ‘special standard’ to judge whether doctors had acted ‘as reasonable men possessing their medical talent presumably would’[50] (in other words, the *Bolam* test). But, he distinguished firmly that the scope of disclosure of information about a treatment ‘is ofttimes a non-medical judgment and, if so, is a decision outside the ambit of the special standard’.[51] Accordingly, there was ‘no basis for operation of the special medical standard where the physician’s activity does not bring his medical knowledge and skills peculiarly into play’.[52]

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[47] *Canterbury* [28], [29].

[48] Ibid [27].

[49] Ibid [13], [14].

[50] Ibid [16].

[51] Ibid [16].

[52] Ibid [16]. Robinson J’s dicta were approved in *Cobbs v Grant* (1972) 8 Cal 3d 229 Supreme Court of California 515. Notwithstanding, up to the early 1980s, the majority of American states continued to apply the ‘professional standard’ (equivalent to the *Bolam* test). See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health*

Having rejected the ‘special standard’, Robinson J ruled that the scope of the information that the doctor was obliged to provide to the patient was to be governed by the ‘general test’. The principle that underpinned this general test was ‘conduct which is reasonable under the circumstances’.[53] In *Bolam*, McNair J, too, had sought reasonable conduct by doctors; but, as I have pointed out earlier, McNair J’s assessment of reasonability relied on the justification of conduct to a body of the doctor’s peers. In contrast, Robinson J required that the conduct be justified to ‘the reasonable man who finds himself in the position of the patient’.[54]

Robinson J goes on to explain that, for the reasonable person in the position of the patient, the ‘scope of the physician’s communications to the patient, then, must be determined by the patient’s need, and that need is the information material to the decision’.[55] Robinson J then sets out the test of materiality—the assessment of what information is material, and what is not—as follows:

> 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.[56]

Accordingly, a patient would have been provided with a fair opportunity to exercise her right of self-determination if she had been informed about material risks of the proposed treatment. Notably, the emphasis is on information about the ‘risk’ of the proposed treatment. Robinson J does not explicate his idea of a risk. The implication is that a risk is the probability of harm from the proposed treatment, and the requirement is

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Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship. Volume One: Report (US Government Printing Office, 1982) 23 fn 30. A prominent judgment that rejects the *Canterbury* dicta is *Bly v Rhoads* (1976) 216 Va 645 Supreme Court of Virginia. For other judgments that declined to follow *Canterbury*, see Jay Katz, *The Silent World of Doctor and Patient* (first published 1984, The Johns Hopkins University Press 2002) 80. Notably, it would seem that at re-trial, *Canterbury*, itself, was decided in favour of Dr Spence (I could not find the re-trial judgment, so I have relied on Katz in making this assertion).

[53] *Canterbury* (n 5) [18], [19].

[54] Robinson J sets out his general test by reference to Jon R Waltz and Thomas W Scheuneman, ‘Informed Consent to Therapy’ (1969) 64 Northwestern University Law Review 628, 640.

[55] *Canterbury* (n 5) [20]. Waltz and Scheuneman (n 54) 637 explain that ‘materiality’ was ‘The traditional legal litmus for measuring the level of significance in decision-making’.

[56] *Canterbury* (n 5) [22]. Robinson J quotes from Waltz and Scheuneman (n 54) 640.

that the doctor must disclose all possible harms that would be material to a patient's decision about whether to accept or reject this treatment.

6.3.3 Public Reason

In *Bolam*, the justificatory constituency—the audience to whom the scope of the disclosed information had to be justified—was a group of responsible doctors. In contrast, in *Canterbury*, the constituency was a reasonable person in the patient's position. Thus, the *Canterbury* constituency was inclusive of considerable diversity, as opposed to that in *Bolam*, which was restricted to a group of doctors and excluded all others. The breadth of the constituency in Robinson J's dicta indicates public reason, as compared to the private reasoning of medical professionals that could be inferred from McNair J's dicta.

I discussed in Chapter 5 that public reason involves conceptions of a reasonable person and a certain structure of reasoning. The reasonable person that emerges from *Canterbury* is perfectly rational in the sense conceived by Rawls (5.3.1.1): she is presumed to have clear goals for her health; once she is provided with material information about the risks of the treatment, she will be able to decide whether to accept or reject the treatment. These are the premises of informed decision-making (4.3.2). The structure of Robinson J's reasoning—'what the physician knows or should know'—is a combination of strong and weak consensus (5.4). Weak consensus relies on what the doctor 'should' know, that is, what would be acceptable to a reasonable person. Strong consensus, on the other hand, would emerge from what the doctor actually knew would be accepted by the patient; for instance, risks about which the patient had actually inquired. Although the requirements of strong consensus have to be satisfied, Robinson J firmly rejects exclusive reliance on strong consensus; instead, the doctor was obliged primarily to disclose all information that would be acceptable to a reasonable person, regardless of any inquiry by the actual patient.[57]

6.3.4 The Process Aspect of the Capability to Achieve Treatment

Robinson J mentions the disclosure of information about 'the therapy alternatives open to him'[58] as part of the doctor's obligation in seeking the patient's consent. Accordingly, it would seem that Robinson J conceived that the doctor was obliged to inform the patient about all treatments that were available to her, in addition to the treatment that was proposed by the doctor.

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[57] *Canterbury* (n 5) fn 36. Later, in *Montgomery UKSC* (n 1) [58], the Supreme Court, too, is strident in rejecting exclusive reliance on a strong consensus.

[58] *Canterbury* (n 5) fn 27.

Yet, the focus of his judgment was on the patient's opportunity to reject the treatment that was proposed by the doctor. Implicitly, the counterfactual position was that Jerry Canterbury would have continued to bear his back pain after declining the laminectomy operation. There was no discussion about any alternative to laminectomy. Dr Spence's proposal of laminectomy as the only available treatment was not challenged. As in *Bolam*, it would appear that the available treatment remained to be decided by the private reason of the doctor.

6.3.5 Normative Framework of Consent

In *Canterbury*, as in *Bolam,* the process aspect of a patient's capability to achieve treatment was assigned to the private reason of the medical professional who was treating the patient. On the other hand, the normative paradigm in *Canterbury* clearly diverges from that in *Bolam* (6.2.5) in regard to the patient's opportunity to reject the treatment that was proposed by the doctor. In *Canterbury*, unlike *Bolam*, the patient's agency freedom was prioritized over her well-being achievement; although, tension persisted in the therapeutic privilege. The patient's opportunity was conceptualized in terms of information about the possible harms ('risks') of the proposed treatment; and judgments about the scope of disclosure of information were to be made by public reason, and not by the private reason of medical professionals.

6.4 Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital

In *Sidaway*, a judicial committee of the House of Lords debated the nature of a person's capability to achieve medical treatment. For 30 years, the common law on consent for medical treatment in the UK remained to be derived from the speeches in *Sidaway*. In this case, Mr Murray Falconer, a neurosurgeon, had performed revisional spinal surgery for backache on Mrs Amy Doris Sidaway. Post-operatively, Mrs Sidaway suffered paralysis, and she alleged that she had not been warned of this possibility. There was no testimony from Mr Falconer because he died prior to the trial; but, based on evidence of his customary practice, Skinner J determined that he had not disclosed the possibility of paralysis.[59] Expert witnesses in neurosurgery supported the omission of this disclosure; and, by application of the *Bolam* test, Skinner J dismissed the claim, declining to follow *Canterbury*.[60] The Court of Appeal did not allow Mrs

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[59] *Sidaway v Board of Governors of the Bethlem Royal Hospital and Maudsley Hospital* (QB, 19 February 1982).

[60] In addition to *Canterbury*, Skinner J was referred to the cases of *Hopp v Lepp* [1980] 2 SCR 192 Supreme Court of Canada and *Reibl v Hughes* [1980] 2 SCR 880

Sidaway's petition; essentially, each of the three lord justices upheld the *Bolam* test,[61] although with some noteworthy nuances to their reasoning. *Sidaway's* case then progressed to the House of Lords.

From the capabilities perspective, it could be viewed that Mrs Sidaway's health agency was to be cured of backache provided that this cure did not involve the possibility of paraplegia; on the other hand, Mr Falconer's view of her well-being would seem to have been cure of backache irrespective of the possibility of paraplegia. In *Montgomery*, the Supreme Court discerned a spectrum of three approaches, to Mrs Sidaway's capability to achieve treatment for backache, in the House of Lords: at one end, Lord Scarman and Lord Templeman; at the other end, Lord Diplock; and, in between, Lord Bridge, with whom Lord Keith agreed. The Supreme Court resoundingly approved Lord Scarman's judgment.[62] The Court deemed that Lord Templeman had 'arrived, by a different route, at an outcome not very different from that of Lord Scarman'.[63] The Court clearly rejected Lord Diplock's judgment, which was the subject of some parody.[64] The Court debated whether 'Lord Bridge might be thought to arrive at a position not far distant from that of Lord Scarman'.[65] But, it then concluded that there was 'uneasy compromise'[66] and 'inherent instability'[67] in Lord Bridge's qualification of the *Bolam* test; and his dicta, as part of the majority view in *Sidaway*, are criticised as 'unsatisfactory'.[68]

6.4.1 Lord Scarman and Lord Templeman

I discussed earlier that Lord Scarman had approved the *Bolam* test in *Maynard*, by reference to *Whitehouse* (6.2.2). In *Sidaway*, he distinguished that these

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Supreme Court of Canada that followed *Canterbury*. For commentary on Skinner J's demurral to follow *Reibl,* see Gerald B Robertson, 'Informed Consent: The Fate of Reibl v Hughes in England' (1993) 17 Legal Medical Quarterly 13.

[61] *Sidaway CA* (n 29) 512 (Sir John Donaldson MR); ibid 517 (Dunn LJ); ibid 522 (Browne-Wilkinson LJ).

[62] *Montgomery UKSC* (n 1) [87] (Lord Kerr and Lord Reed JJSC): 'The correct position, in relation to risks of injury involved in treatment, can now be seen to be substantially that adopted in Sidaway by Lord Scarman'.

[63] Ibid [56]. Lord Scarman had explicitly rejected the *Bolam* test for the assessment of consent; and, the Supreme Court concluded that Lord Templeman did so implicitly. Ibid [55].

[64] Ibid [42].

[65] Ibid [53]. Clark Hobson, 'No (,) More Bolam Please: Montgomery v Lanarkshire Health Board' (2016) 79 Modern Law Review 488 discusses that the Supreme Court's analysis of *Sidaway* is an attempt to portray a theme in the evolution of the common law.

[66] *Montgomery UKSC* (n 1) [60].

[67] Ibid [62].

[68] Ibid [86].

two, earlier decisions of the House of Lords pertained to diagnosis and treatment, respectively; whereas, *Sidaway's* case was about the advice that was owed by a doctor to the patient.[69] He explained that a doctor owed a duty of care to his patient,[70] and that 'advice'—'information as to risk and the options of alternative treatment'[71]—formed a part of this duty that was separate from diagnosis and treatment. Lord Scarman retained his approval of the *Bolam* test for the scrutiny of diagnosis and treatment;[72] but, he rejected this test for assessing advice.[73]

Lord Scarman acknowledges that a 'doctor's concern is with health and the relief of pain. These are the medical objectives'.[74] In other words, Lord Scarman concedes that the goal of the medical profession is to promote a certain normative conception of well-being. However, at the same time, he emphasizes that a patient's agency may diverge from the normative conception of her well-being: 'But a patient may well have in mind circumstances, objectives, and values which he may reasonably not make known to the doctor but which may lead him to a different decision from that suggested by a purely medical opinion'.[75] Lord Scarman can be seen to have conceived a patient's agency as the 'rights of the patient outside the field of medicine';[76] and he insisted that the doctor's duty of care extended not only to the 'the health and well-being of his patient but also to a proper respect for his patient's rights'.[77] Thus, similar to Robinson J in *Canterbury*, Lord Scarman prioritized the patient's agency freedom to reject the proposed treatment over the achievement of the doctor's idea of her well-being through the administration of this treatment.

Yet, as in *Canterbury,* Lord Scarman and Lord Templeman do not reject well-being achievement entirely. In approving the therapeutic privilege, Lord Scarman declares that:

> [I]t is plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that

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[69] *Sidaway HL* (n 3) 881G.
[70] Ibid 876G.
[71] Ibid 876D.
[72] Ibid 882B
[73] Ibid 885F.
[74] Ibid 885H.
[75] Ibid 885H.
[76] The Lord Scarman, 'Consent, Communication And Responsibility' (1986) 79 Journal of the Royal Society of Medicine 697, 698 expands that 'one of those rights is the right, in the light of all information available to him—family and business, as well as medical—to make his own decision as to whether or not he will accept the treatment that is being proposed'.
[77] *Sidaway HL* (n 3) 885G.

> communication to the patient of the existence of the risk would be detrimental to the health (including, of course, the mental health) of his patient.[78]

In an extra-curial capacity, Lord Scarman goes further and he asserts that ‘it is not a privilege, but a duty’.[79] In this way, Lord Scarman implies that the therapeutic privilege embodies a strategy to include an obligation for the doctor to have concern for the patient’s well-being achievement, in addition to her agency freedom. Lord Scarman’s strategy would seem to be consistent with his view that the doctor owed a duty of care to his patient; because, as discussed earlier, the ethic of care explicitly requires attention to both well-achievement and agency freedom (3.7.1). Lord Templeman is more forthright: ‘No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor’s training and experience and as a result of the doctor’s diagnosis of the patient’.[80] He proceeds to make it clear that ‘the provision of too much information may prejudice the attainment of the objective of restoring the patient’s health’.[81]

In short, whilst the patient’s agency freedom is given priority, this priority remains partial, in the sense that agency freedom is ranked above well-being achievement, but the latter is not disregarded completely in deciding the patient’s opportunity to reject the proposed treatment. Rather, the doctor has to make a ‘balanced judgment’ in deciding the patient’s opportunity.[82] Similar to *Canterbury,* Lord Scarman conceptualized the patient’s opportunity in terms of information about the risk that was attached to the proposed treatment, and he adopted the *Canterbury* test of materiality to assess the adequacy of the information.[83] I have explained earlier that the test of materiality invokes public reason because its audience is a reasonable person (6.3.3). Like Robinson J, Lord Scarman and Lord Templeman, too, conceive that this reasonable person is fundamentally rational in the sense that is proposed by Rawls (5.3.1.1): the person will have crystallised goals; and, if she is supplied with information about available means, then she will be select the means that best satisfies her goals.[84]

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[78] Ibid 888F. At 889A, Lord Scarman explicitly approves the ‘therapeutic privilege’.

[79] Scarman (n 76) 699.

[80] *Sidaway HL* (n 3) 904C. At 905A, Lord Templeman clarifies that the doctor’s obligations had not altered because these had ‘ceased to be contractual and become a matter of duty of care’.

[81] Ibid 904H.

[82] Ibid 904F (Lord Templeman).

[83] Ibid 887D.

[84] The idea of rationality that is implicit in the speeches of Lord Scarman and Templeman had been stated explicitly by Sir John Donaldson MR, who had held

The opportunity, in the form of information, that a doctor is obliged to supply to this rational patient will be shaped by considerations of both her agency and well-being (with priority to agency but not to the exclusion of well-being). Yet, once this opportunity has been presented to the patient, then her agency freedom has absolute priority over the achievement of the well-being that is conceived by the doctor. Lord Templeman sets out this space in which agency freedom trumps well-being achievement unconditionally: 'If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational, or irrational, or for no reason at all'.[85] In other words, the doctor was permitted to include some consideration of well-being achievement in advising the patient; but, once he had communicated his 'balanced judgment', then the patient's agency freedom was unrestricted. The actual patient is neither required to satisfy the rationality of her ideal, reasonable counterpart nor to supply the doctor with any reason for her departure from this ideal.

6.4.2 Lord Diplock

Lord Diplock disagreed with Lord Scarman on the compartmentalization of the doctor's duty into diagnosis, advice and treatment. He argued that 'In modern medicine and surgery such dissection of the various things a doctor had to do in

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that the doctor was obliged to place 'the patient in a position to make a rational choice whether or not to accept the doctor's recommendation'. *Sidaway CA* (n 29) 513A. Not dissimilarly, A G Robertson, 'Informed Consent to Medical Treatment' (1981) 97 Law Quarterly Review 102, 112, cited approvingly by Lord Scarman in *Sidaway HL* (n 3) 886E, has described consent as 'the protection of the patient's right to self-determination by means of affording him an opportunity of making a rational decision as to proposed medical treatment'. See also Margaret A. Somerville, 'Structuring the Issues in Informed Consent Issues in Medical Law in Canada' (1980) 26 McGill Law Journal 740, 783, for an argument that a purpose of informed consent is to encourage rational decision-making.

[85] *Sidaway HL* (n 3) 904F. This dictum is endorsed in *Montgomery UKSC* (n 1) [55]. For earlier affirmations of Lord Templeman's dictum, see *Airedale NHS Trust v Bland* [1993] AC 789 (HL) 864C (Lord Goff); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA) 102D (Lord Donaldson MR). For an exception, where a seemingly irrational refusal of a caesarean section was overruled, see *Re S (Adult: Refusal of Treatment)* [1993] Fam 123 (CA) (Sir Stephen Brown P). It is critical to note the distinction between the doctor's obligation and the patient's entitlement: the doctor is obliged to supply information that would place the patient in a position to make a rational choice (n 84); the patient is then entitled to irrationally decline the treatment. In other words, although the ideal of a reasonable person that should be conceived by the doctor is rational, the actual patient does not have to behave rationally. Jones (n 29) 358 seems to have misunderstood this paradigm to indicate that the patient is 'restricted to "rational" choice'.

the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable'.[86] In contrast to Lord Scarman and Lord Templeman, Lord Diplock was forthright in his approval of the *Bolam* test for the assessment of advice as an inseparable part of the doctor's duty of care,[87] and he articulates much of the justification that was tacit in McNair J's dicta.[88]

6.4.3 Lord Bridge and Lord Keith

The initial propositions of Lord Bridge's argument are identical to those of Lord Scarman. The doctor owed 'a duty of care' to his patient and this duty could be 'divided into three phases: diagnosis, advice and treatment'.[89] The patient had a 'right to decide' whether to accept or reject the proposed treatment, and to 'be in a position to exercise that right and, perhaps even more significantly, to seek a second opinion…'.[90] Lord Bridge then debates whether the patient's right to decide about accepting a particular treatment was safeguarded sufficiently by the *Bolam* propositions; and, hereafter, his reasoning diverges from that of Lord Scarman.

Lord Bridge recognised the 'logical force of the *Canterbury* doctrine' but declined to endorse it because he regarded it as 'quite impractical'.[91] Implicitly, he disagreed with the test of the materiality; instead, he favoured a doctor's 'clinical judgment' on:

> [N]ot only as to what treatment is appropriate for a particular patient, but also as to how best to communicate to the patient the significant factors necessary to enable the patient to make an informed decision whether to undergo the treatment.[92]

In other words, the adequacy of the doctor's communication with the patient was to be judged primarily by the *Bolam* test; but with the condition that:

> [E]ven in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might in certain circumstances come to the conclusion that the disclosure of a particular risk was so obviously necessary to an

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[86] *Sidaway HL* (n 3) 893G.
[87] Ibid 895E.
[88] Ibid 891C.
[89] Ibid 896G.
[90] Ibid 898A.
[91] Ibid 899A.
[92] Ibid 899B.

> informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.[93]

Lord Bridge can be seen to have advanced a normative interpretation of the *Bolam* test: what any ‘reasonably prudent’ doctor ought to do, as determined by a judge, regardless of what a body of doctors might do actually. In other words, if a judge did not deem that the private reasoning was of the medical professional was ‘lawlike’ (5.5), then it should not prevail. Thus, Lord Bridge qualified the *Bolam* test for assessing the standard of advice, just as Lord Browne-Wilkinson did later in *Bolitho*[94] with respect to diagnosis and treatment. As pointed out earlier, the Supreme Court found Lord Bridge’s position to be unstable and unsatisfactory and rejected it.[95]

6.4.4 Normative Framework of Consent

A spectrum of views on consent, as a capability to achieve medical treatment, emerges from *Sidaway*. At one end of the spectrum, Lord Diplock’s views retain the *Bolam* premises; in between, making some concession, Lord Bridge emphasizes a normative approach to the *Bolam* argument; and, at the other end, the views of Lord Scarman and Lord Templeman lead to a position similar to that which had emerged from *Canterbury*. Notably, as in *Canterbury*, Lord Scarman alludes to ‘alternative treatment’ (6.4.1), but his focus remains on the patient’s opportunity to reject the treatment that is proposed by the doctor.

From a sociological perspective, Lord Diplock seems to have retained Parson’s notion of a ‘sick role’ that I discussed earlier (6.2.1). In contrast, Lord Scarman appears to have recognised that, by the 1980s, there was a move away from the ‘sick role’, corresponding to a shift in public emphasis from the social contract tradition to individualism, associated with changing public perceptions

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[93] Ibid 900F. Lord Bridge’s qualification of the *Bolam* test was quite similar to the ‘important caveat’ placed by Sir John Donaldson MR in *Sidaway CA* (n 29) 513E: the court had to be satisfied by the standard of professional practice, failing which a judge was entitled to reject a unanimous medical view.

