# Part II:
# Autonomy in the law

## Chapter 4: Autonomy in UK law

Up until now it has been argued that artificial intelligence (AI) in medicine is a technology that is capable of posing a novel threat to patient autonomy, conceived of in a bioethical and pre-legal sense. This part aims to demonstrate that those aspects of autonomy, which were shown to be violated by AI, are also aspects that are valued and protected in the medical law of the respective legal systems. This connects the outlined AI-threat to our specific legal analysis.

Focussing on the notion of autonomy in the law also serves a further purpose. Given the novelty of the problems created by AI, existing mechanisms must, at the very least, be extended to new situations. At most, the specific nature of the AI-threat may call for creative norm-altering or even norm-generating activity. Providing an accurate description of the applicable norms therefore depends on anticipating such applications and developments, while operating in a framework of mechanisms that were not conceived with these specific issues in mind.

It is hypothesised that the law's understanding of autonomy can provide significant guidance for its adaptation to this specific innovation. As argued in the introduction, this is a crucial step that bridges the gap between the limitations of doctrinal stability and the potential for structured adaptation. The following part thus focuses on locating autonomy-related concerns in the law and on investigating how these may make a practical difference to its operation.

Two fundamental questions will shape our exposition of the legal concept of autonomy. The first question that is asked is: 'what is/are the relevant function(s) that autonomy plays?' The aim is to ascertain how the term is able to influence legal norm-creation, norm-application, argumentation and reasoning. Depending on the material that the inquiry must fit, this circles around such matters as whether the concept is incorporated

directly into a legal rule, whether it is one *telos* that provides a possible avenue for interpretation of a particular norm or whether it is a legal principle.

Second, it will also be enquired: 'what is the content that the law ascribes to autonomy?' The aim is to determine how the law interacts with a polysemous concept and whether our bioethical specification offers a defensible interpretation of this interaction. In many ways this question is closely related to the matter of function. For, the content attributed to a term by legal actors will be uniquely related to the function that it plays (and the purpose it fulfils) within the legal system.[495] This suggests the necessity of addressing the question of legal function first. The question of content then has an altogether different focus. Rather than looking towards the formal role, it looks to the substantive content. Nor is the relationship between function and meaning unidirectional. The manner in which a term is understood more generally, may itself influence the parameters within which its functions can be conceived and developed by legal actors.[496]

In this chapter a systematic approach is developed to identify the function and content of the autonomy-concept within the UK jurisdiction, before going on to resolve equivalent questions in the American context. Focussing on England for now, it appears undeniable that autonomy is a notion that has manifested itself in various forms and commands considerable respect across the legal order, spanning a range of legal practice areas, and featuring both in the common law and statute.[497]

---

495 '[T]he law can appropriate philosophical materials, put them to use for its own purposes, engraft them into a distinct mode of reasoning, *and, as a result*, convert a philosophical norm or concept into a legal one. Once philosophical materials form part of a legal reasoning process, rather than part of a philosophical enquiry, they become legal norms and concepts': Wall in Phillips, Campos and Herring, *Philosophical Foundations of Medical Law* (2019) 133.

496 Poscher frames the relevance of more general concepts thus: 'to function well, the law cannot be altogether out of step with the knowledge in the society it is supposed to govern': Poscher in Hage and Pfordten, *Concepts in Law* (2009) 102.

497 This engagement with autonomy is not understood as limited to just those instances where the courts and the legislature expressly utilise that specific term. Rather, as will emerge from the following analysis, the focus is on the range of medium- and low-level considerations that legal actors have associated with autonomy, its synonyms and related notions. For instance, 'self-determination' constitutes one such synonym, which is frequently used in English law: Wicks, *Human Rights and Healthcare* (2007) 64-65. Of course, there are also terms that are related to autonomy but that, upon proper analysis, possess distinct connotations. 'Bodily integrity' would be one example. For an analysis of this concept and its relation

Before addressing the already outlined aspects, a comment will therefore briefly be made on the appropriate scope for our inquiry. Our interest lies with its manifestation in the medical context which, it will be seen, has provided a unique – and especially fertile – ground for the formulation of legal protections of autonomy. After dealing with the matters of scope, function and content, the limits of an autonomy-focussed legal analysis will also be acknowledged.

## *I. Scope*

Since the use of 'autonomy' spans across several areas of UK law and its functions and content cannot be assumed to be consistent across them, we should begin our investigation by demarcating an appropriate scope for our investigation.

A convenient point of departure is our area of interest, medical law, and identify whether the positive law differentiates the use of the autonomy concept within this field from others. With this object in mind, it emerges that the English courts themselves have repeatedly and explicitly sought to draw such a distinction when utilising autonomy and its related concepts. Thus Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital*, when he considered 'the patient's right to make his own decision', rejected the U.S. approach of finding a fiduciary relationship between doctor and patient.[498] He stated that 'there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character'.[499]

Similarly, Lord Walker in *Chester v Afshar* – a case dealing with the non-disclosure of a risk by the treating surgeon – stated that he derived 'very little assistance from analogies based on quite different facts (such as a landowner's duty to warn of the remote risk of a hiker being injured by

to autonomy see: Herring and Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) 76(3) The Cambridge Law Journal p. 566. Such distinct connotations should not distort this investigation. Where the courts nevertheless use such concepts interchangeably – and many common concerns and modes of legal reasoning are indeed identifiable – their use will sometimes also form a proper subject for our analysis.

498 *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 884.

499 ibid 884.

a landslide or a falling tree)'.[500] And in *Re T*, Staughton LJ, ascertaining whether a patient's refusal of medical treatment had resulted from the undue influence of another, was careful to point out that: '[t]he cases on undue influence in the law of property and contract are not, in my opinion, applicable to the different context of consent to medical or surgical treatment. The wife who guarantees her husband's debts, or the widower who leaves all his property to his housekeeper, are not in the same situation as a patient faced with the need for medical treatment.'[501] Such authorities support the proposition that, with respect to autonomy, there is a distinct jurisprudence to be found in medical law that does not readily correspond to related concepts in other fields. Consequently, this analysis is focussed primarily on the medical or healthcare sphere.

Within that field itself, one must then enquire whether the UK courts have distinguished between applications of autonomy. Put simply, this does not appear to be the case. Rather, the courts have implicitly indicated that autonomy-related norms are developed in a coherent manner across a relatively widely defined sphere of health law. The landmark medical negligence case of *Montgomery v Lanarkshire Health Board* is instructive in this regard, with Lord Kerr and Lord Reed stating:

> Under the stimulus of the Human Rights Act 1998, the courts have become increasingly conscious of the extent to which the common law reflects fundamental values. As Lord Scarman pointed out in Sidaway's case, these include the value of self-determination (see, for example, *S (An Infant) v S* [1972] AC 24, 43 per Lord Reid; *McColl v Strathclyde Regional Council* 1983 SC 225, 241; *Airedale NHS Trust v Bland* [1993] AC 789, 864 per Lord Goff of Chieveley). As well as underlying aspects of the common law, that value also underlies the right to respect for private life protected by article 8 of the European Convention on Human Rights. The resulting duty to involve the patient in decisions relating to her treatment has been recognised in judgments of the European Court of Human Rights, such as *Glass v United Kingdom* (2004) EHRR 341 and *Tysiac v Poland* (2007) 45 EHRR 947, as well as in a number of decisions of courts in the United Kingdom.[502]

500 *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [93].
501 *Re T (adult: refusal of treatment)* [1993] Fam 95, 121.
502 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [8].

*Montgomery* itself concerned the question of whether the standard of care to be applied in cases of non-disclosure of risks in medical procedures ought to be amended. Yet, when reflecting on the value of self-determination the majority drew on the outlined range of cases that could be termed medical in a very broad sense. The factual issues that these respectively addressed were: the disclosure of risks in a surgical procedure;[503] the power of the court to compel an adult or child to undergo a blood test;[504] the ability of a local authority to add fluoride to the water supply to increase the dental health of the population;[505] the ending of life-sustaining medical treatment;[506] the legitimacy of a hospital imposing a 'do not resuscitate' order on a patient;[507] and the absence of an effective procedure to challenge refusals of medical practitioners to carry out abortions.[508]

A further basis for potential differentiation, which is conspicuously absent in this statement, relates to the source of law. The Supreme Court developed the notion of autonomy not only by reference to the common law, but also by reference to cases involving statute and the *European Convention on Human Rights* (ECHR). Although there may be a difference in degree, the protected autonomy-interest is assumed to be the same in kind across these different sources of law and coherence is sought between them.[509] Within the field of medical law, the Supreme Court consequently appears to reject differentiating between uses of the concept on the basis of such variations of sources or factual circumstances.

We may say that, in terms of the scope of our analysis, the whole area of UK medical law is of potential interest. To avoid superficiality, some selection on the basis of significance for the present purposes (i.e. how autonomy shapes the legal perception and response of AI-threats) will emerge, as it also emerges for other analyses,[510] but behind this process

503 *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.
504 *S (An Infant) v S* [1972] AC 24.
505 *McColl v Strathclyde Regional Council* 1983 SC 225.
506 *Airedale NHS Trust v Bland* [1993] AC 789.
507 *Glass v United Kingdom* (2004) 39 EHRR 15..
508 *Tysiac v Poland* (2007) 45 EHRR 42.
509 See also: *R (on the application of N) v Mental Health Review Tribunal (Northern Region)* [2005] EWHC 587 (Admin), [2005] ACD 92 [132]. Munby J stated: 'Liberty, autonomy and bodily integrity are interests which traditionally have received a high degree of protection under the common law and are now afforded the added protections conferred by the Convention'.
510 See for example Coggon's, still broad, focus on 'capacity, rationality, life-shortening decisions, advance directives, and the Mental Capacity Act 2005': Coggon, 'Varied

stands the broadly defined field of medical law. This delineates the exploration of the function and content of the autonomy concept.

## *II. Function*

The function of a concept is taken to designate the formal role that it plays within the law. Particularly relevant matters in this regard are: whether it possesses norm-status, its relation to other norms and its position in the legal system more generally. With regard to autonomy, we can begin by building up from the shared understanding that it is a value that motivates and is incorporated throughout many norms of medical law. This follows simply from the hallmark-status of autonomy and individuality in Anglo-American law and society and from its particular relevance to health care, where the choices at play are so significant to the individual patient.[511] Concretely, one can see this reflected in *Montgomery*'s treatment of self-determination above. This was posited as a value that the common law reflects, one that underlies aspects of it and also Article 8 ECHR. This much is taken to be common ground.

Beyond this, however, the consensus begins to breaks down. In this vein, Richards states that autonomy has 'been hailed as either a fundamental right, an important duty or a core principle' but herself argues that it is 'a poorly conceptualised term of art employed by the judiciary to support conclusions that rest on other, more complex and diverse considerations'.[512] In particular, Richards argues that the dominant role of autonomy can be (and should be) reduced to many more specific legal rights, 'such as bodily integrity, freedom from assault, ownership of property and privacy (to name but a few)'.[513]

---

and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15(3) Health Care Analysis: Journal of Health Philosophy and Policy p. 235, 236. Similarly, Maclean's extensive examination of the role of consent in English law and its relationship to autonomy *inter alia* touches on matters of capacity, life-shortening decisions, undue influence and court orders of treatment: Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (2009).

511 *Natanson v. Kline* (1960) 186 Kan. 393, 406-407; Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95(2) The Yale Law Journal p. 219, 220.

512 Richards in Kirchhoffer and Richards, *Beyond Autonomy* (2019) 17-18.

513 ibid 18.

One can follow this sceptical position up to a point. Indeed, some of the functions ascribed to autonomy have been misleading and one should clarify what the concept is not: it has not straightforwardly been incorporated into English law as a legal right.[514] If one takes a typical definition of common law rights as 'something which an individual possesses and which may be vindicated or protected by the provision of a remedy in the event of infringement',[515] then autonomy is not of this kind. At the very least it is strongly contested whether a claim can be based simply on the fact that a patient's autonomy has been violated – what is missing is precisely the ability to have this vindicated by the provision of a remedy. This is most evident from the fact that the courts have altogether rejected a right to demand specific forms of treatment. That is, to have autonomy respected in a positive way in the healthcare context.[516] To this extent it can hardly be conceived of as a right.

514 For one example of such an ascription see: 'Individuals have a right to make important decisions affecting their lives for themselves': *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [14].

515 Meagher, 'Is There a Common Law Right to Freedom of Speech?' (2019) 43(1) Melbourne University Law Review p. 269, 272. More widely, Cane offers a definition of a right as: 'a primary legal entitlement of one person (C) that attracts a secondary legal obligation of another (D)': Cane in Nolan and Robertson, *Rights and Private Law* (2012) 46. For judicial pronouncements to this effect see: *Ashby v White* (1703) 92 ER 126, 136 ('If the plaintiff has a right, he must of necessity have a means to vindicate and maintain it, and a remedy if he is injured in the exercise or enjoyment of it; and indeed it is a vain thing to imagine a right without a remedy'); *Kingdom of Spain v Christie Manson & Woods Ltd* [1986] 1 WLR 1120 [35] ('In the pragmatic way in which English law has developed, a man's legal rights are in fact those which are protected by a cause of action. It is not in accordance, as I understand it, with the principles of English law to analyse rights as being something separate from the remedy given to the individual').