[94] *Bolitho* (n 31) 243A: ‘in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant’s conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk)’. For discussion about Lord Browne-Wilkinson’s exclusion of ‘questions of disclosure of risk’, see Brazier and Miola (n 31); José Miola, ‘On the Materiality of Risk: Paper Tigers and Panaceas’ (2009) 17 Medical Law Review 76.

[95] Lord Kerr and Lord Reed JJSC *Montgomery UKSC* (n 1) [61] viewed that Lord Bridge’s dictum resembled that of Lord Browne-Wilkinson only ‘superficially’ because each was based on fundamentally different premises: a patient’s entitlement to be ‘told of risks where that is necessary for her to make an informed decision whether to incur them’ versus ‘matters of medical skill and judgment’, respectively.

and normative expectations.[96] Yet, despite the differences in their reasoning, all their lordships disallowed *Sidaway*'s appeal.[97] As such, as pointed out by José Miola, the decisions in *Sidaway* were technically not dissenting; yet, the variations in reasoning preclude the extraction of a common ratio decidendi.[98]

6.5 Pearce v United Bristol Healthcare NHS Trust

Miola discusses that Lord Diplock's views in *Sidaway* took lower courts in a 'stranglehold'.[99] Shortly following *Sidaway,* the Court of Appeal applied Lord Diplock's ratio—the *Bolam* test—in *Blyth*[100] and *Gold*[101]. Given the Court of Appeal's reasoning in these cases, it does not seem surprising that lower courts adopted this approach,[102] although Lord Bridge's qualification was applied in some cases.[103] Yet, even shortly preceding *Pearce*, the obiter comments of Swinton Thomas LJ, in *O'Keefe*, summarized the law on consent quite shortly, on the basis of *Sidaway*, as adherence to the *Bolam test*.[104]

The Supreme Court has regarded Lord Woolf MR's judgment in *Pearce* as 'particularly significant' in the tacit departure of some lower courts from the

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[96] See John C Burnham, 'Why Sociologists Abandoned the Sick Role Concept' (2014) 27 History of the Human Sciences 70; Varul (n 14). See also Arthur W Frank, 'From Sick Role to Practices of Health and Illness' (2013) 47 Medical Education 18.

[97] Lord Diplock and Lord Bridge based their decision on the *Bolam* test: expert witnesses had endorsed non-disclosure of the risk of post-operative paralysis. Lord Bridge, *Sidaway HL* (n 3) 900H, did not consider that non-disclosure of the less than one percent risk of spinal cord injury engaged his qualification of the *Bolam* test. Lord Templeman was 'satisfied that adequate information' had been disclosed. Ibid 905C. The rejection of the appeal by Lord Scarman is puzzling. Lord Scarman allows that Mr Falconer did not disclose the less than one percent risk of 'severe injury' to the spinal cord; but; he did not find that this risk was material, on the grounds that expert witnesses had not deemed it to be so, and that Mr Falconer was not alive to testify to his 'assessment of his patient'. Ibid 890B-C. Yet, at trial, Skinner J, *Sidaway QB* (n 59), had concluded that Mrs Sidaway would have declined the operation if she had been warned of the risk, implying that it was significant to her.

[98] Miola (n 94).

[99] Ibid 84.

[100] *Blyth v Bloomsbury HA* [1993] 4 Med LR 151 (CA). This judgment was passed in 1987, but it was not reported until 1993.

[101] *Gold v Haringey Health Authority* [1988] QB 481 (CA). Also, the *Bolam* test was affirmed in obiter in *Thake and Another v Maurice* [1986] 1 QB 644 (CA); *Eyre v Measday* [1986] 1 All ER 488 (CA).

[102] *Smith v Salford Health Authority* (1994) 23 BMLR 137 (QB); *Davis v Barking, Havering and Brentwood HA* [1993] 4 Med LR 85 (QB); *Newbury v Bath District Health Authority* (1998) 47 BMLR 138 (QB).

[103] *Newell and Newell v Goldenberg* [1995] 6 Med LR 371 (QB); *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334 (QB); *McAllister v Lewisham and North Southwark Health Authority* [1994] 5 Med LR 343 (QB).

[104] *O'Keefe v Harvey-Kemble* (1999) 45 BMLR 74 (CA) 85.

Bolam test.[105] Tina Pearce had consulted her obstetrician, Mr Niven, when her pregnancy was 14 days overdue. Mr Niven advised Mrs Pearce to await natural delivery. Seven days later, she delivered a stillborn child. Mr Niven had not disclosed the risk of stillbirth to Mrs Pearce. She claimed that, had she been informed, she would have preferred the risks associated with caesarean section to that of stillbirth from waiting for vaginal delivery. At trial, it was found that both awaiting natural delivery and caesarean section were consistent with responsible medical practice (that is, both options satisfied the *Bolam* test); and Mrs Pearce's claim was dismissed on these grounds.

In considering *Pearce's* appeal, Lord Woolf MR held that:

> [I]f 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.[106]

The probability of stillbirth for Mrs Pearce was quantified as 0.1-0.2%. In disallowing the appeal, Lord Woolf MR explained that 'The doctors called on behalf of the defendant did not regard that risk as significant, nor do I'.[107] There has been much debate on whether, or not, Lord Woolf MR's reasoning diverged from, and advanced upon, that of Lord Bridge in *Sidaway*. In *Montgomery*, the

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[105] *Pearce* (n 4). Cited approvingly in *Montgomery UKSC* (n 1) [64].

[106] *Pearce* (n 4) 174. Notably, Lord Woolf MR did not mention the 'materiality' of risk; instead, he employed a 'significant' risk, and he does not expand on this notion. Alasdair Maclean, 'The Doctrine of Informed Consent: Does It Exist and Has It Crossed the Atlantic' (2004) 24 Legal Studies 386 argues that significance is normative (what information should have been disclosed by the doctor?); in contrast, materiality is factual (what information would have been critical to the actual patient's decision-making?). Miola (n 94) accepts that materiality is the more logical interpretation of Lord Woolf's dictum; but, from the totality of the judgment, feels convinced that Lord Woolf intended significance.

[107] *Pearce* (n 4) 174. Maclean, 'Beyond Bolam and Bolitho' (n 18) 214 observes that, notwithstanding his earlier stricture on risk-percentages, Lord Woolf does take percentages into account, and he continues to rely upon professional reasoning, albeit subject to his own judgment. For discussion of internal inconsistency in Lord Woolf's judgment, see also Maclean, 'The Doctrine of Informed Consent: Does It Exist and Has It Crossed the Atlantic' (n 106) 408; Alasdair Maclean, 'Giving the Reasonable Patient a Voice: Information Disclosure and the Relevance of Empirical Evidence' (2005) 7 Medical Law International 1, 7. In contrast, Brazier and Miola (n 31) 109 consider that Lord Woolf delivered a 'body blow' to the *Bolam* test.

Outer House[108] and the Extra Division of the Inner House[109] of the Court of Sessions concluded that Lord Woolf MR had followed Lord Bridge. In an extra-curial capacity, Lord Woolf MR, himself, has acknowledged that he had relied upon Lord Bridge.[110] Yet, the Supreme Court disagreed: it considered that Lord Woolf MR's approach was closer to that of Lord Templeman and Lord Scarman than that of Lord Bridge[111] .

What was the critical point of Lord Woolf MR's judgment that could have led the Supreme Court to distinguish it from Lord Bridge's reasoning? *Pearce's* case, in common with *Montgomery*, was concerned with pregnancy and childbirth. Unlike, for, say, depression (*Bolam*) or backache (*Canterbury* and *Sidaway*), it simply was not feasible for Mrs Pearce, or Mrs Montgomery, to reject their obstetricians' proposals for natural delivery and retain their status quo. As pointed out by Lady Hale JSC in *Montgomery*, 'Once a woman is pregnant, the foetus has somehow to be delivered. Leaving it inside her is not an option'.[112] Furthermore, Lady Hale JSC highlights that 'it is not possible to consider a particular medical procedure in isolation from its alternatives'.[113] As explained later by Menon CJ in the Singaporean case of *Hii Chii Kok*, which relies on *Montgomery*, 'a patient cannot measure risks in the abstract' without another treatment as a reference for comparison.[114] Consequently, it could be inferred that the Supreme Court's distinction and approval of *Pearce* was triggered by the implicit attention in this case to the process aspect of patient's capability to

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[108] *Montgomery v Lanarkshire Health Board* [2010] CSOH 104, 2010 GWD 34-707 [233]. Rob Heywood, 'Negligent Antenatal Disclosure and Management of Labour' (2011) Medical Law Review 140 criticizes the trial judge, Lord Bannatyne, for not interpreting Lord Woolf's dicta as an advance on those of Lord Bridge. In contrast, Alasdair Maclean, 'From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?' (2012) 20 Medical Law Review 108 argues that Lord Bannatyne appreciated Lord Woolf's reliance on Lord Bridge.

[109] Lord Eassie in *Montgomery v Lanarkshire Health Board* [2013] CSIH 3, 2013 SC 245 [26] points out that the decision in *Pearce* was delivered ex tempore, and he considers that, if it had been Lord Woolf's intent to refine the law as set out in *Sidaway*, it was unlikely that he would have done so other than in a reserved judgment.

[110] Woolf (n 30) 11.

[111] *Montgomery UKSC* (n 1) [65]. Lord Woolf's judgment had been approved previously by Lord Steyn in *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 143E; but, Lord Steyn does not discuss whether Lord Woolf had diverged from the majority in *Sidaway.*

[112] *Montgomery UKSC* (n 1) [110].

[113] Ibid [109].

[114] *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] SGCA 38 Court of Appeal of Singapore [142].

achieve medical treatment: the identification of the range of available treatment options or alternatives to the treatment that is proposed by the doctor.

The preceding inference is supported by Supreme Court approving citation of *Birch* as an example of the adoption of Lord Woolf's approach by lower courts.[115] The facts in *Birch* highlight the inseparability of the process aspect and the opportunity aspect of a person's capability to achieve treatment, and the dependence of the latter on the former. Mrs Birch suffered a stroke following a carotid angiography procedure. She had been warned that stroke was a possibility (1%) following this procedure, and she had accepted this risk. But, she had not been offered magnetic resonance imaging (MRI), which was not associated with stroke, as an alternative investigation. Cranston J found that both angiography and MRI were supported by different bodies of responsible medical practitioners, and arguments in favour of both investigations were logically defensible. As such, the choice of angiography by the treating neurosurgeon satisfied the *Bolam* test, with the qualification placed in *Bolitho*. Yet, Cranston J ruled in favour of Mrs Birch. Relying on *Pearce,* he reasoned that 'unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another.'[116] Shortly after *Birch*, Nicol J took a similar view in *Jones*: he, too, relied on *Pearce*, and he decided that caesarean section should have been offered as an alternative to vaginal delivery.[117]

Apart from the first instance judgments in *Birch* and *Jones*, it is notable that, in *Border*, Richards LJ seems to reason similarly to the Supreme Court in *Montgomery*, and he cites *Chester* but not *Sidaway*.[118] Yet, around the same time, in *Meiklejohn*, Rafferty LJ sets out that 'The duty to advise and warn about diagnosis, treatment and possible side-effects is to be assessed in according with the practice of a responsible body of such doctors: Bolam and the majority in Sidaway'.[119]

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[115] *Birch v University College London Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB), (2008) 104 BMLR 168. Cited in *Montgomery UKSC* (n 1) [69]. For commentary, see Rob Heywood, 'Medical Disclosure of Alternative Treatments' (2009) 68 The Cambridge Law Journal 30.

[116] *Birch* (n 115) [74].

[117] *Jones (by his father and litigation friend) v North West Strategic Health Authority* [2010] EWHC 178 (QB), [2010] Med LR 90.

[118] *Border* [n 17].

[119] *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120, [2014] Med LR 122 [62]. The facts in this case are complex, and it could be argued that Rafferty LJ's statement of law was an obiter dictum and not her ratio decidendi.

6.6 Conclusions

Case law reveals evolving ideas of justice, situated in contemporaneous sociological narratives, about both aspects—process and opportunity—of a patient's capability to achieve treatment. In *Bolam,* there was no explicit reference to the process aspect; implicitly, it was to be decided by the private reason of the doctor who was treating the patient. In *Sidaway,* Lord Scarman alludes to this aspect—'the options of alternative treatment'[120]—but he does not expand upon it; the identification of available treatments remained a matter for the 'clinical judgment' of the treating-doctor, to be assessed by the *Bolam* test. In *Pearce,* Lord Woolf MR seems to reject the reliance on private reason, but he does not set out an alternative, fair procedure for the identification of available treatments.

The focus in case law, up to *Montgomery*, was on the opportunity aspect of the patient's capability to achieve treatment. The idea of a fair opportunity shifted from emphasis on the achievement of a normative conception of well-being, in *Bolam*, to a person's freedom to achieve her health agency*,* in the speeches of Lord Scarman and Lord Templeman in *Sidaway.* The opportunity is conceptualized in terms of information about the potential harms ('risks') of the proposed treatment, so that the patient can reject the proposed treatment; and the implicit focus on an opportunity to reject, rather than to achieve, treatment derives from the traditional sociological paradigm in which a doctor was expected to impose a normative conception of well-being upon the patient. Along with the shift in priority from well-achievement to agency freedom in *Sidaway* (Lord Scarman and Lord Templeman), the normative tool for deciding the scope of information about treatment-related risks switched from the private reason of medical professionals to public reason. Now, the scope of the information had to be justified to a reasonable person, and not to a doctor. This reasonable person is implicitly rational, as idealized by Rawls.

The Supreme Court approached *Montgomery's* appeal in the context of ideas of justice about the process aspect and the opportunity aspect of a patient's capability to achieve treatment from *Pearce* and *Sidaway.* The Supreme Court then expands on both these aspects: it deals with a fair process for identifying available treatments (which I will discuss in Chapter 8); and in advances upon Lord Scarman's views about opportunity, which I discuss in the next chapter.

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[120] *Sidaway HL* (n 3) 876D.

Chapter 7

Montgomery: The Opportunity to Achieve an Available Treatment

7.1 Introduction

It was Nadine Montgomery's first pregnancy.[1] She was short (five feet in height) and she had diabetes. Ante-natal ultrasound examinations showed foetal macrosomia—a larger than expected baby—which is a common occurrence in diabetic women. The obstetrician, Dr McLellan, advised vaginal delivery. Unfortunately, during delivery, there was shoulder dystocia;[2] as a result, Mrs Montgomery's son, Sam, suffered cerebral palsy and brachial plexus injury.

Mrs Montgomery complained that Dr McLellan had not warned her of the possibility of shoulder dystocia during vaginal delivery or offered caesarean section as an alternative to vaginal delivery. Dr McLellan admitted these omissions. The Courts of Sessions referred to *Sidaway*,[3] and ruled in favour of Dr McLellan on the basis of the *Bolam* test, because her omissions were supported by expert witnesses in obstetrics.[4] The Supreme Court reversed the verdict of the Inner House of the Court of Sessions and allowed *Montgomery's* appeal. Implicitly, in the Supreme Court's view, Dr McLellan had not provided Mrs Montgomery with a fair capability to achieve treatment in respect of both aspects of this capability (2.5). The opportunity aspect of this capability was unfair because Mrs Montgomery had not been given certain information about the possible harms of the proposed treatment (vaginal delivery). The process aspect of this capability, too, was unfair, because she had not been offered an alternative—caesarean section—to the proposed treatment, which should have been available to her.

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[1] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [64].

[2] The event, during vaginal delivery, where the baby's head is delivered but the shoulders remain 'stuck' in the maternal pelvis.

[3] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL).

[4] Although, there are suggestions that the Courts of Sessions did not rely entirely on the *Bolam* test. For instance, Lord Bannatyne, *Montgomery v Lanarkshire Health Board* [2010] CSOH 104, 2010 GWD 34-707 [50], reasoned that 'it would not be a risk which would affect the judgement of a reasonable patient'. Lord Eassie, *Montgomery v Lanarkshire Health Board* [2013] CSIH 3, 2013 SC 245 [17], explained that, through the dicta of Lord Bridge in *Sidaway* and Lord Browne-Wilkinson in *Bolitho*, 'there was a place for the court to view matters from the patient's perspective, rather than that of medical practice'.

The Supreme Court explicitly rejected the *Bolam* test for assessing the fairness of Dr McLellan's decision to exclude information about shoulder dystocia from Mrs Montgomery.[5] Lord Kerr and Lord Reed JJSC concede that if a medically-normative conception of the patient's health was the overriding objective, then the scope of the information-disclosure would be decided by the private reason (5.5) of medical professionals.[6] But, they perceived a change in the traditional, sociological narrative of the doctor-patient relationship that framed the majority view in *Sidaway*.[7] Consequently, they affirmed the views of Lord Scarman (6.4.1). Similar to Lord Scarman, Lord Kerr and Lord Reed JJSC instruct that the doctor was obliged 'to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment'.[8] They, too, set out a test of materiality; and, as discussed in Chapter 6, such tests invoke public reason. However, their lordships do not simply embrace Lord Scarman's test. Instead, they adopt the test that was proposed by the High Court of Australia in *Rogers*:

> [A] risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[9]

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[5] *Montgomery UKSC* (n 1) [86], [115]. Charles Foster, 'The Last Word on Consent' (2015) 165 New Law Journal 8 argues that a role for the *Bolam* test has been retained through endorsement of the GMC's guidance in *Montgomery UKSC* [66], [67]: for, how could it be that any responsible body of doctors would fail to follow the GMC? Clark Hobson, 'No (,) More Bolam Please: Montgomery v Lanarkshire Health Board' (2016) 79 Modern Law Review 488 argues differently that the presentation of the judgment as an evolution of the stances in *Sidaway* retains a role for the *Bolam* test.

[6] *Montgomery UKSC* (n 1) [74].

[7] Ibid [75], [81]. In *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] SGCA 38 Court of Appeal of Singapore [120], Menon CJ describes the change as a 'seismic shift in medical ethics, and in societal attitudes towards the practice of medicine'. Previously, in *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [92], Lord Walker, too, had perceived sociological change: 'during the 20 years which have lapsed since Sidaway's case the importance of personal autonomy has been more and more widely recognised'.

[8] *Montgomery UKSC* (n 1) [82].

[9] *Rogers v Whitaker* [1993] 16 BMLR 148 High Court of Australia 157. Quoted in *Montgomery UKSC* (n 1) [72]. Notably, the 'significance' that a reasonable person or a particular patient would 'be likely to attach' to a risk is not a threshold issue, which is to be decided according to the balance of probabilities test that is employed in tort law for determining causation. Gummov J explains that 'It is not necessary when determining materiality of risk to establish that the patient, reasonable or otherwise, would not have had the treatment had he or she been warned of the risk in question. The test is somewhat lower than that'. *Rosenberg v*

The *Rogers* test directs attention, firstly, to a ‘reasonable person in the patient’s position’, similar to the *Canterbury* test that was adopted by Lord Scarman in *Sidaway*.[10] In addition, the second part of *Rogers* test focuses on the ‘particular patient’; and this attention to the particular patient is the ‘refinement’,[11] which is alluded to by the Supreme Court, that is added by *Rogers* to Lord Scarman’s test. I will expand on the *Rogers* test later in this chapter.

In Chapter 6, I had pointed that, although the *Canterbury* test of materiality engages ‘risk’, the idea of a ‘risk’, itself, is unclear. In the Australian case of *Rosenberg*, which follows *Rogers,* Gummow J highlights this ambiguity, and he attempts to segregate the notions of ‘risk’ and ‘material’. Gummov J ponders:

> The first question is “what ‘risk’ is being spoken of here?” Put another way, it is “what are the facts and circumstances, the possibility of the occurrence of which constitutes that ‘risk’? Once that question is answered one may turn to consider whether the risk is “material”?[12]

Following *Montgomery,* the issue of a distinction between the existence of a risk and the assessment of its materiality re-surfaces in the appellate verdicts in *Duce*[13] and *LT.*[14] For instance, Lord Brodie points out that ‘Only if there was a risk and the relevant clinician was or should have been aware of it, does the *Montgomery* duty arise’.[15] Since a person’s opportunity to achieve or reject treatment is conceptualized in terms of information about risk, it is critical to clarify this notion, and I will address this problem in the present chapter. In doing so, I will explore the opportunity aspect of the fair capability to achieve treatment that emerges from *Montgomery.*

Percival [2001] HCA 18 High Court of Australia [80]. Cited approvingly in *Montgomery UKSC* (n 1) [73].

[10] The reasoning of the majority in *Rogers* (n 9) 156 (Mason CJ) and of Gaudron J, ibid 159 (concurring), is very similar to that of Robinson J in *Canterbury.* But, as pointed out by Don Chalmers and Robert Schwartz, ‘*Rogers* v Whitaker and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure’ (1993) 1 Medical Law Review 139, 148, the Australian High Court attempts to distance itself from the American case law by rejecting the use of the terms ‘informed consent’ and ‘self determination’ (*Rogers* 156-157). See also Karen Tickner, ‘Rogers v Whitaker: Giving Patients a Meaningful Choice’ (1995) 15 Oxford Journal of Legal Studies 109.

[11] *Montgomery UKSC* (n 1) [87].

[12] *Rosenberg* (n 9) [61].

[13] *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, [2018] PIQR P18 [33], [43].

[14] *LT (as guardian of RC) v Lothian NHS Health Board* [2019] CSIH 20 [61]. A similar approach had been taken also in *R v Lanarkshire Health Board* [2016] CSOH 133, 2016 GWD 31-556 [115].