516 Lord Phillips MR has stated that if the patient 'refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion': *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [50]. Herring and Wall have also commented on the absence of such a positive obligation and concluded that 'We do not have a right to act autonomously': Herring and Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) 76(3) The Cambridge Law Journal p. 566, 584.

Purely negative violations of autonomy are not straightforward bases for a remedy either. The Court of Appeal, in spite of using rights-language, has rejected emphatically 'the proposition that an additional, free standing, award of damages is available for the infringement of the patient's right of autonomy'.[517] This was subsequently affirmed in *Diamond v Royal Devon and Exeter NHS Foundation Trust*, where it was further held that 'there is no self-standing right to claim damages to compensate [the claimant] for the invasion of her right to personal autonomy/choice'.[518] These recent cases highlight how atypical it is to conceive of autonomy as a traditional legal right in medical law.[519]

While conceding this much to those who are sceptical of the legal role attributed to autonomy, the denial of independent-rights-status can hardly be seen as synonymous with a denial of a distinct norm-status in medical law. Dunn and others appear to assume this latter position, referring to a 'tendency for the law to proactively invoke ethical values to shape legal judgements'.[520] However, the law is then understood to leave its understanding of autonomy ill-defined ('important concerns have been expressed about the level of sophistication in the judicial application of' it) and its impact on legal reasoning is seen as much more limited (it 'needs to be deflated').[521] This highlights that, if autonomy is merely conceived as an ethical value, the meaning attributed to it by the law can be left relatively open, and its prominent role in legal reasoning, *inter alia* shaping other norms, becomes suspect.[522]

---

517 *Shaw v Kovac* [2017] EWCA Civ 1028, [2017] 1 WLR 4773 [65].

518 *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2019] EWCA Civ 585, (2019) 170 BMLR 49 [34].

519 In another context the Court of Appeal has also commented that 'we have some doubts whether autonomy and dignity can properly be described as independent common law rights rather than values or principles which inform more specific common law rights, such as the right to bodily integrity and privacy': *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin), (2012) 127 BMLR 197 [50].

520 Dunn and others, 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Treatment' (2019) 27(2) Health Care Analysis: Journal of Health Philosophy and Policy p. 110, 113.

521 ibid 113. The authors refer specifically to the value's role in shaping the disclosure rule established in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430. Yet, it is a commitment to viewing autonomy merely as an ethical value that sets the stage for the deflation that this specific evaluation is then taken to exemplify.

522 Leading on from the argument established in: Dworkin, *Taking Rights Seriously* (1987) 37.

It is argued here that a formal role can be carved out for autonomy, one which sits between the minimalist claim that it functions merely as a value or descriptor of specific laws on the one hand and the over-ambitious statement that it is a legal right on the other. In particular, it is argued that this intermediary role is that of a legal principle. As opposed to informative values, principles are binding legal norms themselves, possessing a particular formal structure and characteristic modes of influencing other norms and judicial reasoning.[523] They are norms that play a tangible role in structuring, as well as informing, the law, but their mode of functioning is more differentiated and more flexible than that of a right.

Distinguishing characteristics of principles in the common law include: a (perceived) positive value or importance; a level of generality; a certain way of operating in conflicts with one another and with legal rules; the possible performance of a number of roles that a specific system ascribes to them.[524] The rest of this section argues, with respect to each of these features, that autonomy can be understood to fulfil them.

As already noted, it appears undeniable, even amongst its critics, that autonomy is perceived by legal actors as possessing some positive value, 'weight' or 'importance'.[525] This is so even if the precise nature and relative strength of this value are uncertain.[526] It is consequently presumed that autonomy provides reasons for pursuing a certain course of action.[527]

523 Raz, 'Legal Principles and the Limits of Law' (1972) 81(5) Yale Law Journal p. 823, 826; Eisenberg, *The Nature of the Common Law* (1988) 82.

524 MacCormick highlights especially the former two: 'If I seek to ascertain the principles of a given legal system, I ought to search for those general norms which the functionaries of the system regard as having, on the ground of their generality and positive value, the relevant justificatory and explanatory function in relation to the valid rules of the system': MacCormick, *Legal Reasoning and Legal Theory* (1994) 152-153; The others are taken from: Raz, 'Legal Principles and the Limits of Law' (1972) 81(5) Yale Law Journal p. 823, 832-834, 839-842.

525 Dworkin, *Taking Rights Seriously* (1987) 26-27.

526 Foster is one author who is highly critical of those who believe in the primacy of autonomy in health law: Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (2009); Herring has usefully contrasted many of the claims Foster makes with the arguments prevalent in the wider academic debate: Herring, ''Choosing Life, Choosing Death, The Tyranny of Autonomy in Medical Ethics and Law, by Charles Foster'' (2010) 30(2) Legal Studies p. 330.

527 In Raz's terminology one may therefore say that autonomy is seen as a principle of obligation: Raz, 'Legal Principles and the Limits of Law' (1972) 81(5) Yale Law Journal p. 823, 835.

Considering the factor of generality next, by this we mean not only that autonomy may be used as a shorthand to refer to a number of individual, more specific norms.[528] This would indeed indicate that it could be better conceptualised in terms of individual rights and legal mechanisms. Rather, it has been said that principles exist at a level of abstraction from rule-based norms because they prescribe highly unspecific acts, which may include the more specific acts prescribed by various rules, and are justified by more general considerations.[529] This criterion emphasises that a principle imposes a general obligation that is capable of guiding a wide variety of decisions.

That medical law's utilisation of autonomy fulfils this criterion can be seen by revisiting some of the cases touched upon during the delineation of the scope of this investigation. There it was discussed how the principle of self-determination has been invoked to require a wide variety of heterogeneous and relatively specific actions, ranging from the impermissibility of forcing an adult to provide a sample of their blood, to determining the information that a clinician ought to disclose, to suggesting the permissibility of ending life-sustaining treatment. With respect to the relationship of these demands to more specific norms, one can also note that: in the former case, the provisions of an existing rule were affirmed, in the second a contrary rule was overruled and in the final instance a specific act was proscribed, where previously no clear directive had existed. It is in this sense that autonomy is a principle in a formal, logical sense.

One of the most commonly discussed and recognised features of principles is how they operate when they conflict with other laws. Dworkin famously distinguished principles from rules in virtue of the fact that the former have relative weights and can conflict, while not superseding one another.[530] Raz has critiqued and developed this feature by outlining how, at least as a matter of legal policy, 'conflicts between principles are determined by assessing their relative importance together with the consequences for their goals of various courses of action' and conflicts between principles and rules are resolved either in the same manner, or simply on the basis of

528 ibid 828.
529 ibid 839.
530 Dworkin, *Taking Rights Seriously* (1987) 26-27.

the relative importance of the conflicting laws (i.e. without also analysing them in relation to the ensuing consequences).[531]

This kind of functioning is evident with respect to autonomy in UK law. In the medical arena it can, for instance, often be observed to conflict with the principle of beneficence. Particularly where rules are unclear as to a given outcome, the question arises whether one ought to do what is for the perceived clinical benefit of the patient or give primacy to their autonomy. In such cases, the relative importance of the principles, as well as the projected consequences of supporting one over the other, are frequently examined.

One class of examples, which suggests itself, are the judgments that elaborate on the child's ability to consent to medical treatment under established common law principles. In this respect, it has been held that the parents' control over the medical treatment administered to their child is granted on the basis that this is for the benefit of the child.[532] Simultaneously, it was found that this parental right can be disapplied 'if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed', thereby giving 'a consent valid in law'.[533] In other words, once a child is recognised as having the capacity to make medical decisions for themselves, their autonomy must be respected. This finding was reinforced by a consideration of the consequences that may ensue if the child was not able to make such decisions for themselves.[534]

---

531 Raz, 'Legal Principles and the Limits of Law' (1972) 81(5) Yale Law Journal p. 823, 833. Cf. MacCormick: 'the principle sets the limits within which judicial decisions fully justified by consequentialist arguments, are legitimate': MacCormick, *Legal Reasoning and Legal Theory* (1994) 161.

532 '[P]arental rights to control a child (…) exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child': *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 170.

533 ibid 188-189.

534 Specifically in this case, which was concerned with the child's ability to consent to contraceptive advice and treatment, Lord Fraser considered that requiring parental control over a child's medical treatment would have significant adverse consequences. It would mean that children would be more reluctant to seek professional advice regarding contraception and thereby expose them to the risks of pregnancy and of sexually transmitted diseases: ibid 173-174. This was echoed in *R (on the application of Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin), [2006] QB 539 [91].

A comparable, partially-consequentialist mode of reasoning is also evident in some cases where autonomy has interacted with specific rules. For instance, when Lord Diplock rejected altering the standard of negligence (the so-called '*Bolam* test') in *Sidaway*, which would have enhanced the protection of patient autonomy,[535] he did so on the basis of at least two factors. On the one hand he recognised the substantial weight that was due to the existing rule:

> For the last quarter of a century the test applied in English law as to whether a doctor has fulfilled his duty of care owed to his patient has been (…) the *Bolam* test. At any rate so far as diagnosis and treatment is concerned, the *Bolam* test has twice received the express approval of this House.
>
> The *Bolam* test is far from new, its value is that it brings up to date and re-expresses in the light of modern conditions in which the art of medicine is now practised, an ancient rule of common law.[536]

But he further went on to reference the detrimental consequences that would follow from a change to this rule, focussing particularly on its potential to 'encourage "defensive medicine" with a vengeance'.[537]

In other instances of principle-rule-interaction the alternative non-consequentialist mode of reasoning is evident. Indeed, in the very same case, the dissenting Lord Scarman preferred this approach, stating that a rule-change could perhaps contribute to a practice of defensive medicine developing, but that 'in matters of civil wrong or tort, courts are concerned with legal principle: if policy problems emerge, they are best left to the legislature'.[538] He consequently focussed exclusively on the relative weights of the two norms, the autonomy principle and the existing rule, and in his opinion the former outweighed the latter.

Lastly, we stumble upon the difficulty that even norms that meet all of the above criteria are not one monolithic category, but can perform a variety of further roles in the law. These include: (1) explaining and justifying existing law[539] (2) instituting norm-change (3) aiding interpretation (4)

535 This was clearly the opinion of Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 884-885.
536 ibid 892.
537 ibid 893.
538 ibid 887.
539 MacCormick, *Legal Reasoning and Legal Theory* (1994) 152-153.

generating new norms (5) creating exceptions to rules (6) grounding an action directly.[540] A principle could perform all these roles, but it need not; they are conditional in a way that the other functions are not.[541] In the context of autonomy, a good argument can be made that it performs all of these functions, except that of grounding an action.[542]

It has already been seen how some of these functions have manifested themselves in the medical context. *Montgomery* represents an autonomy-informed overhaul of the rule governing the standard of care in medical negligence[543] and in *S v S* a conception of autonomy justified and explained why the law could not compel an adult to submit to a blood test.[544]

Turning to the three remaining roles in UK law, an example of autonomy aiding interpretation in the medical context stems from the jurisprudence around Article 8 of the ECHR. For this, there is a developing line of jurisprudence which holds that the explicitly granted right to private life implicitly includes a right to personal autonomy, or self-determination. Thus, in *Pretty v the United Kingdom* the European Court of Human Rights stated: 'Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees'.[545]

---

540 Raz, 'Legal Principles and the Limits of Law' (1972) 81(5) Yale Law Journal p. 823, 840-842. Eisenberg provides a similar list of functions in his account of common law principles: Eisenberg, *The Nature of the Common Law* (1988) 76-83.

541 For example, both MacCormick and Eisenberg grant that there are only some principles that could (sometimes) have the kind of direct force ascribed by the last function: MacCormick, *Legal Reasoning and Legal Theory* (1994) 178; Eisenberg, *The Nature of the Common Law* (1988) 82.

542 Our above exploration of *Shaw* and *Diamond* suggests that autonomy does not provide the sole ground for an action in English law and we will return to this controversial proposition in Chapter 6. But note that, in contrast with a right where the remedial aspect was an integral definitional element, the status of autonomy as a principle in no way hinges on this one role.

543 For a more general statement of this aspect see Lord Scarman's comment that: 'the mark of the great judge from Coke through Mansfield to our day has been the capacity and the will to search out principle, to discard the detail appropriate (perhaps) to earlier times, and to apply principle in such a way as to satisfy the needs of their own time': *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 183.