[15] *LT* (n 14) [61].

The present chapter is organised in the following sections. In section 2, I discuss the idea of a risk as a multi-dimensional entity that emerges from *Montgomery*. I will point out that the phenomenon of risk perception is such that the idea of a risk, itself, and its materiality cannot be entirely separated. In section 3, I discuss materiality. I will analyse the structure of public reason that underpins each of the two parts of the *Rogers* test of materiality. These structures engage ideas of consensus and positional objectivity, and create significant challenges for the practising doctor. In section 4, I move on to the ideal of a 'reasonable person'—the constituency of public reason—that emerges from *Montgomery*. This ideal is fundamentally rational, and additional characteristics are sparse. Section 5 is the conclusion to this chapter.

7.2 What is a 'Risk'?

In *Rosenberg*, Gummow J pointed out that it was only after a risk had been identified that attention could be directed 'to the content of any warning that could have been given at the time'.[16] Although Gummow J's musings seems to suggest that he conceived of the identification of a risk and its materiality as distinct notions, he does not set out definitions; the two notions remain interwoven in his judgment. For instance, he cautions that 'A slight risk of serious harm might satisfy the test (of materiality), whilst a greater risk of a small harm might not',[17] but he does not separate the assessment of a risk from its materiality. Nonetheless, it is clear that Gummow J relates the risk of a treatment to the potential for harm from that treatment. Also, he distinguishes between two aspects of harm: the probability, or likelihood of occurrence, of a harm; and the seriousness, or impact, of this harm. He directs attention to both aspects of the potential harm in conceiving it as a risk.

Further, in dealing with risks, Gummow J explains that 'A patient's need for the operation is important, as is the existence of reasonably available and satisfactory alternative treatments'.[18] In other words, he does not limit the conception of a risk to the probability and seriousness of a potential harm; rather, he includes considerations of the potential benefits of the proposed treatment (the 'patient's need') and alternatives to the proposed treatment. Thus, Gummow J seems to conceptualize the 'risk' of a medical treatment as a multi-dimensional idea that involves considerations of the harms and benefits of, and alternatives to, that treatment. He can be viewed to have conceptualized

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[16] *Rosenberg* (n 9) [69].
[17] Ibid [77].
[18] Ibid [78].

a 'risk' as shorthand for information about the risk-benefit profile of the proposed treatment versus alternative treatments.

In *Montgomery*, Lord Kerr and Lord Reed JJSC approach risk in a way that is similar to Gummow J. Their lordships explain that:

> The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives.[19]

Similar to Gummow J, Lord Kerr and Lord Reed JJSC do not explicitly separate the conceptions of a risk and its materiality; but, the inference remains that informing about risk is a multi-dimensional notion that involves the weighing and balancing of interconnected considerations. As observed by Menon CJ in the Singaporean case of *Hii Chii Kok*, the approach to risk in *Montgomery* was a 'matrix-based analysis'.[20] This matrix would involve information about a composite of the harms, benefits and alternatives to the proposed treatment. It is this composite of information, then, that constitutes the risk, or risks, of a proposed treatment. By this account, information about the risk of vaginal delivery for Mrs Montgomery did not simply comprise the probabilities of occurrence of cerebral palsy and brachial plexus injury; rather, it was these probabilities in conjunction with their seriousness, coupled with the benefits of vaginal delivery, and contrasted with the potential harms and benefits of caesarean section (the alternative to vaginal delivery).[21]

The overlap between the idea of a risk, itself, and its materiality that is apparent in *Rosenberg* and *Montgomery* is not surprising. This overlap is illuminated by the science of risk perception, which deals with the practical approach to risk. In other words, what do people actually mean when they think, or say, that something is 'risky'? Paul Slovic has explained that there are two different approaches to risk perception: an analytical approach, and an experiential or affective approach.[22] Slovic discusses that professionals, such as doctors, engage in an analytical approach to risk perception, where the emphasis is on scientific and technical information, with some underpinning, normative

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[19] *Montgomery UKSC* (n 1) [89].

[20] *Hii Chii Kok* (n 7) [141].

[21] This multi-dimensional conception of a 'risk' aligns with Joel Feinberg, *The Moral Limits of the Criminal Law: Harm to Others*, vol 1 (Oxford University Press 1984) ch 5: Assessing and Comparing Harms.

[22] Paul Slovic, 'Perception of Risk' (1987) 236 Science 280.

assumptions.[23] In *Montgomery,* Lord Kerr and Lord Reed JJSC endorse such an analytical approach to risk perception: 'what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession'.[24]

In contrast to medical professionals, patients will generally engage in experiential or affective thinking that involves intuition rather than reasoned analyses.[25] Here, the perception of risk is rooted in social and cultural factors, related to difficulties in understanding complex technologies and probabilistic analyses, media coverage of high-profile cases, personal experiences and anxieties. Socio-cultural processes can then amplify or attenuate public perceptions of risk and risk-related behaviour.[26] Consequently, lay perceptions of risk can diverge from professional perceptions. As explained by Slovic, there can be a 'dance of affect and reason' that can lead to different perceptions of risk for the same action.[27] In *Montgomery*, it can be inferred that Lord Kerr and Lord Reed JJSC appreciated this 'dance', by emphasizing that 'The assessment (of risk) is therefore fact-sensitive, and sensitive also to the characteristics of the patient.[28]

Given Slovic's 'dance', it does not seem possible to entirely separate the idea of a risk from its materiality; there is an unavoidable overlap, and a source of persistent ambiguity. Yet, the *Montgomery* judgment does supply insight about two aspects of risk perception: first, about the conceptualization of a harm; and

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[23] Howard Kunreuther and Paul Slovic, 'Science, Values, and Risk' (1996) 545 Annals of the American Academy of Political and Social Science 116.

[24] *Montgomery UKSC* (n 1) [83]. Similarly, in *Rosenberg* (n 9) [69], Gummow J had relied on 'the point of view of what a reasonable medical practitioner in the position of the defendant ought to have foreseen at the time'. In *Hii Chii Kok* (n 7) [133], Menon CJ is more explicit: the existence of a risk was to be 'assessed from the professional perspective of the doctor, applying the *Bolam* test and the *Bolitho* addendum'.

[25] Slovic (n 22) 280.

[26] Roger E Kasperson and others, 'The Social Amplification of Risk: A Conceptual Framework' (1988) 8 Risk Analysis 177; Ortwin Renn and others, 'The Social Amplification of Risk: Theoretical Foundations and Empirical Applications' (1992) 48 Journal of Social Issues 137; Ali Siddiq Alhakami and Paul Slovic, 'A Psychological Study of the Inverse Relationship Between Perceived Risk and Perceived Benefit' (1994) 14 Risk Analysis 1085.

[27] Paul Slovic and others, 'Affect, Risk, and Decision Making' (2005) 24 Health Psychology S35.

[28] *Montgomery UKSC* (n 1) [89]. Parentheses added. The Supreme Court's recognition of conflicts in risk perception can be inferred also from its approving citation of *Tysiac v Poland* [2007] ECHR 5410/03, in which the risk of retinal detachment during pregnancy and childbirth was perceived differently by the patient and by her doctors. The ECHR's majority (Judge Borrego dissenting) favoured the patient's perception of risk.

secondly about the role of probabilities or percentages in perceiving harm. I will deal with each of these aspects separately, in the two sub-sections that follow.

7.2.1 Conceptualization of a Harm

I will, first, briefly discuss two important theories of harm; and, then, the application of these theories in *Montgomery.* Joel Feinberg has proposed an influential theory of harm.[29] He advances the idea of an accounting ledger, in which a person's condition, or state, prior to a relevant action or event, is her baseline condition. If an event results in her condition being lowered below the baseline, then she has been harmed; on the other hand, if her condition is raised above the baseline, then she has accrued a benefit. The direction of the movement of any individual person's condition—above or below the baseline—is identified by reference to her unique interests.[30]

According to Feinberg, harm and benefit from any event are relative notions of the outcome of that event: the setback and advancement, respectively, of interests with reference to the person's condition before the event. Feinberg does not assess the event or action, itself, that resulted in the outcome. Rather, his theory is 'state-based': the identification or recognition of harm, or benefit, relies upon the comparative assessment of a person's condition following a certain event, and not upon the event itself. To be harmed, or to suffer harm, from an action is to be placed into a disadvantageous state or condition as opposed to an alternative condition—a counterfactual position—that would have existed but for the relevant event, regardless of the event itself.

In contrast to Feinberg, Mathew Hanser has proposed an 'event-based' theory that identifies harm by the occurrence of a detrimental event or experience, and not by resultant state or condition. Hanser explains that 'to undergo a harm (or benefit) is to be the subject of an event whose status as undergoing of harm (or benefit) derives from its being the sort of event it is, independently of the badness (or goodness) of any resulting state'.[31] Unlike Feinberg, Hanser's theory does not (fundamentally, it cannot) employ comparisons to identify harms or benefits. Instead, Hanser proposes a normative account, or list, of the

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[29] Feinberg (n 21) ch 1: Harms as Setbacks to Interest.

[30] Joel Feinberg, *The Moral Limits of the Criminal Law: Harm to Self*, vol 3 (Oxford University Press 1986) ch 18: Autonomy. Through his focus on the interests of individuals, Feinberg invokes a certain notion of autonomy—what does the person desire for herself?—in conceiving harms and benefits. I discussed in Chapter 3 (3.6.3.2.2) that Feinberg's conception of autonomy is strongly substantive.

[31] Matthew Hanser, 'The Metaphysics of Harm' (2008) 77 Philosophy and Phenomenological Research 421.

types of events that would constitute harms; and he accepts that such normative assumptions can face critical challenges.

Montgomery's case illustrates the conflict between state-based and event-based conceptualizations of harm, and associated normative dilemmas. An important part of the debate in this case centred on the identification of the potential harms of vaginal delivery of which Nadine Montgomery should have been made aware. What was the relevant harm? Was it the event of shoulder dystocia, or resultant states of brachial plexus injury and cerebral palsy, or both? Shoulder dystocia occurs in about 10% of diabetic women. Dr McLellan exonerated her omission to inform Mrs Montgomery of the possibility of shoulder dystocia on grounds that the event of shoulder dystocia—the restriction to the descent of the baby's shoulders through the birth canal—could, in a large majority of cases, be resolved by midwifery manoeuvres;[32] alternatively, there could be resort to an emergency caesarean section. The probabilities of brachial plexus injury and cerebral palsy—the conditions that might result from the event of shoulder dystocia—were quite small: 0.2% for brachial plexus injury and 0.1% for cerebral palsy.[33] Dr McLellan did not think that these latter probabilities were significant.

Dr McLellan seems to have adopted a state-based conception of harm: she focused on the conditions that could result from shoulder dystocia, and not on the event of shoulder dystocia itself. The Courts of Sessions concurred with Dr McLellan. Lord Bannatyne, in the Outer House, relied on Lord Bridge's dictum in *Sidaway* that it was 'a substantial risk of grave adverse consequences' that should be disclosed to the patient.[34] Lord Bannatyne reasoned that 'If there is a substantial risk of a problem arising but no risk of an adverse outcome following therefrom I can identify no reason why a doctor should advise the patient of that risk.'[35] In the Inner House, Lord Eassie did not differ:

> What is of interest to the patient must be the outcome, adverse or otherwise, and not some possible complication for the medical

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[32] *Montgomery UKSC* (n 1) [10].

[33] Ibid [12], [13].

[34] *Montgomery CSOH* (n 4) [233], citing *Sidaway HL* (n 3) 900F. Lord Bannatyne considered that Lord Woolf MR in *Pearce* had not digressed from this dictum of Lord Bridge. On this basis, Lord Bannatyne, *Montgomery CSOH* [234], declined to follow the approach of Nicol J in *Jones (by his father and litigation friend) v North West Strategic Health Authority* [2010] EWHC 178 (QB), [2010] Med LR 90. The facts in *Jones* were remarkably similar to *Montgomery*, and Nicol J, ibid [50], had concluded that 'I appreciate that the incidence of shoulder dystocia is not the same as the risk of harm to the baby. But there is undoubtedly a risk of harm'.

[35] *Montgomery CSOH* (n 4) [233].

> practitioner which, if it arises, can be dealt with by ordinary procedures entailing no adverse consequences for the patient.[36]

The Supreme Court disagreed: it deemed that both the event of shoulder dystocia, itself, and the resulting outcomes were relevant harms, to which the test of materiality was applicable. The Court considered that the probability of the event of shoulder dystocia was 'substantial', and that the experience of this event was 'a major obstetric emergency which may be traumatic to the mother, and involving significant risks to her health'.[37] Thus, *Montgomery* provides the clarification that both accounts of harms—state-based and event-based—should be considering in perceiving risks; yet, the specification of events that are harmful, or 'traumatic', is implicitly normative.

7.2.2 The Place of 'Percentages'

The probability, or 'percentage', of a harm is one of the several dimensions to be considered in perceiving the existence of a risk. The Supreme Court's instruction that 'the assessment of whether a risk is material cannot be reduced to percentages'[38] could be seen as an attempt to divert focus from numerical analysis of risk. Although, the Court does not instruct that percentages should be disregarded; rather, the instruction is to not rely exclusively on—reduce to—percentages. In this sub-section, I will explore the place of percentages in risk perception.

In *Montgomery*, the existence of harms was not in dispute; the debate centred on whether Dr McLellan should have perceived that these harms were material to Mrs Montgomery. But, in other cases, difficulties could arise in setting a threshold: can the probability of a harm be considered as so low, or sub-threshold, that it can be excluded from the perception of a risk? In *Hii Chii Kok*, Menon CJ admits that a very severe harm could if excluded if the probability is so low that 'the possibility is not worth thinking about'.[39] Such a situation is illustrated in the case of *Tasmin*.[40] Here, it was claimed that a pregnant woman should have been made aware that foetal brain injury was a risk of vaginal delivery, even though the probability of such injury was very small, because of its seriousness. In dismissing this claim, Jay J ruled that:

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[36] *Montgomery CSIH* (n 4) [29].

[37] *Montgomery UKSC* (n 1) [94]. Roderick Bagshaw, 'Modernising the Doctor's Duty to Disclose Risks of Treatment' (2016) 132 Law Quarterly Review 182 points out that, although the claim was on behalf of Sam Montgomery, the judgment was anchored partly to risks to Nadine Montgomery.

[38] *Montgomery UKSC* (n 1) [89].

[39] *Hii Chii Kok* (n 7) [141].

[40] *Tasmin v Barts Health NHS Trust* [2015] EWHC 3135 (QB) [108].

> A risk of 1:1000 is an immaterial risk for the purposes of paragraph 87 of *Montgomery*. The Supreme Court eschewed characterising the risk in percentage terms, but it was doing so in the context of defining the borderline between materiality and immateriality. Here, I am quite satisfied that that the relevant risk was so low that it was below that borderline.[41]

In other words, Jay J deemed that foetal brain injury could not have been perceived to be a potential harm in *Tasmin's* case; consequently, it did not engage the test of materiality. Not dissimilarly, in *A v East Kent*, Dingemans J seems to have considered that a 0.01% probability of chromosomal abnormality was a 'theoretical, negligible or background' possibility that did not engage the test of materiality.[42]

In practice, in order to separate the identification of a harm from it materiality, there would have to be some threshold probability of harm for risk perception. The challenge is, then, to set a threshold; but this problem has been side-stepped. In deciding *Tasmin's* case, Jay J disclaims: 'I am not to be understood as saying exactly where that threshold should be defined'.[43]

7.3 What is 'Material'?

In *Montgomery,* the Supreme Court adopts the test of materiality that is set out in the Australian case of *Rogers* (7.1). In *Rosenberg*, Gummow J has distinguished two limbs—objective and subjective—of the *Rogers* test of materiality.[44] He explained that the objective limb was the first part of the *Rogers* test, which focussed on a reasonable patient in the patient's position. The subjective limb is the second part, the subject of which is the particular patient.[45] Gummow J clarified that the subjective limb allows 'that the particular patient may not be a "reasonable" one; he or she may have a number of "unreasonable" fears or concerns'.[46] Not dissimilarly, Callinan J described the *Rogers* test as 'a universal test for an hypothetical reasonable person in the patient's position, and a test to be applied to the particular patient, even if, perhaps, she or he is an unreasonable one'.[47]

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[41] Ibid [115].

[42] *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB), [2015] Med LR 262 [84], [89].

[43] *Tasmin* (n 40) [115].

[44] *Rosenberg* (n 9).

[45] Ibid [75].

[46] Ibid [79].

[47] Ibid [210]. Kirby J ibid [141] makes a similar concession for the particular patient.

The two limbs of the *Roger's* test involve two different types of consensus (5.4), as the structure of the public reasoning that should be employed in deciding the scope of the material information. The objective limb engages weak consensus: what information should be acceptable to a reasonable person in the patient's position? The objective limb requires the doctor to conceive the ideal of a reasonable person, and to then place this idealized person in the patient's position. This idealization is independent of any explicit request for information, or questioning, by the patient.[48] Implicitly, the extent of information that a doctor will regard as acceptable to the patient will vary according to his ideal of a reasonable person; it will vary, also, according to his view of the patient's position.

On the other hand, the subjective limb focusses on whether the doctor 'is or reasonably should be aware' of the particular patient's informational requirements. This limb invokes a strong consensus: information about risks that is actually required by the particular patient. It can be inferred that the informational requirements of the particular patient are different from those of a reasonable patient, which are covered already by the objective limb; as such, these particular-patient-requirements could be regarded as unreasonable. It is clear that this limb can be engaged only if patient declares her unreasonability to the doctor; because, otherwise, how would the doctor know that she has unreasonable requirements? But, the nature of the declaration that engages the subjective limb is contentious. Gummow J explains that:

> One way of satisfying that condition is if the patient asked questions revealing the fear or concern. However, that is not the only means of satisfying the second limb. There are a multitude of potential circumstances in which a court might find that the medical practitioner should have known of a particular fear or concern held by the patient.[49]

Gummow J does not expand on the 'potential circumstances', other than explicit questioning by the patient, that might trigger the subjective limb. José Miola has pointed out that without clarification of these 'potential circumstances', the advance on Lord Scarman's test of materiality, by addition of the subjective limb, is dubious; because, in *Sidaway*, notwithstanding other areas of dissent,

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[48] *Montgomery UKSC* (n 1) [58].

[49] *Rosenberg* (n 9) [79]. Menon CJ in *Hii Chii Kok* (n 7) [145] states that 'The doctor has no open-ended duty to proactively elicit information from the patient, and will not be at risk of being found liable owing to the idiosyncratic concerns of the patient unless this was made known to the doctor or the doctor has reason to believe it to be so…patient has in fact asked *particular questions* or otherwise expressed *particular concerns*…'. Menon CJ's emphases.

all the law lords agreed that a patient's questions should be answered comprehensively.[50] Also, the distinction between 'position' and 'particularity' is puzzling: if a patient has not directly questioned the doctor, what are the circumstances that would engage 'particularity' but not direct attention to the 'position' of a reasonable patient?

To explicate the *Rogers* test, Gummow J exemplifies the decision in *Rogers* as an application of the subjective limb, and his own decision in *Rosenberg* as an application of the objective limb.[51] I will analyse the application of each limb of the test of materiality in these two Australian cases, as well as in *Montgomery*, in order gain some clarifications.

7.3.1 Objective Limb of the Test of Materiality: What Should be Acceptable to a Reasonable Person in the Position of the Patient?

The objective limb throws light on two important issues in public reason, which I will discuss separately in the sub-sections that follow.

7.3.1.1 The Co-Extensiveness of Acceptability with the Ideal of a Reasonable Person and her Position

In *Rosenberg*, Mrs Percival suffered from severe, chronic pain in her temporo-mandibular joint (TMJ) following a mandibular osteotomy operation for dental malocclusion. She claimed that she would have declined the operation if she had been made aware of the possibility of chronic pain. The surgeon, Mr Rosenberg, conceded that he had not warned her of this possibility. The expert evidence was that about 10% of patients experience mild and temporary TMJ disorders following osteotomy, but chronic pain was rare.[52] Mrs Percival admitted that she had not inquired explicitly about any TMJ disorder, and Gummow J did not find any circumstance that should have triggered Dr Rosenberg's awareness of her particularity to the rare condition of chronic pain; hence, he judged that the subjective limb of the Rogers test was not engaged. As such, the discharge of Dr Rosenberg's duty to provide a fair opportunity to Mrs Percival was to be assessed entirely by the objective limb.[53]

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[50] José Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas' (2009) 17 Medical Law Review 76.

[51] *Rosenberg* (n 9) [76]. Gummow J also cites *Chappel v Hart* [1998] HCA 55 High Court of Australia as illustrative of the subjective limb.

[52] *Rosenberg* (n 9) [74].

[53] Ibid [81].

Gummow J concluded that the objective limb did not demand a warning about TMJ problems from Dr Rosenberg. It can be inferred that, in allowing Dr Rosenberg's appeal, Gummow J will have conjured a certain ideal of a reasonable person in Mrs Percival's position; and he determined that the possibility of TMJ pain would not be significant to this person's decision to accept or reject the osteotomy operation. Gummow J considered Mrs Percival's position as follows: she was suffering from dental malocclusion; she wanted the 'best result' and osteotomy was the most effective remedy; she was an 'experienced and knowledgeable nurse who was certainly aware that all surgery carried some risk'; and she had received advice from a number of sources to proceed with treatment.[54] Gummow J decided that not being informed by Dr Rosenberg of the small possibility of chronic TMJ pain would be acceptable to a reasonable person in this position.