544 Or 'personal liberty' as Lord Reid put it: *S (An Infant) v S* [1972] AC 24, 43.

545 *Pretty v the United Kingdom* (2002) 35 EHRR 1 [61]. Domestically one can see this interpretation also at play, for instance in: *R (Tracey) v Cambridge University*

With respect to autonomy's role in norm-generation, the case of *Rees v Darlington Memorial Hospital NHS Trust*, which will be examined more closely in Chapter 6, can be drawn upon. Here a novel conventional award was made for the loss the claimant suffered to her autonomy in a case of wrongful conception. This award fell outside of traditional categories. It was not compensatory for physical pain and suffering, nor for the economic or mental consequences flowing from such suffering, but for the lost 'opportunity to live her life in the way that she wished and planned'.[546] While invocation of autonomy did not overturn any traditional rules on compensation, the court felt obligated to develop the law and create a rule to award £15,000 for the loss of reproductive autonomy in wrongful conception cases. Finally, one can point to the case of *Chester v Afshar* to illustrate the ability of autonomy to create exceptions to existing rules. As Lord Steyn stated, they understood themselves as providing a 'narrow and modest departure' from the normal rule of but-for causation.[547]

In sum, the manner in which autonomy functions in medical law fits well with the notion of a principle. The roles that such a principle will play are unique to its position in the respective legal system and this must be distinguished from the role played by principles in the wider ethical discourse and from the role that it plays in other legal systems. We may expect the principle to inform the aforementioned aspects of legal reasoning, to operate in the outlined manner in cases of conflict and to act as a driver for further developments of the law. All this will become relevant in our analysis of individual mechanisms.

### *III. Substantive content*

Knowing about the formal functions of autonomy will be of little assistance in the following reasoning and argumentation if one cannot give substance to the underlying concept. Knowing *that* autonomy can do something in UK law and *how* it can do it, is of little use without knowing more about the meaning that is attributed to the norm and the nature of reasons it

---

*Hospitals NHS Foundation Trust & Others* [2014] EWCA Civ 822, [2015] QB 543 [64].

546 *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52, [2004] 1 AC 309 [8], [123].

547 *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [23]-[24].

provides. This section provides the core of this content, keeping in mind that it cannot be divorced from the functional aspects of the law. Otherwise one would risk failing to account for the unique way in which the legal enterprise transforms philosophical considerations.[548]

One fruitful way to think about this task may be in terms of a 'duality of meaning'.[549] This is a theory developed by Balganesh and Parchomovsky that seeks to give content to common law concepts in a manner that reflects their usage in legal practice and accounts for the common law's propensity to 'to accommodate the process of incremental normative change over time'.[550]

Concepts used in such reasoning have one jural meaning that is oriented towards structural concerns, including the provision of coherence, stability and a functional anchoring in legal practice.[551] And they have one normative meaning that allows them to accommodate external interpretative influences, which can be related to situational goals and which seek to keep the common law in line with developing societal ideals, values and preferences.[552] Given the uncertain, open-textured nature of the jural meaning, one must supplement it with the use of a concept that allows one to apply it to a given context.[553] Legal actors consequently have to exercise a structured discretion in the application context, according to which they must choose to rely on additional factors.[554] These factors are unavoidably normative because the process of interpreting a concept involves the normative judgment 'concept *x* should mean *y*'.[555] This can result in contestable normative meanings being ascribed to one settled jural concept and to interpretive

548 'What the norm or concept requires, in the context of the dispute, and in the context of a wider web of legal standards, is a non-philosophical question. It is a legal question': Wall in Phillips, Campos and Herring, *Philosophical Foundations of Medical Law* (2019) 135.

549 Balganesh and Parchomovsky, 'Structure and Value in the Common Law' (2015) 163(5) University of Pennsylvania Law Review p. 1241, 1255-1265.

550 ibid 1255.

551 ibid 1244.

552 ibid 1243-1244. See also Sunstein for his understanding of 'incompletely theorised agreements', which also appeals to an open-ended structure that relies on external influences for full specification: Sunstein, *Legal Reasoning and Political Conflict* (1998) 35-61.

553 Balganesh and Parchomovsky, 'Structure and Value in the Common Law' (2015) 163(5) University of Pennsylvania Law Review p. 1241, 1262.

554 ibid 1259-1260.

555 ibid 1263.

changes that precede (or do not effect) doctrinal change.[556] At the same time, there is a sense in which there is a dominant or accepted meaning that fits well with established doctrine.

To apply this approach to the autonomy concept, we begin with the understanding that there is a settled jural reference to autonomy and relevant synonyms. This functions in the way that we outlined. Concurrently, as an open-textured jural concept, autonomy has no settled or agreed-upon normative content that is consistently infused into interpretations of it. In UK law this uncertainty is arguably compounded by the relatively recent prominence that the value has assumed, so that references to contested moral notions remain relatively underdetermined and inconsistent. Different conceptions of autonomy are expressly and implicitly articulated by the courts.[557] Indeed, it is conspicuous just how diverging and haphazard direct appeals to philosophical analyses of autonomy are. So that even where they do occur, they can hardly be taken to establish universal rules.[558] There clearly has not been a concerted effort by the legislature or the judiciary to incorporate a high-level, abstract conception of autonomy into the law. Consequently the stage is set for a dual meaning to emerge: the structural, jural one and the contested, wider, normative one.

Now we turn to examining whether the jural concept, and the normative meaning attributed to it, can be aligned with the bioethical theory expounded in the previous chapter. This use must not be uncontested, but it should be sufficiently supported, either explicitly or implicitly, so as to

556 ibid 1274.

557 Coggon has convincingly argued that three different conceptions of autonomy can be found in the positive medical law of England and Wales: ideal desire autonomy, best desire autonomy and current desire autonomy: Coggon, 'Varied and Principled Understandings of Autonomy in English Law' (2007) 15(3) Health Care Analysis: Journal of Health Philosophy and Policy p. 235, 240. Cf. also Herring and Wall who identify autonomy with the thicker (second) notion, which requires one 'to identify standards, preferences and values and to have your own actions and events in your life conform to those standards, satisfy those preferences and realise those values': Herring and Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) 76(3) The Cambridge Law Journal p. 566, 575-576.