I discussed in Chapter 5 (5.4) that a structure of reasoning that involves weak consensus, as in the objective limb, is co-extensive with the idealization of a reasonable person. If a different ideal of a reasonable person is adopted, or a different view is taken of her position, then weak consensus might result in a different outcome. In *Rosenberg*, Kirby J arrived at an outcome that was different to Gummow J. In Kirby J's view, the *Rogers* test did demand disclosure of the risk of TMJ problems, because 'as was obvious to all who dealt with her, the respondent (Mrs Percival) was also a person who gave attention to detail. She stressed that she wanted her dental malocclusion to be properly attended to'.[55] Kirby J does not specify whether he employed the objective limb or the subjective limb. If it was the objective limb, then Kirby J construed Mrs Percival's 'position' differently than Gummow J; or, he idealized a reasonable person differently. On the other hand, if it was the subjective limb, then, too, Kirby J differed from Gummow J in the idealization of a reasonable person: by invoking the subjective limb, Kirby J would have deemed Mrs Percival as 'unreasonable', and he would have considered that her 'obvious' aspects declared her particularity. Thus, as observed by Callinan J, 'the word "reasonably" has real work to do'.[56] I will address the ideal of a reasonable

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[54] Ibid [81].

[55] Ibid [150].

[56] Ibid [219]. Callinan J, ibid [220], avoids making a final decision on the reasonability, or otherwise, of the opportunity was provided to Mrs Percival, and he accepts the trial judgment in favour of Dr Rosenberg. Gleeson CJ and McHugh J, too, do not opine on whether Dr Rosenberg had provided adequate warning. Regardless, all five justices agreed that Mrs Percival would have decided to undergo the osteotomy, regardless of a warning about TMJ problems, and all allowed Dr Rosenberg's appeal against the decision of the lower appellate court in Mrs Percival's favour.

person in the next section (7.4); here, I will proceed to discuss the notion of this reasonable person's 'position'.

7.3.1.2 Position: Entitlement or Enlightenment?

Miola points out that 'position' is specified poorly in case law, and that judicial focus has been principally on the physical characteristics of the patient.[57] Although, in *Rosenberg*, Gummow J took Mrs Percival's occupation and previous consultations as part of her position. He considered that it would be acceptable to a reasonable person, who was an experienced nurse and had consulted other surgeons previously, to not be informed of the very small risk of chronic TMJ pain by her treating surgeon.[58] In other words, Gummow J appears to assume that a reasonable person in Mrs Percival's position would have been aware of the possibility of a TMJ problem, regardless of a warning by Mr Rosenberg. In this way, Gummow J includes a patient's epistemic and cognitive characteristics—her pre-existing knowledge and her abilities to think and reason—in assessing her position. Gummow J's view of a person's position seems broadly consistent with Amartya Sen's idea of positional objectivity as assessed by an 'impartial spectator', who brings in ideas of both entitlement and enlightenment (see 5.3.2).

In *Montgomery*, the Supreme Court does not specify the limb of the test of materiality that it employed in allowing the appeal. In reversing the verdict of the Inner House of the Court of Sessions, Lord Kerr and Lord Reed JJSC declared that 'the exercise of reasonable care undoubtedly required that it (the event of shoulder dystocia) should be disclosed'.[59] In explaining their decision, their lordships do not hold out any 'particularity' for Mrs Montgomery; rather, by allusions to 'the mother'[60] and 'No woman',[61] their reference seems to be any reasonable woman in Mrs Montgomery's position. Similarly, Lady Hale JSC

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[57] Miola (n 50). For examples, *Moyes v Lothian Health Board* 1990 SLT 444 (CSOH); *Smith v Salford Health Authority* (1994) 23 BMLR 137 (QB); *Smith v Barking, Havering and Brentwood HA* [1994] 5 Med LR 285 (QB); *Lybert v Warrington Health Authority* [1996] PIQR P45 (CA). Although, in *McAllister v Lewisham and North Southwark Health Authority* [1994] 5 Med LR 343 (QB) attention was given to the patient's personality and her employment.

[58] A similar approach appears to have been taken by Kay LJ in *Wyatt v Curtis* [2003] EWCA Civ 1779 [23]: 'whatever the precise legal test, I would be reluctant in the extreme to hold that there was any greater duty on the second doctor, whatever his or her status, to do any more than satisfy himself that a warning had already been given by an apparently competent doctor who ought to have had sufficient expertise to give the necessary advice'.

[59] *Montgomery UKSC* (n 1) [94]. Parentheses added.

[60] Ibid [94].

[61] Ibid [94].

mentions ‘any reasonable mother’ with insulin-dependent diabetes.[62] Accordingly, it could be inferred that the Court employed the objective limb of the test of materiality in allowing *Montgomery’s* appeal: it considered that not being made aware of the risk of shoulder dystocia would not be acceptable to any reasonable person in Mrs Montgomery’s position.

In conceiving Mrs Montgomery’s ‘position’, the Supreme Court does seem to have continued the focus on physical characteristics—short stature, insulin-dependent diabetes and foetal macrosomia—that has been pointed out by Miola. At trial, it had been established that Mrs Montgomery was a molecular biologist and a hospital-specialist for a pharmaceutical company,[63] and that she was ‘clearly a highly intelligent person’,[64] whose mother and sister were general practitioners.[65] Lord Bannatyne, the trial judge, had determined that she was aware of the options of vaginal delivery and caesarean section, and she did not require to be informed of the choice between these two options.[66] But, the Supreme Court does not refer to these findings of the trial judge in characterising Mrs Montgomery’s position.

The Court’s silence on the trial judge’s findings in applying the objective limb of the test of materiality is puzzling, because Lord Kerr and Lord Reed JJSC caution explicitly that it ‘would therefore be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors’.[67] By this dictum, it would seem that not attending to a patient’s epistemic and cognitive characteristics as part of her position would be a ‘mistake’, and that position should include more than attention to physical characteristics only; and it could be claimed that there is internal inconsistency in the Supreme Court’s decision.[68] On the other hand, it could be argued that the Supreme Court did not agree fundamentally with Gummow J’s view of position in the manner of Sen. In the light of the entirety of the Supreme Court’s verdict, and its application by lower courts (discussed below), this latter interpretation seems more likely. From Sen’s viewpoint, the Supreme Court has taken ‘position’ as reflective of a person’s entitlements through her membership of a group with certain characteristics, and not of the enlightenment of an impartial spectator (5.3.2).

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[62] Ibid [113].

[63] Ibid [6].

[64] *Montgomery CSOH* (n 4) [246].

[65] Ibid [17], [171]-[178].

[66] Ibid [245].

[67] *Montgomery UKSC* (n 1) [76].

[68] See Jonathan Montgomery and Elsa Montgomery, ‘Montgomery on Informed Consent: An Inexpert Decision?’ (2016) 42 Journal of Medical Ethics 89.

Following *Montgomery*, in *Thefaut*,[69] Green J is firm in focusing on the entitlement aspect of a person’s position, and in excluding the enlightenment that might be introduced by considering a patient’s epistemic situation as a part of her position. Here, it had been pleaded that the surgeon was justified in making some assumptions about Mrs Thefaut’s awareness of the risks of an operation because she was an experienced midwife. Green J dismissed this defence peremptorily:

> A surgeon giving advice cannot quiz a patient about his or her state of knowledge and then trim down the advice accordingly. And nor can a surgeon simply make assumptions about an individual because it is known that the patient is professionally qualified. This would render the process arbitrary and subjective. It would also make the process needlessly over complicated since the far simpler course is to proffer full advice and not shape it according to the patients perceived state of knowledge. Assumptions of this sort should therefore not he made. The clinician should simply give the relevant complete advice.[70]

On the other hand, in *Webster*, the Court of Appeal indicates that the patient’s ‘background (a university degree in nursing)’[71] should have been taken into consideration. However, the thrust was, once again, towards entitlement rather than enlightenment: ‘background’ was employed as a justification for the provision of more, rather than less, information to this patient by the treating-doctor.

7.3.2 Subjective Limb of the Test of Materiality: What is Accepted by the Particular Patient?

I mentioned earlier that Gummow J exemplifies the decision in *Rogers* as an application of the subjective limb of the test of materiality. Here, Maree Whittaker had lost sight in her right eye at the age of nine years, but she retained good sight in her left eye. About 40 years later, Dr Rogers, an ophthalmic surgeon, advised that an operation could improve the appearance of, and restore some sight to, her right eye. Dr Rogers did not warn her of the possibility of sympathetic opthalmia: a 1 in 14,000 chance of loss of vision in her good left eye as a consequence of operating on her blind right eye; and, she suffered this harm. Mr Rogers’s defence was that a responsible body of

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[69] *Thefaut v Johnston* [2017] EWHC 497 (QB), [2017] Med LR 319.

[70] Ibid [75].

[71] *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62, [2017] Med LR 113 [41].

surgeons would not give warning of this rare problem. Mrs Whittaker conceded that she had not explicitly questioned Dr Rogers about the risk of sympathetic opthalmia; but, she had inquired 'incessantly' about possible complications of the operation.

In deciding that sympathetic ophthalmia was a material risk of the operation on Mrs Whittaker's right eye, and that it should have been disclosed, the High Court of Australia emphasized that 'The respondent may not have asked the right question, yet she made clear her great concern that no injury should befall her one good eye'.[72] In using *Rogers* to exemplify the subjective limb, Gummow J seems to be alluding to the court's attention to Mrs Whittaker's expressions of concern about her good eye as an illustration of one of his 'multitude of potential circumstances' that could trigger the subjective arm. Not dissimilarly, in *Montgomery*, Lords Kerr and Reed state that Mrs Montgomery's anxieties 'reinforced'[73] their conclusion about the materiality of the event of shoulder dystocia; with the implication that, by voicing her anxieties, Mrs Montgomery had declared her 'particularity' and this should have engaged the subjective limb, in addition to the objective limb.[74]

Gummow J's exemplification of *Rogers* as an application of the subjective limb provokes further debate about the idealization of a reasonable person. An implication of invoking the subjective limb in *Rogers* is that the risk of sympathetic opthalmia should have been disclosed to Mrs Whittaker only because she expressed concern about her functioning eye; otherwise, by the objective limb alone, it would have been acceptable to withhold this information from a reasonable person in her position.[75] By this approach, Dr Rogers would have been able to justify the exclusion of information about the risk of

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[72] *Rogers* (n 9) 157.

[73] *Montgomery UKSC* (n 1) [94].

[74] At trial, Lord Bannatyne, *Montgomery CSOH* (n 4) [55], had decided that Mrs Montgomery's anxiety did 'not engage the duty to fully explain all the risks involved in vaginal delivery'. At appeal, Lord Eassie, *Montgomery CSIH* (n 4) [36], accepted the importance of attention to the 'precise tone and terms of the relevant communications between the patient and the medical practitioner'. But, he deemed that 'the same cannot in our view be said of general anxieties and concerns which, of themselves, set no obvious parameters for a required response. In such a case there may be no plausible stopping-point short of a legal duty to explain all possible risks to all patients who express general anxieties or concerns'. Ibid [41]. In contradistinction, Lord Kerr and Lord Reed JJSC *Montgomery UKSC* (n 1) [58] rejected 'the drawing of excessively fine distinctions between questioning, on the one hand, and expressions of concern falling short of questioning, on the other hand: a problem illustrated by the present case'.

[75] Gummow J *Rosenberg* (n 9) [77] displays some internal inconsistency; despite using *Rogers* to exemplify the subjective limb, he accepts that the risk of sympathetic opthamia 'becomes one of an altogether greater magnitude' for any one-eyed person as compared to others.

sympathetic ophthalmia to reasonable persons with sight in one eye only; but, given Mrs Whittaker's expressions of concern, he was not able to vindicate his non-disclosure to her in particular. Similarly, the application of the subjective limb only in *Montgomery* would imply that the obstetrician's obligation to explain the risks of vaginal delivery and to offer a caesarean section would not have been triggered if Mrs Montgomery had not expressed anxieties about vaginal delivery.

In conclusion, the ideal of a reasonable person is critical to the employment of both limbs of the test of materiality. As discussed in Chapter 5, this ideal is co-extensive with the structure of public reason; if the ideal is unclear, then the structure of reasoning will be correspondingly problematic. In the test of materiality, this ideal is intertwined with the appreciation of a patient's position in the objective limb, and it is indispensable to the recognition of patient's particularity in the subjective limb. Without clarification of this ideal, doctors will struggle to make the judgments that are required by the test of materiality. I will discuss the ideal of a reasonable person that emerges from *Montgomery* in the next section.

7.4 Who is a 'Reasonable' Person?

Lord Reed JSC has explained that the reasonable person belongs 'to an intellectual tradition of defining a legal standard by reference to a hypothetical person, which stretches back to the creation by Roman jurists of the figure of the *bonus paterfamilias* (good family-father)'.[76] In English law, the archetype of the reasonable person is the man on the 'Clapman omnibus'.[77] Lord Reed JSC clarifies that this man on the Clapham omnibus is a 'legal fiction'[78] and not an actual person. Lord Scarman had done similarly in *Sidaway*, in explaining that a 'prudent' patient 'is a norm (like the man on the Clapham omnibus), not a real person: and certainly not the patient himself'.[79] From these dicta, it would seem clear that the judicial notion of a reasonable person is a philosophical ideal, as conceived by John Rawls (5.2). However, as I discuss below, the Supreme

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[76] *Healthcare at Home Ltd v Common Services Agency* [2014] UKSC 49, [2014] 4 All ER 210 [2]. Parentheses added.

[77] Ibid [1]. The Clapham omnibus was a horse-drawn public carriage that ran between Knightsbridge and Clapham in London. Lord Reed JSC attributes the origin of the man on the Clapham omnibus to Lord Bowen. I could not locate a source by Lord Bowen. The earliest reference that I could find is *McQuire v Western Morning News Co Ltd* [1903] 2 KB 100 (CA) (Lord Collins MR).

[78] *Healthcare at Home* (n 76) [2].

[79] *Sidaway HL* (n 3) 889A.

Court's judgment in *Montgomery* could be interpreted to diverge, at least to some extent, from the intellectual tradition.

In *Montgomery*, Lord Kerr and Lord Reed JJSC indicate that passengers on the Clapham omnibus are 'now widely regarded as persons holding rights, rather than passive recipients of care of the medical profession. They are also widely treated as consumers exercising choices'.[80] Their lordships' reliance on sociological premises—'widely regarded' and 'widely treated'—in the conception of a reasonable person is perplexing. Earlier, in emphasizing that the reasonable person was a legal ideal, Lord Reed JSC had clarified that:

> [I]t would *(sic)* misconceived for a party to lead evidence from actual passengers on the Clapham omnibus as to how they would have acted in a given situation or what they would have foreseen, in order to establish how the reasonable man would have acted or what he would have foreseen.[81]

In other words, the conceptualization of the reasonable person does not rest on what the public might actually do or think, but on the court's ideal of a reasonable person. Yet, in *Montgomery*, Lord Kerr and Lord Reed JJSC refer to what was actually 'regarded' or 'treated'; and, in doing so, they appear to contradict the dicta of Lord Reed JSC himself.

What is the ideal of a reasonable person that emerges from *Montgomery*? Rawls has set out three main characteristics of a reasonable person: rationality, reciprocity and acceptance of the burdens of judgment (5.3.1). The reasonable person from *Montgomery* is implicitly rational: she has clear health goals, and she will be able to select, or reject, corresponding treatment provided that she is supplied with adequate information. The Supreme Court's endorsement of rationality is in keeping with the Rawlsian ideal of a reasonable person that has appeared in case law in *Canterbury* (6.3.3) and in *Sidaway* (6.4.1); and, accordingly, the Supreme Court embraces an informative style of decision-making that rests on the rational choice theory (4.3.2.2).

The notion of rationality from *Montgomery* does not seem to include the 'bounds' on the rationality—the epistemic and cognitive limitations to rational choice—that are emphasized by Sen (4.3.2.3; 5.3.2). Nor does the Supreme Court's judgment in *Montgomery* allude to the characteristics of reciprocity and acceptance of burdens of judgment, which Rawls considered transformative of a merely rational person into a reasonable person. Through Rawls's idea of reciprocity as lying somewhere between altruism and mutual advantage

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[80] *Montgomery UKSC* (n 1) [75].

[81] *Healthcare at Home* (n 76) [3].

(5.3.1.2), it could be argued that a reasonable person, as a citizen of a welfare state, should accept certain civic obligations and responsibilities in making demands on the NHS with its inescapably finite resources.[82] Such an idea of reciprocity has surfaced in some cases. For instance, in *McDonald* (a case about social care), Lady Hale JSC has conceded that ‘She too can be expected to co-operate with the authority in choosing the most economical and acceptable way of meeting the need that she has’.[83] Earlier, in *Bland*, Sir Thomas Bingham MR had considered that ‘An objective assessment of Mr Bland’s best interests, viewed through his eyes, would in my opinion give weight to…if altruism still lives, to a belief that finite resources are better devoted to enhancing life than simply averting death’.[84] However, no such notion of reciprocity can be discerned in *Montgomery;* rather, it would seem that the Supreme Court conceives a reasonable patient as a consumer-citizen with quite limited responsibilities.[85]

In addition to reciprocity, Rawls proposes that a reasonable person will accept certain ‘burdens of judgment’ (5.3.1.3). Rawls explained that these burdens of judgment are various sources of uncertainty that are accepted by reasonable persons. In considering such uncertainties, it would seem that ‘In the end the question seems to be reduced to one of determining the extent of the knowledge which is to be attributed to the reasonable person standing in the position of the plaintiffs’.[86] Traditionally, judges have allowed various assumptions about the knowledge that can be expected of a reasonable person. For instance, a reasonable person would know, and not require to be warned of, the possibility of being hit by a cricket-ball when watching a match at Lord’s stadium, or being injured in a crash during a motor-racing show.[87] In *Sidaway*, Lord Templeman reckoned that a reasonable person would fathom the ‘general danger of unavoidable and serious damage inherent in the operation’[88] from a description of the nature of the operation, and that the doctor’s duty was limited to warn about ‘danger which may be special in kind or magnitude or special to the patient’.[89] Lord Scarman was less explicit but, he,

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[82] See Margaret Brazier, ‘Do No Harm: Do Patients Have Responsibilities Too?’ (2006) 65 The Cambridge Law Journal 397.

[83] *R (on the application of McDonald) v Kensington and Chelsea RLBC* [2011] UKSC 33, [2011] 4 All ER 881 [74A].

[84] *Airedale NHS Trust v Bland* [1993] AC 789 (CA) 813E.

[85] See Kenneth Veitch, ‘Obligation and the Changing Nature of Publicly Funded Healthcare’ (2019) 27 Medical Law Review 267.

[86] *Thake and Another v Maurice* [1986] 1 QB 644 (CA) 686 (Norse LJ).

[87] *Hall v Brooklands Auto Racing Club* [1933] 1 KB 205 (CA) 218.

[88] *Sidaway HL* (n 3) 903A.

[89] Ibid 903C.

too, conceded that ‘With the world-wide development and use of surgical treatment in modern times the court may well take the view that a reasonable person in the patient’s situation would be unlikely to attach significance to general risks…’.[90]

In *Montgomery,* the Supreme Court does not appear to allow any assumptions about the knowledge that a reasonable person could be expected to possess. As with ‘position’ (7.3.1.2), the Court’s view of a reasonable person’s knowledge seems to tilt towards entitlement rather than enlightenment.[91]

7.5 Conclusion

The Supreme Court’s judgment in *Montgomery* places the patient’s opportunity to achieve medical treatment within the sociological milieu of the early 21st century. Whilst the traditional idea that opportunity is transmitted through the provision of information about the ‘risks’ of treatment is retained, the notion of a risk, itself, is distanced from simply the probability of a harm. Rather, a risk is conceived as a multi-factorial notion. Yet, the perception of a risk, which involves placing the harms of a treatment into the context of its benefits and alternatives, as well as underlying health conditions, remains inseparable from evaluative judgments about its materiality to the patient’s decision. These judgments call upon public reason, through the conceptualization of a reasonable person, and the responses of this person when placed in the position of the patient. The reasonable person that emerges from *Montgomery* is essentially a rational decision-maker, who views the patient’s position as circumstances that entitle her to the provision of material information by the doctor.

It could be claimed that the Supreme Court does not make any substantive, conceptual advance on Lord Scarman’s views on the opportunity aspect of a patient’s capability to achieve treatment; and that the importance of *Montgomery* is only technical in affirming Lord Scarman’s views.[92] The Supreme Court does adopt Lord Scarman’s approach and, prima facie, the only

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[90] Ibid 889D.

[91] It could be argued that the view of Lord Kerr and Lord Reed JJSC *Montgomery UKSC* (n 1) [81] that ‘[A]dults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risk affecting their own lives, and living with the consequences of their choices’ reflects some acceptance of burdens of judgment. However, placed contextually, this dictum is more representative of the Court’s view of rationality than of acceptance of burdens of judgment.

[92] See Anne Maree Farrell and Margaret Brazier, ‘Not so New Directions in the Law of Consent? Examining *Montgomery v Lanarkshire Health Board*’ (2016) 42 Journal of Medical Ethics 85.