558 Coggon, 'Varied and Principled Understandings of Autonomy in English Law' (2007) 15(3) Health Care Analysis: Journal of Health Philosophy and Policy p. 235, 235-236. For example, in *Chester* an off-hand reference was made to the definition of autonomy offered by Ronald Dworkin, without attempting to establish it as a wider legal standard or reference point: *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [18].

accord the requisite priority to the legal documentation of the principle's use.[559]

This brings one to our rationalist, procedural notion of autonomy, according to which the law should apply autonomy considerations in a way that recognises: (1) the importance of the theoretical quality of reasoning about beliefs (2) the particular significance of preferences and acceptances that make up the patient's character system, and (3) a variable obligation to promote the positive freedom of individuals by supporting their theoretical and reflective capabilities and by providing them with different classes of information that are necessary to make clinical choices.

## A. Rationality

One facet of our account of autonomy stated that the process of decision-making ought to be receptive to the norms of theoretical rationality. This is arguably the most challenging dimension to attribute to the jural autonomy concept, given that English law seemingly eschews a standard of rationality as an indicator of autonomy in the clinical sphere.[560]

The courts have repeatedly stated that there is a need to respect the patients' 'choice to make decisions that others, including the court, might regard as unwise, irrational or harmful to their own interests'.[561] They endeavour to respect the patient's apparent desires without judging on the wisdom of their choices. The force of such considerations can be gleaned from the judiciary's refusal to second-guess decisions that entail even the most serious consequences, such as the risk of grave harm befalling a moth-

559 Robertson treats the priority accorded to legal documentation as a limitation on the use of policy factors in private law reasoning: Robertson in Robertson and Tang, *The Goals of Private Law* (2009) 270. We will return to his further arguments in Section IV. below.

560 Recognised by Pugh himself: Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (2020) 183.

561 *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2019] EWCA Civ 585, (2019) 170 BMLR 49 [13]. A similar statement is seen much earlier in *Re T (adult: refusal of treatment)* [1993] Fam 95, 99.

er and her foetus.[562] So it initially appears that the law does not impose conditions on the historical process that led up to an individual's choices.[563]

However, these arguments are misdirected in so far as they are based on the anti-paternalist concern explored in Chapter 3.[564] The courts are expressing the worry that, by imposing a standard of rationality, many individuals will be denied the opportunity to make meaningful choices for themselves.[565] In the form expressed above, this concern posits a much more demanding interpretation of rationality than the one espoused by our adopted theory of autonomy.

It is worth recalling that, under this theory, the individual remained the primary source for the identification of their interests and, even more so, for the balancing of these interests. One should not dismiss the rationality criterion on the basis that it would deny individuals the ability to make choices that are deemed unwise by others. Pugh's theory leaves open the possibility for such disagreements and we will return to the significance of individual value judgments in the assessment of the reflective dimension below.

A more appropriate yardstick by which to measure the autonomy of the patient, is by reference to whether the law has adhered to those fairly minimal aspects touched upon in Chapter 3. That means, the patient's ability to gather appropriate evidence, to weigh it for themselves and to incorporate this into a process of reasoning.

From this perspective it seems clear that, at least in recent times, the courts' view of the patient has shifted to incorporate these abilities. Most

562 Referencing the principle of self-determination, Judge LJ stated: 'how can a forced invasion of a competent adult's body against her will even for the most laudable of motives (the preservation of life) be ordered without irremediably damaging the principle of self-determination?': *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936, 953. This case was also cited with approval by Lady Hale in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [115].

563 This is most clearly so where an individual has formed a desire to refuse a physical interference with their body: Herring and Wall, 'The Nature and Significance of the Right to Bodily Integrity' (2017) 76(3) The Cambridge Law Journal p. 566, 582.

564 Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (2020) 199.

565 Purshouse encapsulates this in an analysis of a specific aspect of English law, stating that such an approach: 'would allow the interference of a person's decisions in their best interests (to ensure they comply with an objective rule or to ensure they comply with their own thought-through values). In other words, these definitions of autonomy are indistinguishable from autonomy's polar opposite, paternalism': Purshouse, 'How Should Autonomy Be Defined in Medical Negligence Cases?' (2015) 10(4) Clinical Ethics p. 107, 110-111.

notable in this respect is *Montgomery*, where the Supreme Court objected to a default view of patients as 'medically uninformed and incapable of understanding medical matters' or as 'wholly dependent upon a flow of information from doctors'.[566] Instead, they were viewed as consumers who make choices.[567] For these choices, they gathered 'information about symptoms, investigations, treatment options, risks and side-effects via such media as the internet'.[568] This meant they had to sift through sources of variable quality, identifying reliable ones, and had to then integrate these into their wider reasoning with other sources, including: materials provided by hospitals, patient support groups and, of course, the information received from their doctors.[569]

Patients are consequently seen as individuals with abilities that are not undemanding. Yet, this is not to be equated with ascribing a certain intellect to them or a certain preference.[570] Rather, it posits an ability to engage in the process of medical decision making that approximates closely to the cognitive dimension of autonomy developed in the previous chapter. As will be discussed below, the courts further recognise that realising patient autonomy involves *inter alia* placing a patient in an informational context where they can exercise these capabilities.

### B. Individual reflection

Under our normative approach, a process of theoretical reasoning, as well as an awareness of certain foundational facts and values, were deemed prerequisites for any meaningful exercise of autonomy. At the same time, a reflective element was adduced to signify the way in which autonomous decisions must be the patient's own. The patient was able to form commitments that were particularly significant to their self-determination because they were resilient to challenge, long-lasting and cohered with the other elements of their character. These commitments ultimately shape a form of decision-making that is receptive to, and representative of, one's own personal interests.

566 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [76].
567 ibid [75].
568 ibid [76].
569 ibid [76].
570 Contrast the view of Lord Diplock in *Sidaway*, which reserved the disclosure of certain information for 'highly educated men of experience': *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 894-895.

To show that UK law understands autonomy in a way that fits with this dimension, one can point to two related aspects. First, the respect that it accords to the patient's balancing of even fundamental interests. Second, that such respect is especially due where the patient invokes commitments that are deeply held.

Regarding the first element, the law emphasises that patients can align their actions with their goals, even when the highest stakes are involved. For example, as Coggon has stated, a life-saving treatment may be refused under UK law, citing *Re C* and *Ms B*.[571] This is surely beyond doubt.

More pertinently for the recognition of a reflective component to autonomy, we should pause to consider how the law approaches cases where it is in doubt whether patients have the capacity to make such serious decisions. For, they arguably place great emphasis on the fact that the individual has been able to reflect and balance their interests for themselves. This requirement can be found in section 3(1)(c) of the *Mental Capacity Act* (MCA) 2005, enshrining the previous common law position under *Re C*.[572] In effect this means that, for the law to accept a patient's life-or-death decision, it will require that patient to provide some evidence that they are capable of balancing, or that they have in fact balanced, the relevant interests in their care.[573] This targets the law's protection of medical decisions towards a reflective dimension of autonomy.

Coming to the second element, one can identify a trend in the case law to primarily protect long-lasting, defensible preferences. Given that the courts often defer to the patient's current desires, which are arguably assumed

571 Coggon, 'Varied and Principled Understandings of Autonomy in English Law' (2007) 15(3) Health Care Analysis: Journal of Health Philosophy and Policy p. 235, 239.

572 *Re C (adult: refusal of treatment)* [1994] 1 WLR 290.

573 Compare in this respect: *Trust A v H (an adult patient)* [2006] EWHC 1230 (Fam), [2006] 5 WLUK 706 and *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP), (2014) 137 BMLR. 232. In the former case, the patient's mental impairment meant that she was simply unable to weigh the need for life-saving surgery, which was supported by numerous concerns of hers, with countervailing considerations. In the latter case, the patient merely exhibited a tendency to minimise risks of inaction, which was a normal human way of dealing with a serious medical decision. It did not amount to any incapacity in her ability to weigh information.

to constitute such commitments,[574] the strongest evidence for this can be found where the court protects the individual's own higher-order objectives over their current wishes.

This is reflected in *Re MB*, where a pregnant woman consented to the necessary caesarean section in principle, but refused it in the moment because of her needle-phobia. The court understood actions against the woman's momentary decision, which may be for irrational reasons or based on no reason at all, to constitute an interference with her autonomy.[575] However, it also framed an exception, which was based on a lack of capacity to decide, and applied this to the woman's needle-phobia. This was considered to be so dominant in the woman's thinking that she was not able to make a decision at all.[576] Arguably, this finding was driven by the woman's own deeply desired result: a caesarean section and the safe delivery of her baby.[577] In virtue of this, *Re MB* could be distinguished from a case where a woman declined the treatment and gave no reason at all.[578] It can be argued that the court, while denying the woman's capacity for autonomous decision-making altogether, was merely prioritising her deep commitments – which were entirely coherent with her character and presumably long lasting – over preferences that the woman herself recognised as anomalous and undesirable.

A similar distinction emerges in instances where an external influence has been found to override an individual's will in a particular moment, so that 'consent or refusal of consent may not be a true consent or refusal'.[579] Specifically, in *Re T*, although the patient expressed a refusal of blood transfusions, this was not determinative and could not have been determinative in light of the influence brought to bear on her by her mother.[580] The judges emphasised particularly how the patient's apparent refusal had come 'out of the blue' and how it was influenced by religious beliefs that were not

574 Often this dimension doesn't come through because of the alignment between immediate desires and best desires: Keren-Paz in Barker, Fairweather and Grantham, *Private Law in the 21st Century* (2017) 426-427.

575 *Re MB* [1997] EWCA Civ 3093 [30], [60].

576 ibid [30]-[31].

577 ibid [30], [36]. Although conceding its tangential relevance, the court also referred to the favourable reaction of similarly situated patients after the fact: ibid [31].

578 It is also notable that the court found it necessary to state that 'panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence': ibid [30].

579 *Re T (adult: refusal of treatment)* [1993] Fam 95, 122.

580 ibid 110-111.

shown to be an established part of the patient's character.[581] In short, an inability to demonstrate the significance of the patient's choice to her wider belief system once again led to a situation where it was not equated with an autonomous decision.

To a lesser extent, one can also see the described trend in the retrospective causation analysis undertaken in negligence claims for lack of informed consent. As will be discussed at length in Chapter 6, this requires a claimant to show how they personally would have acted, had they been given the relevant information at that time. In this respect, as Turton has noted: 'it is generally best desire autonomy that can be effectively protected rather than current desire autonomy since the patient will have difficulty persuading a court on the balance of probabilities that they would have refused treatment if such a decision cannot be explained by their wider values and priorities'.[582] In medical decisions this has enabled courts to refer to the 'cautious and conservative nature' of patients,[583] their well-documented overwhelming desire to be cured,[584] their non-emphasis of cosmetic factors and their recorded hesitancy to be involved in an experimental, uncertain procedure.[585] These concerns illustrate the relevance of the patient's more general character to the individual decision.

Indeed, at times it appears that the courts are on the verge of departing from an individual assessment, almost conducting a generalised assessment of reasonableness.[586] This would violate the first element of our analysis. which demands that the individual be afforded pride of place in the balancing of their own interests. However, given that no such departure from the subjective assessment has explicitly occurred, the courts' causation analysis

581 ibid 109-112, 118-120.

582 Turton, 'Informed Consent to Medical Treatment Post-Montgomery: Causation and Coincidence' (2019) 27(1) Medical Law Review p. 108, 114.

583 *Shaw v Kovac* [2017] EWCA Civ 1028, [2017] 1 WLR 4773 [28]. In another case it was accepted that a claimant was a cautious person, which was evidenced by their rejection of surgery in the past: *Thefaut v Johnston* [2017] EWHC 497 (QB), [2017] 3 WLUK 328 [84].

584 *C v Colchester Hospital University NHS Foundation Trust* [2018] 2 WLUK 850 [61].

585 *Mills v Oxford University Hospitals NHS Trust* [2019] EWHC 936 (QB), (2019) 170 BMLR 100 [209], [219].

586 *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2019] EWCA Civ 585, (2019) 170 BMLR 49 [9], [19]-[22]; *Thefaut v Johnston* [2017] EWHC 497 (QB), [2017] 3 WLUK 328 [54], [84]; *Ollosson v Lee* [2019] EWHC 784 (QB), [2019] 3 WLUK 562 [158]. Although the distinction is fluid, all these cases still focussed in on the individual position of the patient, as required in *Montgomery*, and thus cannot be taken as an approach that is incompatible with reflective autonomy.

remains focused merely on the wider character of the individual patient. To this extent the common law therefore incorporates the outlined reflective dimension within its protection of the autonomy interest.

Further, it can be argued that UK law pays particular respect to the patient's central commitments because it recognises that interferences with such desires are more significant. For example, in *Rees v Darlington Memorial Hospital NHS Trust*, it was a denial of 'the opportunity to live her life in the way that she wished and planned' – an interference with clearly established, long-term objectives – that weighed particularly heavily with the House of Lords and inspired the exercise in norm generation referred to above.[587] It is further notable that the patient's beliefs and values are considered separately under section 4(6)(b) MCA 2005. The application of this requirement has prompted Pattinson to note that an incapacitated individual's 'longstanding beliefs and values have particular weight' in the determination of their best interest.[588]

In sum, it is undeniable that the UK courts have accommodated a reflective component within their reasoning on patient autonomy. This dimension has manifested itself in numerous ways and across different areas of law.