‘refinement’ is the addition of the subjective limb to the test of materiality. However, there is another, critical distinction. I discussed in Chapter 6 that Lord Scarman had deemed that the availability of treatment was to be decided by the ‘clinical judgment’ of the doctor who was treating the patient (6.4.1); and, in this paradigm, the patient’s opportunity to achieve treatment was, essentially, an opportunity to reject the treatment that was proposed by the doctor. The Supreme Court’s idea of opportunity is fundamentally different: in the language of the capability approach, it is an opportunity for a person to achieve her valued health-goals through the means of a fair range of medical treatments, including alternatives to the treatment that is proposed by the doctor. I will explore this fair range of treatments that should be made available to the patient, which is encompassed by the process aspect of the capability to achieve treatment, in the next chapter.

Chapter 8

Montgomery: A Fair Process for Identifying Available Medical Treatments

> Having conquered many grave diseases and provided relief from suffering, its (the medical profession's) mandate has become muddled. What are its aims? Where is it to stop? Is its prime duty to keep people alive as long as possible, willy-nilly, whatever the circumstances? Is its charge to make people lead healthy lives? Or is it but a service industry, on tap to fulfil whatever fantasies its clients may frame for their bodies…?[1]

8.1 Introduction

In *Montgomery,* Lord Kerr and Lord Reed JJSC set out that the patient is entitled to decide 'which, if any, of the available forms of treatment to undergo'.[2] In the capabilities framework, these available treatments constitute the process aspect of the patient's capability to achieve treatment: the means, or inputs, to the patient's opportunity to achieve the health goals that she has reason to value (2.5). I have discussed earlier that the capability approach provides a normative framework that enables the doctor to make fair judgments about the process aspect and the opportunity aspect of this capability. I dealt with the Supreme Court's views on the opportunity aspect in the previous chapter. In the present chapter, I will discuss the Supreme Court's approach to the process aspect of a person's capability to achieve treatment.

The Supreme Court's test of materiality, which I analysed in Chapter 7, pertains to the opportunity aspect of a patient's capability to achieve treatment. It does not seem that this test can be extended to the process aspect. As observed by Judge Worster in *Bayley,* 'material' was not:

> [T]he qualification applied to provision of information as to alternative treatments. The concept of materiality has an obvious application to risks, but the question of what is a reasonable treatment is a different one, and the concept of materiality is not such an easy fit.[3]

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[1] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (Harper Collins 1997) 717. Parentheses added.

[2] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [87].

[3] *Bayley v George Eliot Hospital NHS Trust* [2017] EWHC 3398 (QB) [60].

Indeed, Lord Kerr and Lord Reed JJSC can be seen to have separated out the opportunity aspect and the process aspect, respectively, in their dictum that medical professionals were obliged to make the patient aware of 'material risks involved in the recommended treatment, *and* of any reasonable alternative or variant treatments'.[4]

The question, then, is 'Who is to decide whether an alternative treatment is or is not "reasonable", and by what standard?...Even if there are in theory alternative treatments, the doctor may not consider them to be reasonable ones'.[5] For instance, in *Bayley*, it was claimed that venous stenting should have been offered as an alternative to compression stockings, for the treatment of deep venous thrombosis, on the basis of some publications from the USA and Europe. But, stenting was not routinely practised in the UK, and an eminent British expert argued against stenting.[6] How was Judge Worster to decide whether, or not, stenting was a 'reasonable' option that ought to have been 'available' to the patient?

I have discussed earlier that capabilities approach calls upon different ideas of justice for the opportunity aspect and the process aspect of a person's capability to achieve treatment. For the opportunity aspect, the capabilities approach relies on public reason, which is embodied in the test of materiality that I discussed in Chapter 7. The process aspect, on the other hand, is grounded in procedural justice (5.6). A certain procedure for the identification of available treatments has to be agreed; whatever is the range of treatments that is identified as available by this procedure, is then fair. In the present chapter, I will explore the procedure that is followed by the Supreme Court in *Montgomery.*

This chapter is set out in the following sections. In section 2, I will discuss that the range of available treatments has to be restricted to treatments that are in the public interest. In Section 3, I will investigate the determinants of medical treatments that are in the public interest. The inference from *Montgomery* is that treatments in the public interest are identified by applying the laws of resource allocation and medical professional judgments. I will outline public law and discuss the notion of a professional judgment. In Section 4, I induce a three-step test that emerges from *Montgomery* for dealing with variable professional judgments, in order to arrive at the range of available or reasonable treatment

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[4] *Montgomery UKSC* [87]. Emphasis added.

[5] *Britten v Tayside Health Board* 2016 GWD 37-668 (Sheriff Court) [23] (Sheriff Collins QC).

[6] The argument in favour of stenting had been advanced by a retired vascular surgeon, who had never employed stenting in his own practice.

options. This three-step test supplies the fair procedure for the identification of available treatments. Section 5 is the conclusion to this chapter.

8.2 Public Interest

The notion of public interest enters into considerations of both the opportunity aspect and the process aspect of a person's capability for medical treatment. But, critically, the priority of public interest is different in each aspect. I will, first, clarify the place of public interest in the opportunity aspect, and, then, expand upon the role of public interest in the process aspect.

8.2.1 The Opportunity Aspect

In *Sidaway*, Lord Templeman had declared that a patient was entitled to refuse treatment 'for reasons which are rational, irrational, or for no reason'.[7] I discussed in Chapter 6 (6.4.4) that Lord Templeman's dictum sets out the space of opportunity in which the patient's agency freedom has complete priority over the achievement of her wellbeing. Lord Mustill later clarifies that this primacy of a person's agency freedom to decline treatment is not contingent upon the consequences to her well-being:

> If the patient is capable of making a decision on whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interest. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue.[8]

Yet, refusals of treatment can create substantial tension because, as explained by Lord Donaldson MR, there is a 'very strong public interest in preserving the life and health of all citizens'. [9] Consequently, a patient's refusal of treatment:

> [G]ives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature

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[7] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL) 904F.

[8] *Airedale NHS Trust v Bland* [1993] AC 789 (CA) 891H. Similarly, Lord Goff ibid 864C states that 'the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so'.

[9] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA) 115G.

> death. Society’s interest is in upholding the concept that all human life if sacred and that it should be preserved if at all possible.[10]

In line with Lord Templeman and Lord Mustill, Lord Donaldson MR resolves this conflict by allowing self-determination to override the public interest.

Lord Donaldson MR does not explain the prioritization: why is self-determination more important than public interest with regard to refusal of medical treatment? The inference is that negative liberty—protection against interference by society—has primacy over public interest with respect to declining medical treatment. I had discussed in Chapter 3 (3.5) that the boundaries of negative liberty for any society will be based in political institutions: for refusal of medical treatment, the House of Lords has determined that there should be no restriction, whatsoever. As pointed out by John Coggon, the common law has secured self-determination, in case of refusal of treatment, as negative liberty.[11]

8.2.2 The Process Aspect

The unrestricted freedom to decline medical treatment that is proposed by the doctor does not extend to the availability of alternatives to the proposed treatment. Claims to an agency-led opportunity to demand any medical treatment, as a prima facie corollary to the unrestricted freedom to decline a proposed treatment, have been rejected repeatedly. In *Burke*, Lord Phillips MR explained that:

> Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as the doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.[12]

Previously, in *Re J*, Lord Donaldson MR had indicated similarly in the context of deciding on the best interests of a child.[13] In *Aintree*, Lady Hale JSC refers approvingly to *Burke* and to *Re J*. Here, in deciding on the best interests of a

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[10] Ibid 112E.

[11] John Coggon, ‘Best Interests, Public Interest, and the Power of the Medical Profession’ (2008) 16 Health Care Analysis 219.

[12] *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [31].

[13] *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33 (CA) 41F: ‘The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reasons is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist upon treatment C’.

patient without capacity, Lady Hale JSC declares: 'That is not to say that his wishes must prevail, any more than those of the fully capable patient must prevail. We cannot always have what we want'.[14]

Lord Phillips MR does not pinpoint the 'source of the duty'—the doctor's 'legal obligation'—to make medical treatments available to the patient.[15] In *Aintree*, Lady Hale JSC provides some clarification: she states that 'any treatment which the doctors do decide to give must be lawful'[16] and she refers to 'a doctor's common law duty of care'[17] that obliges him to offer certain treatments. In setting out these dicta, Lady Hale JSC relies upon decisions of the House of Lords in *Re F* and *Bland*. In *Re F*, Lord Griffiths had explained that:

> Although the general rule is that the individual is the master of his own fate the judges through the common law have, in the public interest, imposed certain constraints on the harm that people may consent to being inflicted on their own bodies.[18]

Later, in *Bland*, Lord Mustill conceived a scale of injuries that a person could consent to receive from another. He emphasized that there was point on this scale, which was higher than scope of the maxim '*volenti non fit injuria'* (no harm is done to the willing), at which consent ceased to be a defence.

Lord Mustill referred to the concurrent case of *R v Brown* for the location of the point up to which consent provided sufficient justification for a medical activity. In *R v Brown*, Lord Templeman had set out that consent was sufficient justification for an activity that could result in personal harm only if that activity had, in the first place, been deemed to be in the public interest.[19] For example, 'If one person cuts off the hand of another it is no answer to say that the amputee consented to what was done'.[20] As discussed by Roger Brownsword, consent, simply in the sense of agreement or acquiescence (however well-informed), cannot be a free-standing justificatory standard for medical

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[14] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591 [45].

[15] *Burke* (n 12) [31].

[16] *Aintree* (n 14) [19].

[17] Ibid [18].

[18] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL) 70D. Subsequently, in *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (CA) 22 Lord Donaldson expressed the point differently: 'However consent by itself creates no obligation to treat. It is merely a key that unlocks a door'.

[19] *R v Brown and other appeals* [1993] 2 All ER 75 (HL) 79. Lord Jauncey ibid 92 sets out a similar view.

[20] *Bland* (n 8) 891F (Lord Mustill).

treatment.[21] Rather, for consent to valid, the medical treatment, itself, has to be a treatment that is in the public interest. By corollary, in seeking consent, a doctor is obliged to offer only treatments that are in the public interest. Lord Mustill labels such medical treatments, which would be in the public interest, as 'proper medical treatment'.[22]

In balancing self-determination and public interest, the House of Lords has distinguished between a person's opportunity to reject a proposed medical treatment and her right to demand any medical treatment.[23] For the former, self-determination trumped public interest. But, for the latter, the converse applied: public interest took priority. I had inferred earlier that the priority of self-determination in rejecting treatment reflects an unrestricted view of negative liberty. In contradistinction, for achieving treatment, negative liberty does not seem to be the relevant sense of liberty that was engaged by the House of Lords. Instead, in case of achieving treatment, the House of Lords appears to have employed the positive sense of liberty (3.5): what is the scope of a person's freedom to authorize the medical treatment that she can receive? Their lordships have determined that boundaries of this positive sense of liberty are to be set by public interest; and not, as for negative liberty, by self-determination.

Coggon argues that, by reliance on public interest, a person's positive liberty is not secured.[24] I argue differently. The limits of both positive liberty and negative liberty are contingent upon normative boundaries. For negative liberty, the House of Lords has set the boundary according to self-determination; on the other hand, for positive liberty, it has set the boundary by public interest. In this way, the boundaries of the two senses of liberty—negative and positive—are secured differently; but, nonetheless, each is secured. Coggon, with José Miola, later accepts that laws that are grounded in political philosophy can legitimately set limits on liberty.[25] From this viewpoint, the prioritization of public interest,

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[21] Roger Brownsword, 'The Cult of Consent: Fixation and Fallacy' (2004) 15 King's College Law Journal 223. See also Neil C Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press 2008) 72.

[22] *Bland* (n 8) 891G.

[23] For further discussion of the judiciary's distinction between demands for 'positive intervention' and 'non-intervention', see John Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (2016) 24 Medical Law Review 396.

[24] Coggon, 'Best Interests, Public Interest, and the Power of the Medical Profession' (n 11) 223.

[25] John Coggon and José Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70 The Cambridge Law Journal 523.

over self-determination, for setting the boundaries of positive liberty is consistent with John Rawls's political argument that:

> The principle of right, and so of justice, puts limits on which satisfactions have value; they impose restrictions on what are reasonable conceptions of one's good. In drawing up plans and in deciding on aspirations men are to take these constraints into account. Hence, in justice as fairness one does not take men's propensities and inclinations as given, whatever they are, and then seek the best way to fulfil them. Rather, their desires and aspirations are restricted from the outset by the principles of justice which specify the boundaries that men's systems of ends must respect.[26]

Yet, the justification for the reliance on public interest has been the subject of considerable debate.[27] Notwithstanding, it is clear that the common law relies on public interest for the selection of proper medical treatment. As such, I will move on to the determinants of proper medical treatment: what are the determining factors, or principles, that doctors ought to follow in identifying 'available' or 'reasonable' or 'proper' treatments?

8.3 Determinants of Medical Treatments in the Public Interest

In *Montgomery*, Lord Kerr and Lord Reed JJSC declare that:

> [T]he treatment which they (doctors) can offer is now understood to depend not only upon their clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost containment and hospital administration.[28]

By this dictum, two principles are involved in determining proper medical treatment: 'clinical judgment' and 'bureaucratic decisions'. Justificatory arguments for determining the proper range of treatment options, then, have to employ premises that derive from these principles, and no others.

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[26] John Rawls, *A Theory of Justice* (first published 1971, Harvard University Press 1999) 27. See also John Rawls, *Political Liberalism* (first published 1993, Columbia University Press 2005) 190.

[27] See Richard E Ashcroft, 'From Public Interest to Political Justice' (2004) 13 Cambridge Quarterly of Healthcare Ethics 20; Richard Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law' (2014) 22 Medical Law Review 459. See also Penney Lewis, 'The Medical Exception' (2012) 65 Current Legal Problems 355; Margaret Brazier and Sara Fovargue, 'Transforming Wrong into Right: What is 'Proper Medical Treatment'?' in Sara Fovargue and Alexandra Mullock (eds), *The Legitimacy of Medical Treatment What Role for the Medical Exception?* (Routledge 2016).

[28] *Montgomery UKSC* (n 2) [75].

What constitutes fair bureaucratic decisions and fair clinical judgments? The ideas, and the unresolved debates, that emerge from *Montgomery* are analysed in the sub-sections that follow.

8.3.1 Bureaucratic Decisions

Their lordships acknowledge that bureaucratic decisions 'are taken by non-medical professionals', and they clarify that:

> [S]uch decisions are generally understood within a framework of institutional rather than personal responsibilities, and are in principle susceptible to challenge under public law rather than, or in addition to, the law of delict or tort.[29]

As explained by their lordships, such bureaucratic decisions pertain to matters of resource allocation, and doctors have to take these decisions into account in offering treatments to patients. The fairness, or otherwise, of such bureaucratic decisions is to be judged according to public law.

The public law that guides resource allocation for the availability of treatments in the NHS is dealt with comprehensively in textbooks of medical law, and I will not set out a detailed analysis here.[30] In short, the Court of Appeal has consistently accepted that the NHS has limited resources, and that limits have to be set on treatments that are made available to individuals, in the context of applications about both waiting list-management[31] and funding for certain types of treatment.[32] The Court of Appeal has declined to set such limits, itself; instead,

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[29] Ibid [75].

[30] For example, Emily Jackson, *Medical Law. Text, Cases and Materials* (2 edn, Oxford University Press 2010) ch 2(4).

[31] In *R v Central Birmingham Health Authority, ex parte Walker* (1987) 3 BMLR 32 (CA) 35, Lord Donaldson MR asserts that it was not for a court 'to substitute its own judgment for the judgment of those who are responsible for allocation of resources'. He explains that a court would not have knowledge of competing claims on resources and was, therefore, not in position to direct the deployment of these resources. He decided that a 'court could only intervene where it was satisfied that there was a prima facie case, not only of failing to allocate resources in the way in which others would think that resources should be allocated, but of a failure to allocate resources to an extent which was *Wednesbury* unreasonable'. Lord Donaldson re-states these principles in *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15 (CA) 28B; *Re J (A Minor) (Wardship: Medical Treatment)* (n 13) 41H.

[32] In dismissing an appeal to fund chemotherapy and a second-marrow transplant for a nine-year-old girl with leukaemia, Lord Bingham MR in *R v Cambridge Health Authority, Ex p B* [1995] 1 WLR 898 (CA) 906D-F (cited approvingly by Lady Hale JSC in *Aintree* (n 14) 600C) explained that 'in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court

it has deferred to policy-makers—'non-medical professionals'—to make such decisions, on the grounds that these decisions are ultimately political.

The Court of Appeal has restricted its own role, in dealing with claims that certain treatment was unfairly denied or delayed, to assessments of the policy for limit-setting and its application to a particular case. In early cases, the test inquired whether the limit-setting decision was '*Wednesbury* unreasonable';[33] in recent cases, a nuanced approach may be discerned.[34] Nonetheless, in all cases, the Court of Appeal essentially has employed procedural justice by scrutinizing whether health authorities had made rational decisions.[35] The Court of Appeal's approach is approved by Lord Dyson JSC in *McDonald* (a case on resource allocation for social care): in examining a limit-setting policy, he declares that 'if it is not irrational, it is not unlawful'.[36]

The Supreme Court's reliance on public law would indicate that doctors ought to offer, or make available, only such treatments as have been approved, in the first place, by policy makers. In other words, doctors ought to restrict their clinical judgments to such approved treatments. If policy makers have declined to fund a certain treatment, then it would be outside the universe of treatments from which a doctor can identify treatments that are available for individual patients. For example, in *Condliff*, doctors agreed that a gastric bypass operation would be of benefit for the patient, who was morbidly obese; however, they were unable to offer this operation—to make it available—because the

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were to proceed on the basis that we do live in such a world…Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients'.

[33] In *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 (CA) 229, Lord Greene MR had explained that, when executive authority had been granted to a body by Parliament, the courts could interfere only if that body's decision was 'something so absurd that no sensible person could ever dream that that it lay within the powers of the authority'. He clarifies (230) that for the decision to be regarded as unreasonable 'it must be proved to be unreasonable in the sense that the court considers it to be a decision that no reasonable body could have come to. It is not what the court considers unreasonable, a different thing altogether'.

[34] For discussion of a change in the Court of Appeal's approach to reasonability in limit-setting, see Daniel Wei L Wang, 'From Wednesbury Unreasonableness to Accountability for Reasonableness' (2017) 76 The Cambridge Law Journal 642. See also Keith Syrett, 'Impotence or Importance? Judicial Review in an Era of Explicit NHS Rationing' (2004) 67 The Modern Law Review 289; Charles Foster, 'Simple Rationality? The Law of Healthcare Resource Allocation in England' (2007) 33 Journal of Medical Ethics 404.

[35] For a practical outline of policy-making for rational limit-setting in the NHS, see Daphne Austin on behalf of The Primary Care Trust Network (part of the NHS Confederation), *Priority Setting: An Overview* (2007).

[36] *R (on the application of McDonald) v Kensington and Chelsea RLBC* [2011] UKSC 33, [2011] 4 All ER 881 [60].

patient's condition did not satisfy the criteria to be selected for this operation that had been specified by the local health authority.[37]

Notably, in *Montgomery*, Lord Kerr and Lord Reed JJSC do not rely on public law only: they instruct that resource-allocation decisions could be challenged by public law 'rather than, or in addition to, the law of delict or tort'.[38] Their lordships do not set out any situation, or cite any case, in which the law of tort would be applicable instead of public law. It could be inferred that their lordships had in mind some case where, despite the absence of any lawful policy on limit-setting (or in the presence of an explicit policy to provide certain treatments), some treatment was not provided to an individual patient because of the scarcity of resource.[39] In this way, their lordships might have been directing attention to the practice of implicit rationing in the NHS.

It is widely recognised, especially by practising clinicians, that simply the approval (or non-exclusion) of treatments by bureaucratic decisions does not translate practically into the availability of resource for individual patients in a timely manner. Consequently, medical professionals have to incorporate these practical constraints into their clinical judgments, which now serve to disguise resource allocation in situations where explicit rationing, as a matter of public law, would simply not be socially or political acceptable. Instead, rationing becomes implicit in clinical judgments.[40] For example, in case of renal dialysis:

> Rationing decisions were mostly hidden in clinical appraisals made by practitioners who, aware of the budgetary constraints, have told patients that nothing more could be done to benefit their health, rather than by saying explicitly that a treatment could not be provided because resources were not available or were to be used for other priorities.[41]

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[37] *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910, [2012] 1 All ER 689.

[38] *Montgomery UKSC* (n 2) [75].

[39] In *Bull v Devon Heath Authority* (1989) 22 BMLR 79 (CA) it was alleged that the health authority had breached its duty by not providing a timely caesarean section. But, the claim was not that the doctors had erred in not offering a caesarean section when it was required; rather, a doctor was simply not present to do it because he was occupied elsewhere. The Court of Appeal decided against the health authority because it found inefficiencies within the existing system of resource-allocation, rather than illegitimacy of the system itself (Slade LJ 101).

[40] Louise Locock, 'The Changing Nature of Rationing in the UK National Health Service' (2000) 78 Public Administration 91; Chris Ham and Angela Coulter, 'Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices' (2001) 6 Journal of Health Services Research & Policy 163.

[41] Robert Schwartz and Andrew Grubb, 'Why Britain Can't Afford Informed Consent' (1985) 15 The Hastings Center Report 19, 24.

In other words, medical professionals implicitly had to ‘change some of the attributes that, if there were sufficient services for all who might want them, would be considered personal values to be weighed by the patient, into medical criteria to be evaluated by the doctor’.[42]

The issue of implicit rationing did not surface directly in *Montgomery*. Nonetheless, it is intriguing to speculate whether, in relying on ‘maternal interests’ to justify her omission to offer a caesarean section to Nadine Montgomery, Dr McLellan might have been considering the interests of other pregnant women in her obstetric unit, which had resource that was sufficient to do a certain number of sections only in a timely manner. In this situation, a caesarean section for Nadine Montgomery would have translated into marginal loss of another pregnant woman’s opportunity for a section. Practising clinicians in the NHS encounter such dilemmas regularly: in offering treatment to any individual patient, should the doctor consider the interests of that patient only and isolate his clinical decision from the practical realities; or, should he consider the interests of all patients in his care; or, should his consideration extend even further, in expanding circles, to all patients in his department, his hospital or the entire NHS?

The GMC is silent on the issue of implicit rationing. Yet, the ethic of care is clear that a care-provider should be partial to care-recipients according to proximity: the obligation to care diminishes as the recipient becomes more distant to the provider (3.7.1). The GMC has emphasized a doctor’s obligation to care for his patient; and a duty of care has been recognised by the House of Lords (6.4.1), and approved by the Supreme Court. On this basis, it could be argued that doctors should not practice implicit rationing: in offering treatment to an individual patient, the doctor should consider that individual only, and ignore the implications of his treatment-decision for the opportunities of the wider community of patients. Such an approach could rely on Martha Nussbaum argument that some situations are simply tragic (2.3.4). Although, an opposing argument, from Amartya Sen, would point out that failing to consider social realities and their consequences is unfair.

There are limited, and conflicting, views on implicit rationing in case law. In *Bland*, Hoffmann LJ indicated support for implicit rationing by observing in obiter that ‘No one is under a moral duty to do more than he can, or to assist one patient at the cost of neglecting another. The resources of the National Health

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[42] Ibid 24.

Service are not limitless and choices have to be made'.[43] But, Lord Browne-Wilkinson rejected Hoffmann LJ's approach:

> [I]t is not legitimate in reaching a view as to what is for the benefit of the one individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources or the impact on third parties of altering the time at which death occurs.[44]

Later, the (now) Lord Hoffmann re-asserted his views: 'The doctor, for example, owes a duty to the individual patient. But he also owes a duty to his other patients which may prevent him from giving one patient the treatment or resources he would ideally prefer'.[45]

Montgomery does not provide any clarification on the problem of implicit rationing in deciding about treatments that should be made available to individual patients. Implicit rationing blurs into professional judgments, which I will discuss next.

8.3.2 Medical Professional Judgment

I have discussed earlier that Lord Kerr and Lord Reed JJSC identify proper medical treatments by reference to 'bureaucratic decisions' about resource allocation and 'clinical judgments'. In the previous section, I pointed out that the separation of these two types of decisions is somewhat artificial, because considerations of resource allocation seem to be pervasive in, rather than simply external to, clinical judgments in the NHS. I will now explore the meaning of a clinical judgment. What constitutes an appropriate 'judgment' by a medical professional? What are the considerations that should be included in, and excluded from, such a judgment?

I will deal with the notion of a clinical judgment by separate reference to the main judgment in *Montgomery,* delivered by Lord Kerr and Lord Reed JJSC, and supplement from Lady Hale JSC, because each seems to engage different (yet connected) ideas of medical professionalism. Lord Kerr and Lord Reed JJSC use the term 'clinical judgment' interchangeably with 'professional judgment'.[46] Thus, they engage a notion of professionalism: what is normative

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[43] *Bland* (n 8) 833C.

[44] Ibid 880B. Although, Lord Browne-Wilkinson did not reject the premises of implicit rationing; rather, he held that this issue was not a matter for the judiciary, and he recommended parliamentary discussion.

[45] *Arthur J S Hall & Co v Simons* [1999] 3 WLR 873 (HL) [11].

[46] Such interchangeable use of these terms can be found in other cases, too. For example, in *Re J (A Minor) (Child in Care: Medical Treatment)* (n 31), Lord Donaldson MR and Balacombe LJ employ 'clinical judgment', whereas Leggatt LJ uses 'professional judgment'.

for a doctor—what ought he to do—in making judgments or decisions in his role as a medical professional? On the other hand, Lady Hale JSC engages the notion of morality: what, if any, role do morals play in decision-making by medical professionals?

8.3.2.1 The Reliance by Lord Kerr and Lord Reed JJSC on Professionalism

The reliance on medical professional judgment for the identification of proper medical treatment is not distinctive to *Montgomery*. Lord Scarman had relied on the doctors' 'clinical judgment' in *Maynard.*[47] Jonathan Montgomery has discussed that judges have traditionally and consistently depended on the professional judgment of doctors on certain matters, rather than to substitute their judgment for that of doctors.[48] Such reliance is grounded implicitly in a certain understanding of a profession as a way of organising a particular type of work, such as medicine. This understanding involves an acceptance that any profession encompasses a unique set of knowledge and skills.[49] Furthermore, such knowledge and skills are so complex and esoteric that these can be possessed by only the members of that profession—the professionals or experts—and by no one else. Moreover, professionalism involves critical skills of interpretation and application of abstract propositions to concrete problems; and, such skills often demand tacit, experiential heuristics that are distinct from formally-articulated knowledge. Consequently, the professionals themselves, and none others, are equipped to make competent decisions in the area of their specialisation.

The complex of nature of professionalism generates normative dilemmas in medical law. How ought a doctor to make an appropriate or fair professional judgment? Who is to decide whether a doctor's professional judgment is correct or wrong? An influential view is that society grants a form of 'autonomy' to professionals. In this view, only the professionals, themselves, have the right to determine what is correct or true in their area; and no one outside the profession can legitimately dictate what those professionals do or how they do it. Eliot Freidson has labelled this model of professionalism as the 'third logic'.[50]

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[47] *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 (HL) 638C.

[48] Jonathan Montgomery, 'Medicine, Accountability, and Professionalism' (1989) 16 Journal of Law and Society 319; Jonathan Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition' (2000) 53 Current Legal Problems 363.

[49] See Julia Evetts, 'The Sociological Analysis of Professionalism: Occupational Change in the Modern World' (2003) 18 International Sociology 395; Elizabeth H Gorman and Rebecca L Sandefur, '"Golden Age," Quiescence, and Revival: How the Sociology of Professions Became the Study of Knowledge-Based Work' (2011) 38 Work and Occupations 275.

[50] Eliot Freidson, *Professionalism Reborn: Theory, Prophecy and Policy* (Wiley-Blackwell 1994), ch 10: Professionalism as Model and Ideology.

The third logic model assumes certain political legitimacy for the medical profession that relates to role of doctors as social-control agents,[51] to which I alluded in Chapter 6 (6.2.2). As a result, this model is vulnerable to criticisms of professional struggles for political power and control, self-interest and elitism.[52]

Jonathan Montgomery argues in favour of a third logic-like model, which relies heavily on self-regulation, by highlighting that medical professionalism involves substantially more than the possession of special technical knowledge and skills.[53] He points out that the tacit and experiential qualities of medical professionalism cannot be captured by outsiders, however well-informed. To be sure, he does not claim that individual doctors should be 'autonomous' and regulate themselves; rather, his argument is that the medical profession, as a body, should have its own regulatory mechanisms. In contrast, Charles Foster and José Miola argue that professional judgments increasingly involve complex legal and ethical issues that the medical profession is ill-equipped to handle on its own.[54] These authors accept that certain 'technical decisions'[55] should be within the exclusive purview of medical professionals; and they reject any idea of a 'free-market' in medicine, akin to, say, running a beauty parlour, where clients choose whatever treatment they like and the workers simply have to provide a service. But, they object to the variability in technical decisions amongst doctors, and they advocate greater legal oversight of the medical profession.

In *Montgomery*, Lord Kerr and Lord Reed JJSC seem to have concurred with Foster and Miola. Their lordships acknowledged that 'the doctor's role when

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[51] See Alison Pilnick and Robert Dingwall, 'On the Remarkable Persistence of Asymmetry in Doctor/Patient Interaction: A Critical Review' (2011) 72 Social Science and Medicine 1374.

[52] See Rupert Jackson, 'The Professions: Power, Privilege and Legal Liability' (2015) 31 Professional Negligence 122. See also Michael Thomson, 'Abortion Law and Professional Boundaries' (2013) 22 Social & Legal Studies 191.

[53] Jonathan Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 Legal Studies 185; Jonathan Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (2017) 70 Current Legal Problems 73.

[54] Charles Foster and José Miola, 'Who's in Charge? The Relationship Between Medical Law, Medical Ethics, and Medical Morality?' (2015) 23 Medical Law Review 4. See also José Miola, 'Making Decisions About Decision-Making: Conscience, Regulation, and the Law' (2015) 23 Medical Law Review 263.

[55] Foster and Miola rely on Ian Kennedy's distinction between 'technical' and 'not technical' decisions in medicine. Ian Kennedy, *Treat Me Right. Essays in Medical Law and Ethics* (Clarendon Press Oxford 1988) 30 had explained a technical decision involved 'the knowledge of what therapies, if any, are available in the context of a particular condition of ill health'. On the other hand, the not technical decision pertained to whether, or not, these therapies should be administered to a particular patient.

considering possible investigatory or treatment options'[56] was 'a matter falling within the expertise of members of the medical profession'.[57] Yet, they explicitly rejected the *Bolam* test for assessing the adequacy of the advice, which includes the availability of 'treatment options', that was provided by a doctor to the patient. In other words, the Supreme Court did not accept that the adequacy of a doctor's professional judgment about treatments that were available to a patient should be assessed simply by reference to the views of a body of the doctor's professional peers. Thus, the Supreme Court appears to have re-appraised medical professionalism. As observed by Judy Laing, 'We have come a long way from Friedson's model of an autonomous and self-regulating profession. *Montgomery* recognises that we have arrived at a new model of professionalism'.[58]

Laing acknowledges that the 'new model' of medical professional that emerges from *Montgomery* remains to be clarified. The re-defining of medical professionalism involves significant challenges.[59] Until some new model is clearly articulated, it would have to be conceded that medical professionals possess certain exclusive knowledge and skills for the identification of proper medical treatments. Accordingly, the appropriateness, or otherwise, of a medical professional's judgment about proper treatment would have to be, in some way, examined by his peers. If so, the *Bolam* test would appear to prevail despite the Supreme Court's stricture to the contrary. I will discuss the Supreme Court's strategy for dealing with the *Bolam* test, in this context, in the next section. But, first, I will move on to Lady Hale JSC's reference to morality in a medical professional judgment.

8.3.2.2 Lady Hale JSC's Distinction Between a 'Moral Judgment' and 'A Purely Medical Judgment'

In her supplementary judgment in *Montgomery*, Lady Hale JSC criticizes Dr McLellan's omission to offer a caesarean section on the grounds that 'this does not look like a purely medical judgment. It looks like a judgment that vaginal delivery is in some way morally preferable to a caesarean section…'.[60] Prima facie, Lady Hale JSC's admonition suggests that a professional judgment should be 'purely medical' and free of moral considerations. Yet, it seems

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[56] *Montgomery UKSC* (n 2) [82].

[57] Ibid [83].

[58] Judy Laing, 'Delivering Informed Consent Post-Montgomery: Implications for Medical Practice and Professionalism' (2017) Professional Negligence 128, 148.

[59] See Montgomery, 'Medicine, Accountability, and Professionalism' (n 48); Stefan Timmermans and Hyeyoung Oh, 'The Continued Social Transformation of the Medical Profession' (2010) 51 Journal of Health and Social Behavior S94.

[60] *Montgomery UKSC* (n 2) [114].

improbable that Lady Hale JSC would have excluded any form of morality from medical professionalism because it is widely accepted that medicine has a moral basis; the unresolved debate is about the acceptable account of medical morality.

One account is of an intrinsic morality of medicine: norms that are binding on a doctor principally because these are goods that are intrinsic to medicine—its telos*,* or ultimate object or aims—as a socially-generated form of human activity.[61] Jonathan Montgomery advances such an internal morality by arguing that 'professional practice already takes into account the moral dimension and approaches its regulation on that basis. Hence, reinforcing prevailing professional standards is also to reinforce moral practice'.[62] He considers that judges have deliberately made decisions to uphold medical professional judgments because they recognised the inherently moral basis of medicine.[63] On the other hand, by calling upon professional regulators to fashion a 'corporate conscience' for the medical profession, Miola appears to advocate an external account of morality; in this way, he, too, admits a moral dimension to medical professionalism.[64]

What, then, could have been the basis for Lady Hale JSC's criticism of morality in *Montgomery's* case? Lady Hale JSC had viewed that the factually-identified risks of caesarean section were 'so low'[65] that there could be no benefit to

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[61] A comprehensive discussion of the philosophies of the internal morality of medicine is beyond the scope of this thesis. For an account of internal morality as essentialism—a teleological account that is based upon reflection on the proper nature and ends of clinical medicine—see Edmund D Pellegrino, 'The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions' (2001) 26 The Journal of Medicine and Philosophy 559. Pellegrino argues that the internal morality is not defined or authenticated by doctors or professional regulators of medicine; it is independent of whether doctors actually accept or reject it. For a different perspective, in which professional norms evolve over time and create tension with societal standards of morality, see Franklin G Miller and Howard Brody, 'The Internal Morality of Medicine: An Evolutionary Perspective' (2001) 26 The Journal of Medicine and Philosophy 581. See also John D Arras, 'A Method in Search of a Purpose: The Internal Morality of Medicine' (2001) 26 The Journal of Medicine and Philosophy 643. For arguments that reject an internal morality, see Robert M Veatch, 'The Impossibility of a Morality Internal to Medicine' (2001) 26 The Journal of Medicine and Philosophy 621.

[62] Montgomery, 'Law and the Demoralisation of Medicine' (n 48) 200.

[63] Jonathan Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square' (2015) 23 Medical Law Review 200.

[64] Miola (54) 266. Tom Beauchamp, 'Internal and External Standards for Medical Morality' (2001) 26 The Journal of Medicine and Philosophy 601 explains that an external account of medical morality is derived from standards outside medicine, such as public opinion or law.

[65] *Montgomery UKSC* (n 2) [110].

vaginal delivery other than it being a ‘unique and wonderful experience’.[66] Based on this understanding, it could be inferred that Lady Hale JSC criticised Dr McLellan for having exercised her personal or private, but not professional, morality in judging that vaginal delivery was preferable to caesarean section for Nadine Montgomery. In other words, Lady Hale JSC saw that Dr McLellan had invoked a morality—a distinction between right and wrong—that was inconsistent with her professional identity but was connected to her membership of, or identification with, some non-professional, say, religious, community.[67]

By this interpretation, Lady Hale JSC’s rebuke would appear to the pertain to the inappropriate exercise of private morality, as a form of conscience-based objection,[68] and not to professional morality, as conceived by either Jonathan Montgomery or Miola. As such, it can be concluded that Lady Hale JSC’s rebuke was not an all-inclusive rejection of moral considerations by doctors in making professional judgments; rather, it prohibits the entry of moral considerations that call upon non-medical-professional justificatory constituencies.[69]

8.4 The Test of ‘Available’ Treatment Options

The propositions that have emerged, so far, are as follows: first, a doctor should offer only proper medical treatment to his patient. Secondly, the range of treatments (which could be none, one or several) that is defined as proper, or available or reasonable, should be determined according to the public law on resource allocation and medical professional judgments. Thirdly, the *Bolam* test appears to remain the measure of adequacy of a professional judgment because it is undisputed that medical professionals have certain unique

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[66] Ibid [113]. Evidence-based medicine contradicts Lady Hale JSC’s understanding of the risks of caesarean section. See Jane Sandall and others, ‘Short-Term and Long-Term Effects of Caesarean Section on the Health of Women and Children’ (2018) 392 The Lancet 1349. See also Jonathan Montgomery and Elsa Montgomery, ‘Montgomery on Informed Consent: An Inexpert Decision?’ (2016) 42 Journal of Medical Ethics 89. In *Clark v Greater Glasgow Health Board* [2016] CSOH 24, 2016 GWD 9-166 [51], Lord Stewart disagrees with Lady Hale JSC: ‘I must respectfully distance myself from the view advanced by Baroness Hale of Richmond, a view apparently uninstructed by evidence, that the widespread obstetric ambition for vaginal delivery represents some kind of moral stance’.

[67] See Daniel Weinstock, ‘Conscientious Refusal and Health Professionals: Does Religion Make a Difference?’ (2014) 28 Bioethics 8. See also Chloë Fitzgerald, ‘A Neglected Aspect of Conscience: Awareness of Implicit Attitudes’ (2014) 28 Bioethics 24.

[68] See Avery Kolers, ‘Am I My Profession's Keeper?’ (2014) 28 Bioethics 1.

[69] For the debate on separation of private and professional morality, over and above the statutory conscience clauses, see Mary Neal and Sara Fovargue, ‘Conscience and Agent-Integrity: A Defence of Conscience-Based Exemptions in the Health Care Context’ (2016) 24 Medical Law Review 544.

knowledge and skills that can be assessed by the professionals themselves only. In other words, a professional judgment is, essentially, the private reason of medical professionals: a way of reasoning that can be grasped by fellow professionals only, and by none others.

I discussed in Chapter 5 (5.5) that private reasoning can legitimately result in many solutions for the same problem. As observed by Lord Scarman in *Maynard*, ‘Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment’.[70] I have discussed in Chapter 6 (6.2.3) that the *Bolam* test recognises and accommodates private reason: it accepts that there can be genuine differences in judgments on the same case amongst medical professionals, and that the existence of opposing judgments does not necessarily mean that one judgment is wrong. But, in *Montgomery,* the Supreme Court rejects the *Bolam* test for assessing the doctor’s advice to the patient. Implicitly, the Supreme Court regarded it as unfair that the treatment that is available to a patient should be determined by the private reason of her doctor.

How, then, does the Supreme Court deal with medical professional judgments to identify the fair range of treatment options that should be available to a patient? In *Montgomery*, the Supreme Court was faced with two opposing professional judgments, each in favour of a different treatment option, namely, vaginal delivery and caesarean section. Each option was accepted by one group of professionals, as represented by one set of expert witnesses, who disagreed with the other group that held the opposing judgment. The Court found that both options were acceptable: it did not conclude that either one should be rejected because it was logically unsound. Instead, the Court decided that both options, each of which was accepted and acceptable, should have been offered to the patient. In this way, the Court’s reasoning, for determining the range of proper medical treatments that should be offered to a patient, seems to have consisted of a test that was organised in three sequential steps: first, was each contested option actually accepted by a group of professionals? Second, was each of the accepted-options acceptable? And third, were all the accepted and acceptable options offered to the patient? I will discuss each of these steps separately, in the sub-sections that follow:

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[70] *Maynard* (n 47) 638H.

8.4.1 Was Each Option Actually Accepted?

The Supreme Court was presented, on the one hand, with three expert witnesses in obstetrics who supported Dr McLellan's proposal of vaginal delivery to Mrs Montgomery. On the other hand, two expert witnesses disagreed with Dr McLellan: in their professional judgments, a caesarean section should have been offered. Their Lordships seem to have resolved the issue of whether each of the two professional judgments, assessed separately, was appropriate by reference to the expertise of medical professionals. Having found that vaginal delivery was supported by a body of professional opinion, the Court did not conclude that this option was inappropriate: it did not criticise Dr McLellan for having exercised professional judgment of inadequate standard in selecting vaginal delivery as an option. Rather, the Court discerned that both vaginal delivery and caesarean section were accepted options, and it rebuked Dr McLellan for having offered only one of these two options to her patient.

The Supreme Court's strategy to rely on the expertise of a group of medical professionals to decide whether a professional judgment was appropriate, and to maintain that this judgment remained appropriate despite the disagreement of another group of professionals, is, essentially, the *Bolam* test. Thus, as has been pointed out by Jonathan Montgomery,[71] the Court's rejection of the *Bolam* test was limited: this test was rejected for assessment of the materiality of risk, but not for the assessment of individual treatment options. This is the strategy that was suggested in *Sidaway* by Lord Scarman (6.4.1); and, tacitly, the Supreme Court approved this strategy in *Montgomery*. Although, unlike Lord Scarman, the Supreme Court does not restrict available treatments to the private reason of only the doctor who was treating the patient.

It is critical to note that, at this stage, the Court's assessment of the contested treatment options was restricted to a determination of whether each option was actually accepted by a group of medical professionals; the assessment did not extend to options that might, or should, have been acceptable. In other words, the Court's view was that the starting point of a patient's choice was a set of options that was actually accepted by doctors, and it did not include other options that might be advanced on a theoretical basis. The preceding inference is consistent with doctrine on best interests decision-making for patients without capacity, where courts have declined to direct that a treatment that is not accepted by any group of professionals should be provided, notwithstanding

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[71] Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (n 48).

arguments to the contrary.[72] For example, in *AVS*, it was claimed that it was in the best interests of a patient with advanced CJD to continue with an experimental treatment. But, despite arguments in favour of this treatment from a foreign expert in neurology, no practising, domestic neurologist, who was actually prepared to administer this treatment, could be found. In declining to make a declaration for this treatment to be given, Ward LJ explained that 'It is well established that the court does not decide hypothetical questions'.[73] In other words, the courts will deal only with medical professional disagreements, or controversies, that are actual, and not simply theoretical.[74]

In conclusion, in this first step of the test of available treatments, the Supreme Court used the prevalent-practice interpretation of the *Bolam* test: would a particular professional judgment have been actually adopted and followed by a body of professionals? But, the *Bolam* test was redeployed: it was not used to simply approve a clinical judgment on the basis of professional endorsement; instead, the test was used to explore whether an alternative judgment, too, would have been accepted. In this way, the *Bolam* test is used, at this stage, to assess not only the standard of the judgment that was made in a particular case, but also to investigate the existence of an alternative to this judgment. If the contested alternative, for example, caesarean section in *Montgomery*, was accepted, then the case would proceed to the second step of the test. On the other hand, if the contested alternative would not be offered actually by any body of professionals, in the particular circumstances of an individual case, then the claim would simply fail at this stage. Following *Montgomery*, Judge Worster seems to have followed this approach in *Bayley*. He rejected the claim that venous stenting should have been offered as an alternative to compression stockings on the grounds that 'this procedure was nowhere near being accepted practice'.[75] Not dissimilarly, Lord Brodie explains that 'For a decision or choice to have to be made there must of course be more than one choice

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[72] For examples, *AVS v An NHS Foundation Trust* [2011] EWCA Civ 7, [2011] 2 FLR 1; *NHS Trust v L* [2012] EWHC 4313 (Fam); *Re N (An Adult) (Court of Protection: Jurisdiction)* [2015] EWCA Civ 411, [2016] Fam 87. See also Richard Huxtable and Giles Birchley, 'Seeking Certainty? Judicial Approaches to the (Non-) Treatment of Minimally Conscious Patients' (2017) 25 Medical Law Review 428.

[73] *AVS* (n 72) [32]. Similar ratios were applied by Moylan J in *NHS Trust v L* (n 72) [90], [112]; and by Munby P in *Re N* (n 72) [19]. The extension of doctrine on best interests decision-making to patients with capacity is supported by Lady Hale JSC in *Aintree* (n 14) [45].

[74] See Eric Vogelstein, 'Professional Hubris and its Consequences: Why Organizations of Health-Care Professions Should Not Adopt Ethically Controversial Positions' (2016) 30 Bioethics 234 for a typology of controversies in medicine.

[75] *Bayley* (n 3) [99].

which is available and as to which a decision must be made. The availability of choice in any particular case is again a matter for medical evidence'.[76]

8.4.2 Were All Accepted-Options Acceptable?

A major criticism of a prevalent-practice interpretation of the *Bolam* test is that it does not seek accountability from professional judgments. In *Bolitho*, Lord Browne-Wilkinson restricted unaccountability by requiring that, for an accepted professional judgment to deemed as appropriate, it was necessary to 'demonstrate that such opinion has logical basis'.[77] In this way, his lordship emphasized the normative aspect of the *Bolam* test; that is, a professional judgment was required to be not only accepted but also acceptable (6.2.2). In other words, in scrutinising accepted disagreements amongst medical professionals, the inquiry must extend to the assessment of whether the disagreement was genuine, that is, supported by logical arguments on either side; or whether the disagreement was false, that is, the position that was asserted by one side was devoid of logical grounds.[78]

The engagement of the *Bolam* test, in the Supreme Court's strategy, requires its normative version to be applied in the second step of the test of available treatments: was each of the accepted-options acceptable? If any accepted option did not have a logical basis, then it would be discarded at this stage, and the claim would not progress further. In *Montgomery*, there were logical arguments to support both options;[79] and, as such, the Court did not reject vaginal delivery as one acceptable option. In contrast, for example, consider the case of *Holdsworth*.[80] Here, it was accepted that a body of orthopaedic surgeons would have offered uni-compartmental knee replacement, as an alternative to total knee replacement, but it was argued that it was illogical to do so. Judge Freedman agreed that 'In accordance with Bolitho, that raises the question as to whether the decision withstands logical scrutiny',[81] and that a treatment should not be offered if it did not withstand such scrutiny.

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[76] *LT (as guardian of RC) v Lothian NHS Health Board* [2019] CSIH 20 [62].

[77] *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) 242A.

[78] See Vogelstein (n 74).

[79] See citations in Royal College of Obstetricians and Gynaecologists Green-top Guideline No. 42 on *Shoulder Dystocia;* NICE CG132 on *Caesarean Section*.

[80] *Holdsworth v Luton and Dunstable University Hospital NHS Foundation Trust* [2016] EWHC 3347 (QB), (2017) 154 BMLR 172.

[81] Ibid [39]. On analysis of expert evidence, Judge Freedman found that uni-compartment knee replacement did, in fact, withstand logical scrutiny, and he decided that it was appropriate to offer this operation as an alternative to conservative treatment.

8.4.3 Were All Actually-Accepted and Acceptable Options Offered to the Patient?

Even by its normative interpretation, the *Bolam* test admits more than one professional judgment. Different judgments may acceptable to different professional groups. In such a situation, as pointed out by Butler-Sloss P, ‘the duty to act in accordance with responsible and competent professional opinion may give the doctor more than one option since there may well be more than one acceptable medical opinion’.[82] In *Montgomery*, the Supreme Court seems to have approved and applied Butler-Sloss P’s approach. The Court concluded that there were two professionally-accepted and acceptable treatment options: vaginal delivery and caesarean section. The Supreme Court decided that Dr McLellan should have offered both these options to her patient.

Thus, Dr McLellan was obliged to offer treatments that were identified by not only her own professional judgment but also the judgments of other members of her profession. In other words, a doctor is obliged to offer, or make available, all acceptable treatments that are accepted by at least some of his colleagues, regardless of whether or not he, himself, actually accepts these treatments. This paradigm can place a doctor in one of the following two positions:

One position would be that the doctor, who is treating the patient, does not reject all the acceptable options. For example, in *Montgomery*, one expert witness conceded that, although he favoured caesarean section, he did not reject that vaginal delivery was an available option, and he would have conducted the option with which Nadine Montgomery was ‘happy’.[83] In other words, for this obstetrician, the basis of decision-making (4.2) included both caesarean section and vaginal delivery. This obstetrician was now in a position of equipoise to embark on shared decision-making (SDM; 4.3) with Mrs Montgomery about a choice between these two options.

The other position, which was occupied by Dr McLellan, was that she did not view both vaginal delivery and caesarean section as acceptable options. Although caesarean section was accepted by a body of obstetricians, it was not accepted by the body of obstetricians with whom Dr McLellan identified. In Dr McLellan’s professional judgment, which was supported by a group of her peers, caesarean section was not acceptable because it was ‘not in the maternal interests’.[84] Consequently, she could not be in equipoise about the choice between vaginal delivery and caesarean section; and, therefore, it could

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[82] *Re S (Adult Patient: Sterilisation: Patient's Best Interests)* [2001] Fam 15 (CA) 27F.
[83] *Montgomery UKSC* (n 2) [24].
[84] Ibid (n 2) [13].

be argued that she would not be able to undertake SDM with Mrs Montgomery. For any practice of shared-decision making, it is essential that the doctor is in a state of equipoise about alternative treatments; because, if the doctor believes that there is only one medically proper treatment, then he will not be able to share any other decision with the patient.[85] In such a situation, where the doctor and patient cannot share the treatment-decision, SDM cannot completed, regardless of the amount of information that might have been shared.[86]

How should a doctor, in Dr McLellan's position, deal with the situation in which a body of his professional colleagues holds an opinion, or judgment, that is contrary to his own, yet not rejectable?[87] In *Burke*, Lord Phillips MR had dealt with a related situation: he had considered a doctor's response to requests for treatment that were contrary to the doctor's own professional judgment. Here, Lord Phillips MR had ruled that a doctor 'should offer to arrange a second opinion'.[88] Lord Phillips MR may have been guided by Lord Bridge's reference to a second opinion in *Sidaway* (6.4.3). Notwithstanding, the law on seeking second opinions seems presently unclear because, in analysing *Burke*, Lord Dyson MR has discerned that 'It is not clear whether Lord Phillips meant that the doctor is under a *legal obligation* to offer to arrange a second opinion or whether he should do so as a matter of good practice'.[89] Lord Dyson MR concluded that he 'would be reluctant to hold that a doctor is under a legal obligation to arrange a second opinion in all circumstances'.[90]

In any case, in *Montgomery*, the Supreme Court does not make any mention of a second opinion. Rather, the Court's stance was that Dr McLellan, herself, should have offered and provided a caesarean section, although this was contrary to her own professional judgment. By this account, Lady Hale JSC's concession that a patient could not 'force her doctor to offer treatment which he

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[85] Glyn Elwyn, Dominick Frosch and Stephen Rollnick, 'Dual Equipoise Shared Decision Making: Definitions for Decision and Behaviour Support Interventions' (2009) 4 Implementation Science 75, 77 explain that equipoise is 'the existence of options that are in balance in terms of their attractiveness, or that the outcomes are, to a degree at least, equally desirable (or possibly, undesirable)'.

[86] See Cathy Charles, Amiram Gafni and Tim Whelan, '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 emphasize that a fundamental requirement of SDM is both, information and the treatment-decision, have to be shared by the doctor and the patient.

[87] As discussed earlier (5.4), non-rejectability makes stronger demands than acceptability. Although Dr McLellan did not accept a caesarean section, she would not have been to reject it altogether.

[88] *Burke* (n 12) [50v].

[89] *R (on the application of Tracey) v Cambridge University Hospital NHS Foundation Trust* [2014] EWCA Civ 822, [2015] QB 543 [63]. Lord Dyson's emphases.

[90] Ibid [63].

or she considers futile or inappropriate'[91] opens to a different interpretation: the 'he or she' does not refer to the individual treating-doctor but to the entire body of professionals in the relevant specialty. The inference from Lady Hale JSC's dictum is that Mrs Montgomery could not force Dr McLellan to offer treatment that all obstetricians considered to be inappropriate; but, Mrs Montgomery was entitled to treatment that, despite being considered inappropriate by Dr McLellan, was appropriate in the view of some other obstetricians.

In summary, a doctor is obliged to provide all acceptable treatments that are actually accepted by his peers. Following *Montgomery*, some lower courts have adopted this approach. For instance, in *Webster*, it was claimed that induction of labour should have been offered as an alternative to spontaneous delivery. Each option was accepted by opposing experts, and arguments on both sides had a logical basis. Simon LJ rejected a submission about a second opinion; instead, he decided that the treating-obstetrician, himself, should have offered to induce labour as an alternative to awaiting natural childbirth.[92] Similar approaches may be detected in in the judgments of Lord Brailsford in *Britten*[93] and Judge Freedman in *Diamond*.[94] On the other hand, in *Barrett*, Blair J appears to have followed the first and second steps of the Montgomery procedure, but then deviated in deciding in favour of what he considered to be the 'better advice'.[95] Also, in *Grimstone*, McGowan J diverged by deciding in favour of the surgeon simply on the basis that his advice would be accepted by a body of his peers and that it was logically sound.[96]

8.5 Conclusions

The process aspect of a person's capability to achieve treatment—the identification of proper treatments should be made available to the patient—relies inescapably on medical professional judgments. The nature of professionalism is such that there can be genuine differences in judgments amongst doctors about the availability of treatment for the same patient. In *Montgomery*, the Supreme Court implicitly regards it as unfair that a person's

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[91] *Montgomery UKSC* (n 2) [115].

[92] *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62, [2017] Med LR 113 [41].

[93] *Britten* (n 5).

[94] *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB). Affirmed in *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2019] EWCA Civ 585, [2019] Med LR 273.

[95] *Barrett v Sandwell and West Birmingham Hospitals NHS Trust* [2015] EWHC 2627 (QB), (2016) 147 BMLR 151 [162].

[96] *Grimstone v Epsom and St Helier University Hospitals NHS Trust* [2015] EWHC 3756 (QB) 10.

treatment options should be restricted because of disagreements, even if genuine, amongst doctors. Yet, the Court does not abandon the traditional reliance on medical professional judgments for identifying proper medical treatment. Rather, the Court uses a certain procedure for dealing with professional judgments; the outcome of this procedure is, then, the fair range of treatments that should be made available to the patient. A doctor now ought to use this fair procedure in making judgments about the treatments that are available to a patient: he should offer all acceptable treatments that are actually accepted by, at least, some of his professional peers; even if he, himself, does not accept these treatments.

The Supreme Court’s procedure for the identification of available treatments is subject to various practical difficulties. I will discuss these difficulties in the process aspect of the capability to achieve treatment, and associated challenges in the opportunity aspect, in the next chapter.

Chapter 9

A Fair Capability to Achieve Medical Treatment

9.1 Introduction

The doctor’s obligation to seek and obtain a patient’s consent implicitly has two stages, and the doctor is required to make evaluative judgments in each of these two stages (1.2). The reconceptualization of a doctor’s obligation to obtain consent to an obligation to provide the patient with a fair capability to achieve medical treatment supplies conceptual clarity about the nature of the judgments in each of these stages. Furthermore, the two aspects of the capability to achieve treatment—the process aspect and the opportunity aspect—allow a clear distinction between the two stages of consent (2.5). The process aspect deals with the treatments that the doctor ought to make available to a patient. The opportunity aspect, then, does not include a chance for the patient to choose the range of available treatments; instead, it pertains to the real or effective possibilities for a person to use the available treatments, which have been identified through the process aspect, as the means to achieve the health-goals that she has reason to value. The judgments in regard to the process aspect should be made according to an agreed, fair procedure (5.6). On the other hand, judgments about the opportunity aspect require public reason, and involve the balancing of a patient’s agency freedom with her well-being achievement.

In *Chester*, Lord Hope observed that ‘litigation on informed consent could provide stimulus to the broader debate about the nature of the doctor-patient relationship’ and it could serve a powerful symbolic and galvanising role in shaping medical professionalism; but, it cannot frame practical guidance for doctors.[1] Accordingly, the analysis of *Montgomery* in the present thesis supplies important insights to the Supreme Court’s views on the fair capability to achieve treatment that should be provided to a patient; however, this work, on its own, cannot generate detailed rules for making the judgments that are required in the two aspects of this capability. Rather, the present thesis illuminates areas that require further research in order that the capability to achieve treatment can

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[1] *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 154D.

‘operationalised’,[2] that is, put into practice as mechanism for doctors to obtain consent from patients, and for this activity to be monitored.

Montgomery provokes debates within both the process aspect and the opportunity aspect of the capability to achieve treatment. In section 2, I deal with the process aspect. I will discuss three difficulties that can arise in the practical application of the fair procedure for the identification of available treatments that can be inferred from case law. Each of these difficulties pertains to an aspect of medical professionalism, and outlines further work that is required in order to clarify the ‘new model’ of professionalism that emerges from *Montgomery* (8.3.2.1). In section 3, I turn to the opportunity aspect. I will trace the origin of this aspect in case law to the distancing of consent practices from the private reasoning of medical professionals; and I will point out the tension that emerges from continuing to rely on the perfectly rational agent of John Rawls’s theory of public reason, rather than acknowledging the epistemic and cognitive limitations of real persons that are emphasized by Amartya Sen and feminist theorists. Section 3 is the conclusion to this chapter and to this thesis.

9.2 The Process Aspect of the Capability to Achieve Treatment

The process aspect of the capability to achieve treatment is the fair procedure that should be employed in deciding the treatments that are available to a patient. From *Montgomery,* a three-step procedure—a test of available treatments—can be induced (8.4). In short, this procedure requires the doctor to make available all treatments that are accepted by his professional peers, provided that these treatments are acceptable; even if the doctor, himself, does not accept one or another of these treatments.

The three-step procedure that emerges from *Montgomery* is a significant departure from the procedure that was relied upon traditionally in case law (6.2.4; 6.3.4). Up to *Montgomery*, the assessment of availability of medical treatment was based simply on the private reason (5.5) of the doctor who was treating the patient:[3] would the treatment, or treatments, that this doctor had made available be endorsed by a body of his peers; even if another body of his peers disagreed with that doctor’s choice of treatment? The *Montgomery* procedure continues to rely on the private reason of medical professionals; but, it includes the private reason of all relevant medical professionals, instead of

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[2] See Tania Burchardt and Polly Vizard, ‘‘Operationalizing’ the Capability Approach as a Basis for Equality and Human Rights Monitoring in Twenty-first-century Britain’ (2011) 12 Journal of Human Development and Capabilities 91.

[3] Although, a departure from this practice could be discerned in the judgment of the Master of the Rolls in *Pearce* (6.5).

relying exclusively on the private reason of the doctor who was treating the patient. In this way, *Montgomery* imputes a powerful change to medical professionalism: the professionals are no longer entitled to rely upon differences in private reason within the profession.

Despite the encompassment of differences in private reason, the *Montgomery* procedure continues to be fundamentally reliant on the private reason of medical professionals: treatments that are ‘available’ have to be restricted to treatments that can be justified to some constituency of medical professionals. Professionalism, then, essentially remains as the private reason of the professionals; the ‘new model’ of medical professionalism from *Montgomery* does not invoke public reason, or any other way of reasoning, for identifying available treatments. Rather, the *Montgomery* procedure introduces a strategy for dealing with diverse private reasons about the availability of treatments; yet, the scrutiny of these private reasons—are these reasons indeed ‘lawlike’ (5.5)?—stays largely internal to the medical profession.[4]

The Supreme Court’s strategy for dealing with private reason—the inclusion of the private reason of all relevant professionals—poses three main difficulties for practical implementation. Each of these difficulties relates to an attribute of professionalism that remains to be clarified through future work.

9.2.1 The Epistemic Difficulty

The epistemic difficulty pertains to the first step of the *Montgomery* procedure: the identification of all treatments that are actually accepted by practising doctors. This is a knowledge-related, or epistemic, difficulty. In the clinical situation—the doctor’s office or the hospital ward—how is the treating-doctor to ascertain, or know, whether his peers would offer treatments other than the one which he deems suitable (that is, accepts)? In some cases, for example, caesarean section as an alternative to vaginal delivery, the identification of treatments that will be accepted by other doctors might be quite easy; but, in case of complex diseases, the obligation to recognise treatments that would be actually offered by other doctors can be extremely challenging.

In Chapter 1, I discussed an example of deciding a patient’s ‘fitness’ for a gastrectomy operation for stomach cancer; and, in Chapter 3, I pointed out that evidence-based medicine (EBM) relies on professional judgments to set

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[4] It is not entirely internal because the introduction of logic in the second stage of the test allows some external scrutiny. Yet, as I will discuss in (9.2.2), the role of logic is restricted.

'eligibility checkpoints',[5] or thresholds, for such determinations of 'fitness'. However, such thresholds are usually vague and not explicitly articulated. Moreover, there can be various types of uncertainty about treatment outcomes, and published literature might be interpreted differently by different professionals in the context of individual patients.[6] How, then, is the treating-doctor to deal with the possibility that a certain treatment that he does not accept as available for an individual patient might be accepted by his peers?

Some attempt to seek diverse opinions is made through discussion of complex cases in multi-disciplinary team (MDT) meetings. However, it is not practically feasible for every, single case to be discussed by an MDT. Moreover, the composition of an MDT is local, and the diversity of opinions in an MDT is often restricted; indeed, an important reason for geographic area variations in medical treatments is that medical professionalism is often characterised by provincial practice patterns.[7] For example, a certain surgical procedure is taught by an influential surgeon, and his trainees then get appointed to the staff of the same hospital and neighbouring hospitals, such that this procedure now becomes the 'surgical signature'[8] of that area. Alternatively, all professionals in an MDT might be guided by similar values and resource constraints that may be quite different to other regions of the country. Thus, MDT recommendations can be inward-

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[5] Justin T Clapp and others, 'Surgical Consultation as Social Process: Implications for Shared Decision Making' (2019) 269 Annals of Surgery 446.

[6] See Paul K J Han, William M P Klein and Neeraj K Arora, 'Varieties of Uncertainty in Health Care: A Conceptual Taxonomy' (2011) 31 Medical Decision Making 828.

[7] For example, The Royal College of Surgeons of England Clinical Effectiveness Unit and others, *National Oesophago-Gastric Cancer Audit 2018: An Audit of the Care Received by People with Oesophago-Gastric Cancer in England and Wales 2018 Annual Report* (Version 2, 2019) 45 shows significant differences in the proportion of patients who received radical treatment according to geographical area: ranging from 57% in the Thames region to 30% in South Yorkshire, despite the absence of any significant differences in disease characteristics or patient-preferences in different regions of England; and the existence of National Institute for Health and Care Excellence, *Oesophago-Gastric Cancer: Assessment and Management in Adults* (NICE Clinical Guideline NG83, 2018). For discussion of variations in treatment decisions, see John E Wennberg, Benjamin A Barnes and Michael Zubkoff, 'Professional Uncertainty and the Problem of Supplier-Induced Demand' (1982) 16 Social Science and Medicine 811; John E Wennberg, 'Unwarranted Variations in Healthcare Delivery: Implications for Academic Medical Centres' (2002) 325 The British Medical Journal 961.

[8] John D Birkmeyer and others, 'Understanding of Regional Variation in the Use of Surgery' (2013) 382 The Lancet 1121, 1128. See also Christopher T Aquina and others, 'Surgeon, Hospital, and Geographic Variation in Minimally Invasive Colectomy' (2019) 269 Annals of Surgery 1109.

looking, and it could be argued that it is unfair to restrict the availability of treatment on this basis.[9]

In conclusion, it does not seem that a practising doctor can always depend on a forum of actual debate, such as an MDT meeting, to discern whether his peers might accept a treatment that he, himself, does not view as proper for a particular patient. Rather, it would appear that there has to be dependence on some attribute of professionalism, itself, to claim that an individual professional must recognise judgments, other than his own, that would be put forward by his peers. The ‘new model’ of professionalism that emerges from *Montgomery* implies such a professional attribute, but this remains to be clarified.

9.2.2 The Political Difficulty

The political difficulty concerns the second step of the *Montgomery* procedure: the assessment of whether the accepted options are acceptable. How is it to be decided what is acceptable, and what is not? It does not seem that acceptability can hinge simply on a ‘logical basis’, as demanded in *Bolitho*.[10] For instance, there does not appear to be any logical fallacy in the following argument: gastrectomy is the only curative treatment for stomach cancer; the 5-year survival rate for stage I stomach cancer, treated by gastrectomy, is about 90%; without gastrectomy, death is certain within about two years; the patient, who is very well-informed and intelligent, has estimated peri-operative mortality of 50%, and she is willing to take the risk; therefore, gastrectomy should be an available treatment-option for her. Yet, it is highly unlikely that any cancer surgeon in the UK would judge that gastrectomy was acceptable, or proper, treatment for this patient, and would agree to do this operation.

It would appear that the normative argument of the acceptability, or otherwise, of a treatment pivots, ultimately, on value judgments. I have discussed in Chapter 4 that value judgments are integral to clinical practice policies in the form of clinical guidelines, which constitute the modern form of EBM. Similarly, value judgments are unavoidable in deciding policy in individual cases, such as the one exemplified in the preceding paragraph. The ‘logical basis’ of *Bolitho*,

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[9] For an argument about the unfairness of restricting the availability of medical treatments on grounds that are not, themselves, justifiable by equitable principles, see Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008) ch 2: When are Health Inequalities Unjust? See also Fabienne Peter, ‘Health Equity and Social Justice’ in Sudhir Anand, Fabienne Peter and Amartya Sen (eds), *Public Health, Ethics, and Equity* (Oxford University Press 2004).

[10] *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) 242A (Lord Browne-Wilkinson).

then, implicitly seeks to transmute evaluative assessments into medical scientific policy. As explained by Séverine Deneulin and Allister McGregor:

> Although policy decision-making cannot escape the reality of value judgments, public policies often have been presented as an unavoidable technical solution to an objective problem. This turn of the social science, of course, has also been reinforced over the long haul by processes of bureaucratization and the embedding of technocratic expertise and technique within public policy processes, but the screen of depoliticization cannot fully obscure the fact that technocratic discourses disguise value judgments about the good society.[11]

I have pointed out the requirement for doctors to make value judgments at several places throughout this thesis. My aim has been to provide doctors with a normative framework for making such judgments. However, the capability approach, which I have used in the present thesis, cannot address the problem of value judgments in this particular instance, that is, for policy-making about the acceptability of medical treatment in particular situations. As I have explained in Chapter 2, the capability approach is an underspecified theory of justice that does not deal with distributive problems. As such, the normative attributes of professionalism, which apply to making value judgments about the acceptability of treatments, require further engagement with political philosophy and public debate.

9.2.3 The Craftsman's Difficulty

The craftsman's difficulty involves the third step of the *Montgomery* procedure: the provision of treatments that are acceptable but not actually accepted by the treating-doctor. This difficulty is especially pertinent to the surgical specialties, which involve large elements of craft, over and above the science and art that are common to all medical specialties. In some instances, the treating surgeon may simply not have the skills—the abilities of a craftsman—to conduct the alternative treatment that he does not accept; fundamentally, he does not accept a certain operation because he does not have the skills to perform it.[12]

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[11] Séverine Deneulin and J Allister McGregor, 'The Capability Approach and the Politics of a Social Conception of Wellbeing' (2010) 13 European Journal of Social Theory 501, 508.

[12] The question arises, also, of whether a surgeon who does not perform a certain procedure can inform adequately about this procedure that he does not perform. Lord Glennie alludes to this difficulty in *Johnstone v NHS Grampian* [2019] CSOH 90.

For example, the National Oesophago-Gastric Cancer Audit shows that about 20% of all gastrectomy operations in the UK are conducted by laparoscopy, and the remainder by conventional, open surgery.[13] Laparoscopic surgery has several advantages over open surgery;[14] at the same time, laparoscopy poses significantly greater technical challenges than open surgery, and the majority of surgeons in the UK do not have required the technical skills. If laparoscopic surgery were to be offered to all patients with gastric cancer, then the patients who accepted this offer (and it is commonly seen that the vast majority of patients who are offered laparoscopy will prefer this technique) would have to be referred to a surgeon who is accomplished in conducting laparoscopic gastrectomy; and there simply is not a sufficient number of such surgeons in the UK.

For the third step of the test to be workable practically, medical professionalism would require significant re-organization, such that all professionals in any specialty have uniform skill-sets and experience.

9.3 The Opportunity Aspect of the Capability to Achieve Treatment

The opportunity aspect of a patient’s capability to achieve treatment pertains to the real or effective possibilities for the patient to use the available treatments to achieve the ends or goals that she has reason to value. In the capabilities paradigm, these valued ends are not identified simply according to a patient’s agency (which corresponds broadly to authentic desires in two-stage theories of autonomy; 3.3.1); rather, the identification corresponds to a balance of agency with well-being (which aligns with the Kantian conception of principled autonomy; 3.2.3). In explaining agency (2.3.1), Amartya Sen highlights the relevance of social plurality and diversity; at the same time, he emphasizes that agency is unavoidably shaped by a person’s social context and situation (consistent with feminist ideas of relational autonomy; 3.6). Consequently, a person’s agency may not align with her well-being, which is a normative notion, not only because of social diversity but also because the person simply does not possess the necessary epistemic and cognitive abilities to identify her own well-being.

In recognition of the limitations of agency, the capability approach holds that, in deciding about the opportunity that is to be provided to a person, decision-

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[13] NOGCA 2018 (n 7).

[14] See Abeezar I Sarela, ‘Entirely Laparoscopic Radical Gastrectomy for Adenocarcinoma: Lymph Node Yield and Resection Margins’ (2009) 23 Surgical Endoscopy 153.

makers have to take into account both the person's 'agency freedom' and her 'well-being achievement'; because, notwithstanding the primacy of freedom, a fair society cannot be blind to outcomes (2.3.2). The normative conception of a person's well-being, the balancing of well-being with agency and the construction of the corresponding opportunity are matters for public reason (2.3.4). According to Sen, a patient would have been provided with a fair opportunity if all decisions could be justified to an 'impartial spectator' (5.4).

9.3.1 The Evolution of Opportunity in Case Law

It can be inferred that a fair opportunity to achieve treatment in case law was conceived in response to prevailing sociological ideas. The sociological narrative of the mid-20th century focussed on the limitations of a person's agency in regard to appreciating her own well-being (6.2.1). It does not appear to have been recognised that a person's agency might diverge from normative ideas of well-being because of social plurality and diversity of values; alternatively, social heterogeneity was not prized. Furthermore, there was a strong emphasis on patients' civic responsibilities and on the role of doctors as social control-agents who had implicit political authority (6.2.2). On this background, the balancing of agency freedom with well-being achievement and the construction of the corresponding capability to achieve treatment (including both the process aspect and the opportunity aspect) were delegated to the private reason of medical professionals (6.2.3). The *Bolam* case is set in this sociological paradigm; the idea of justice in this case was not that of the capability approach.

By the latter part of the 20th century the sociological narrative had shifted, and case law attempted to respond accordingly. Social plurality and diversity were now recognised and promoted. Agency freedom was prioritised over well-being achievement, and there was an assumption that a person's agency was determinative of her well-being, regardless of normative convention (6.3.1). The patient was now conceived as the rational ideal of a reasonable person: if provided with relevant information, she would be able to make choices that satisfied her own well-being (5.3.1.1). Since the orthodoxy was that the doctor, as a social control agent, imposed a treatment that targeted a normative conception of well-being, the thrust was to provide the patient with an opportunity to reject the proposed treatment. A rational person would not be able to reject the proposed treatment unless she was in possession of information about the harms of this treatment; as such, the patient's opportunity was conceptualized in terms of provision of material information about the risks of the treatment (6.3.2). The patient would now be able to make an informed decision about her own medical treatment (4.3.2). The judgment in *Canterbury*

(6.3) and the speech of Lord Scarman in *Sidaway* (6.4) reflect the sociological shift; and the notions of justice align with Rawlsian public reason.

Yet, there remains an undercurrent of apprehension that the real patient, as opposed to the ideal agent of theory, may not possess the decision-making abilities that would allow her to identify and pursue her own well-being.[15] A tacit acceptance of the limitations of real persons surfaces through the admittance of a ‘therapeutic privilege’ in case law (6.3.2). However, the justification for this privilege comes perilously close to the *Bolam* test; hence, whilst not completely rejecting this privilege, case law has attempted to restrict it stringently.[16] Instead, attention has been focused on a patient’s ‘position’ in order to distinguish the real person from the ideal agent of Rawlsian theory.[17] However, there is ambivalence in case law about the meaning of a patient’s ‘position’ and the influence of this position in conceiving fair opportunities (7.3.1). It does not seem that judges have interpreted or employed ‘position’ in the sense of an enlightening appreciation of the variability amongst peoples’ epistemic and cognitive abilities, as proposed by Sen (5.3.2); rather, in case law, position seems to be a surrogate for entitlement to implied agency (7.3.1.2).

Sen warned that indiscriminate acceptance of a person’s positional views could admit parochial values, as well as amorphous goals and preferences, that obfuscated and clashed with the person’s well-being rather than clarifying her agency; and he argued in favour of an ‘impartial spectator’ who could enlighten the discussion (5.4). In contrast, case law has seemed reluctant to accept that, despite the formal presumption of capacity, the variety and diversity of peoples’ positions translates into unavoidable differences in their decision-making capacities. As pointed out by John Coggon, case law largely overlooks that ‘The

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[15] The continuing apprehension pertains to people who retain the formal presumption of capacity, because, although mental capacity legislation sets a binary threshold, decision-making capacity is, in reality, a continuum and not a categorical variable.

[16] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [85] refers to a ‘therapeutic exception’, rather than a privilege. Ibid [91] cautions that the therapeutic exception does not intend to enable the doctor ‘to prevent the patient from making an informed choice which the doctor considers to be contrary to her best interests’. Emma Cave, ‘The Ill-Informed: Consent to Medical Treatment and the Therapeutic Exception’ (2017) 46 Common Law World Review 140 points out that the therapeutic exception has been exercised only rarely as a defence, and she argues that the attention to the ‘position’ of a patient that is required by *Montgomery* makes it unnecessary to continue to include this exception in law.

[17] Although, Rawls’s ideal of a reasonable person is not predicated simply upon rationality (5.3.1). Rather, rationality is the starting characteristic; reciprocity and acceptance of burdens of judgments are, then, transformative of the merely rational person into a reasonable person. Yet, the reasonable person that emerges from *Montgomery*, is characterised by rationality only, without the requirements of reciprocity or burdens of judgment (7.4).

crucial point is that all patients are not equal…not all patients—even all 'competent patients'—are relevantly similar'.[18] Moreover, the persisting, implicit assumption in case law is that a patient's agency is determinative of her well-being. Case law does not seem to consider the arguments of Sen; or of Cass Sunstein and Richard Thaler that it is a false assumption 'that almost all people, almost all of the time, make choices that are in their best interest or at the very least are better, by their own lights, than the choices that would be made by third parties'.[19] Rather surprisingly, recent judgments on consent, as typified by *Montgomery*, do not extend their vision to the parallel strand of common law that recognises the vulnerability of human beings, notwithstanding the formal retention of decision-making capacity, which I have discussed earlier (4.4).

9.3.2 The Challenge of Providing Fair Opportunity

The opportunity aspect of a patient's capability to achieve treatment can be segregated into three domains, corresponding to the second, third and fourth layers of the pyramidal model of respect for autonomy that I proposed in Chapter 3 (the first layer of the pyramidal model corresponds to the process aspect of the capability) (3.7.2). The second domain pertains to the provision of information that would place the patient in a counterfactual position; that is, information that would enable the patient to make choices that she would not have been able to make without this information. The focus of case law has been on this second domain. The Supreme Court's judgment in *Montgomery,* through its test of materiality, continues the focus on this second domain. The style of decision-making, as the practical tool for delivering opportunity, that is endorsed by the Supreme Court is essentially informative (4.3.2); and this style, which is grounded in the rational choice theory, attends exclusively to the second domain.

The third domain pertains to enhancement of the patient's competence to use the information to serve the ends that she would have reason to value. The distinction between the second and third domains derives from feminist scholars, particularly care theorists (3.6.2), who (via a different route) arrive at conclusion similar to Sunstein and Thaler: people are not always equipped to recognise and make decisions about their own well-being. In the capability approach, Sen highlights this point through his distinction between agency and well-being (2.3.1). It could be inferred that *Montgomery* recognises this third

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[18] John Coggon, 'Would Responsible Medical Lawyers Lose their Patients?' (2012) 20 Medical Law Review 130, 133.

[19] Cass R Sunstein and Richard H Thaler, 'Libertarian Paternalism Is Not an Oxymoron' (2003) 70 The University of Chicago Law Review 1159, 1163.

domain by the reference to a ‘dialogue’[20] between the doctor and patient, and that it admits some normative conception of well-being, over and above agency, into the construction of the patient’s opportunity to achieve treatment. The style of decision-making, as the practical tool for the third domain, would be the deliberative style (4.3.3). But, the Supreme Court’s concession to well-achievement achievement, in opposition to agency freedom, and the admittance of a deliberative style, is only allusive. The idea that a person, inextricably woven into her social context, influences and perceptions, may simply not possess the cognitive and analytical abilities to recognise her own well-being, and to apprehend that her agency conflicts with normative conceptions of well-being, does not surface in *Montgomery*.[21]

Finally, the fourth domain pertains to the space in which agency has absolute priority over normative conceptions of well-being, regardless of any conflicts between agency and well-being and the consequences of such conflicts. This fourth domain is articulated by Lord Templeman in *Sidaway* (6.4.1), and affirmed widely in case law: irrespective of how the opportunity to achieve treatment has been conceived, once this opportunity is presented to the patient, the patient’s agency freedom to reject treatment is unrestricted. The fourth domain is sequential to the second and third domains; the balancing of agency freedom and well-achievement, however the balancing has to be done, has to be accommodated within the second and third domains. The achievement or rejection of the opportunity that emerges from the second and third domains is, then, in the fourth domain, subject to the patient’s agency only. Both the informative style and the deliberative style accept this supremacy of the fourth domain. As discussed earlier, the patient’s agency freedom to reject treatment corresponds to the negative sense of liberty, on which there is no restriction (8.2.1).

The obligation that is imposed on the doctor by the fourth domain is clearly articulated in case law, and it is unambiguous. The second domain-obligation is discussed extensively in case law, although it is not entirely clear in practical terms because of contradictory ideas about a reasonable person (7.4), and the notions of position (7.3.1) and particularity (7.3.2). For instance, does a person’s position necessarily expand the scope of information that should be provided by the doctor; or, can it restrict the scope, too? Might a doctor be charged with

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[20] *Montgomery UKSC* (n 16) [90].

[21] Emma Cave, ‘Protecting Patients from their Bad Decisions: Rebalancing Rights, Relationships, and Risk’ (2017) 25 Medical Law Review 527 argues to the contrary. She cites recent decisions in cases of ‘borderline capacity’ and ‘vulnerable’ people as indicative of *Montgomery*’s intention to protect patients from making decision that are inimical to their well-being.

having breached his obligation if he discloses excessive information, over and above the requirement of the test of materiality?[22] The practising doctor continues to struggle with such questions. Notwithstanding, the emphasis in case law is on the second domain. The ambivalence about the third domain, then, is a missing link between the resoluteness of the fourth domain and the concentration on the second domain. The third domain is an essential link between the second and the fourth domains because the progression through these domains is necessarily sequential (3.7.2); and this link is largely missing because there is little attention to it in case law, other than the passing reference to 'dialogue' in *Montgomery.*[23]

It is the missing link of the third domain that now creates consternation for the doctor in making judgments about the opportunity aspect of a patient's capability to achieve treatment. Having moved away from sociological paradigm of the mid-20th century, doctors no longer see their role as control agents, who impose treatments on patients in order to maintain the social contract. The modern doctor is not interested in imposing treatments; the contemporary sociological narrative does not make this demand on doctors. Instead, the modern doctor is concerned with discharging the duty of care that is set out by the GMC. The struggle is now to reconcile the demands of care with the apocryphal assumption that a person's agency is determinative of her well-being. As discussed earlier, the ethic of care is clear that agency does not take

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[22] In *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 (HL) 904G, Lord Templeman warns that a reasonable person 'may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality'. In *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1984] 1 QB 493 (CA) 513A, Sir John Donaldson MR had cautioned similarly that 'there are cases in which the imparting of too much information may well hinder rather than assist the patient to make a rational choice'. In *Montgomery UKSC* (n 16) [90], Lord Kerr and Lord Reed JJSC, too, caution that 'The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp'. I was unable to any litigation that includes a charge of excessive disclosure of information.

[23] It could be counter-argued that *Montgomery* attends to the third domain by placing a duty on doctors to 'ensure that the patient understands' information (1.1). The demands of this duty then engage a comprehension of 'understanding', itself, which requires exploration of hermeneutics. Moreover, a duty to 'ensure' is practically vague. As pointed out by Simon J in *Al Hamwi v Johnston* [2005] EWHC 206 (QB), [2005] Lloyd's Rep Med 309 [69]: 'It is difficult to see what steps could be devised to ensure that a patient has understood short of a vigorous and inappropriate cross-examination. A patient may say she understands although she has not in fact done so, or has understood part of what has been said, or has a clear understanding of something other than what has been imparted. It is common experience that misunderstandings can arise despite reasonable steps to dispel them'.

invariable priority over well-being; to the contrary, well-being achievement has to be prioritised occasionally over agency freedom (3.7.1). In contrast to the Supreme Court in *Montgomery*, care theorists explicitly admit a paternalistic style of decision-making that prioritises well-being achievement over agency freedom in some situations (4.3.1).

Doctors are now apprehensive that submission to the agency of a patient, resulting in either the selection of one available treatment instead of another or the rejection of all available treatments, that conflicts with normative conceptions of the patient's well-being will be seen as a dereliction of their obligation to care for the patient.[24] Despite the changes in the sociological narrative of the early 21st century, as compared to the mid-20th century, doctors remain obliged to promote the patient's well-being achievement: now, as care-providers, rather than as the social control agents of Talcott Parson's theory (6.2.2). Case law does not supply doctors with satisfactory normative tools for making judgments, in their role as care-givers, about a fair opportunity for a patient to achieve medical treatment.

The challenge, now, is to find a practical route, which acknowledges the inherent limits on human rationality that have been pointed out by Sen and the inescapable, resource-related constraints of NHS practice, for doctors to satisfactorily discharge their duty of care in obtaining patients' consent. I have argued elsewhere, prior to commencing work on this thesis, that doctors are obliged to make recommendations, over and above sharing information with patients.[25] Recommendations can serve as a way for doctors to promote well-being achievement as an integral component of their duty to care for patients. A recommendation may then be the practical tool to supply the content of the missing link of the third domain of the capability to achieve treatment. There has been some work on 'nudging' by doctors, as a form of recommendation, in obtaining patient's consent for treatment.[26] This supplies an avenue for further

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[24] Although, in *Worrall v Antoniadou* [2016] EWCA Civ 1219, (2017) 153 BMLR 14 [22], Tomlinson LJ can be seen to provide some reassurance: 'A defendant medical professional ought not to be liable in such circumstances unless either he/she is responsible for the patient getting hold of the wrong end of the stick or, having realised that the patient has or is in danger of getting hold of the wrong end of the stick, or in circumstances where the medical professional ought so to have realised, he/she takes no step to dispel the misapprehension'.

[25] Abeezar I Sarela, 'Stop Sitting on the Fence: Recommendations are Essential to Informed Decision Making' (2013) 347 The British Medical Journal f7600.

[26] Shlomo Cohen, 'Nudging and Informed Consent' (2013) 13 American Journal of Bioethics 3; Thomas Ploug, 'Physicians' Framing and Recommendations. Are they Nudging? And do they Violate the Requirements of Informed Consent?' (2018) 44 Journal of Medical Ethics 543.

theoretical research, and empirical research, on advancing the opportunity aspect of a patient’s capability to achieve medical treatment.

9.4 Conclusion

The reconceptualization of the doctor’s obligation to obtain the patient’s consent as an obligation to provide the patient with a fair capability to achieve treatment supplies conceptual clarity about two distinct aspects—process and opportunity—of this obligation; it also supplies the doctor with normative tools for making judgments that are essential for discharging this obligation in the National Health Service. These normative tools make various demands on doctors, but also set boundaries. The present thesis sets out a framework for conceptualizing these demands and boundaries, and it outlines certain areas for further research in order to practically implement this framework.

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