### C. Positive and negative freedom

That UK law values both negative and positive freedom and promotes the practical dimension of autonomy to some degree can be established relatively straightforwardly. With respect to negative freedom, one can refer again to the case of *Re MB*. In this case Butler-Sloss LJ cited authority for the emphatic proposition that: 'A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death'.[589] Although such a right must be qualified in certain ways, as our analysis of the reflective component illustrates, the

587 *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52, [2004] 1 AC 309 [8].

588 Pattinson, *Medical Law and Ethics* (Sixth Edition 2020) 150, referring to: *Newcastle upon Tyne Hospitals Foundation Trust v LM* [2014] EWHC 454 (COP), (2014) 137 BMLR 226.

589 *Re MB* [1997] EWCA Civ 3093 [17].

fundamental commitment of the courts to the protection of the patient's negative freedom is deeply entrenched.

The legal position with regard to the protection of a patient's positive freedom is, by comparison, much more ambivalent. The courts will neither intervene to force medical professionals to provide a procedure they do not wish to provide,[590] nor will they interfere in resource-allocation decisions that may frustrate a desire for a certain treatment, unless this frustration would also violate some pertinent public law duty.[591]

Crucially for our purposes, a different route has been taken in relation to the facilitation of patient-decision making through information provision. The common law has endeavoured to protect this dimension. *Webster v Burton* highlights the special status of this category. It was presciently stated that the patient 'cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision'.[592]

More widely, there are a variety of ways in which UK law associates autonomy with conditions on patient understanding. Such a criterion has featured in cases dealing with the capacity for autonomous action,[593] those addressing the validity of consent[594] and those specifying the doctor's standard of care.[595] The law's engagement with this criterion indicates that

590 *An NHS Trust v L* [2013] EWHC 4313(Fam), (2014) 137 BMLR 141 [78]; *Portsmouth NHS Trust v W* [2005] EWHC 2293 (Fam), [2005] 4 All ER 1325 [32]-[36], citing: *Re J (a minor) (child in care: medical treatment)* [1993] Fam 15, 26-27.

591 The following cases all dealt with issues of resource allocation and duties to render positive assistance to patients in light of Article 8 of the European Convention on Human Rights: *R v North West Lancashire Health Authority ex p A* [2000] 1 WLR 977; *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 (Admin), [2011] 4 WLUK 189; *McDonald v Kensington and Chelsea Royal Borough of Kensington and Chelsea* [2011] UKSC 33, [2011] 4 All ER 881.

592 *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62, (2017) 154 BMLR [97].

593 For example, in *Gillick* Lord Scarman made 'the child's right to make his own decision' dependent upon reaching 'a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision': *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 186.

594 See for example: *R v Melin*, where reference was made to 'what was known and understood by the complainants concerned': *R v Melin* [2019] EWCA Crim 557, [2019] QB 1063 [33].

595 'The patient is entitled to consider and reject the recommended treatment and for that purpose to understand the doctor's advice and the possibility of harm resulting from the treatment': *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 904.

if a patient lacks a relevant aspect of understanding regarding a medical decision and, more especially, if they were not furnished with adequate information and opportunity to gain such an understanding, then there is a potential violation of autonomy.

In particular, the law insists on medical professionals generating opportunities for understanding. In the case of *Al Hamwi v Johnston* the judge rejected as too onerous the notion 'that the clinician's duty is to ensure that the information given to the patient is understood'.[596] Rather, the duty arising in negligence required only that '[c]linicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided'.[597] Similarly, in cases dealing with the reality of consent, the issue is often framed as the doctor having sufficiently informed the patient of relevant aspects.[598] Perhaps this feature is influenced by the nature of the legal process, where – as was made clear in *Al Hamwi* – the obligations of the defendant are one of the most significant concerns. However, it also appears to be an acceptable specification of a procedural conception of positive freedom, which does not seek to guarantee understanding, but rather to facilitate informed decision making.

In addition, it is conspicuous how much the courts have, more recently, emphasised aspects relating to the process of information disclosure, including especially those of deliberation and dialogue. In *Bell v Tavistock and Portman NHS Foundation Trust* the Divisional Court mentioned repeatedly the level of information that was provided for a controversial and sensitive form of treatment, as well as the nature of the discursive and iterative dialogue through which it was conveyed.[599] In *Montgomery* too it was stated

596 *Al Hamwi v Johnston* [2005] EWHC 206 (QB), [2005] Lloyd's Rep Med 309 [69].

597 ibid [69]. Cf. also *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334, 339: 'When recommending a particular type of surgery or treatment, the doctor, when warning of the risks, must take reasonable care to ensure that his explanation of the risks is intelligible to his particular patient. The doctor should use language, simple but not misleading, which the doctor perceives from what knowledge and acquaintanceship that he may have of the patient (which may be slight), will be understood by the patient so that the patient can make an informed decision as to whether or not to consent to the recommended surgery or treatment'.

598 *Chatterton v Gerson* [1981] QB 432, 443.

599 *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), (2021) 177 BMLR 115 [37], [39], [98]. These findings were not criticised in the successful appeal: *Bell v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363, [2022] 1 All ER 416 [22].

that 'the doctor's advisory role involves dialogue'[600] and Lord Kerr and Reed cited with approval guidance of the General Medical Council that required doctors to '[w]ork in partnership with patients. Listen to, and respond to, their concerns and preferences. Give patients the information they want or need in a way they can understand'.[601] It was also noted that such understanding would not be furthered 'by bombarding the patient with technical information which she cannot reasonably be expected to grasp'.[602] UK law therefore places certain standards on the facilitation of patient decision making, including at least a process of cooperative reasoning, dialogue and adequately focussed disclosure.

Finally, one must consider the requirement that autonomous decisions are based on certain beliefs that are accurate representations of the world. As will be explored in more depth in Chapter 6, the courts appear to implicitly establish a hierarchy of information, according to which the most significant beliefs of the patient must actually be true.[603] This includes an accurate understanding of the broad nature and purpose of their treatment.[604] Similarly, certain motivations of the professional are seen as highly relevant for an individual's understanding, covering at least financial and sexual motivations for the acts performed.[605] Below these considerations, there lies the information that a doctor should provide about certain risks and consequences of a given procedure The judiciary has clearly stated that it regards this information as an important facet of a patient's decision, but it does not afford it the same kind or level of protection as the two other categories.[606]

600 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [90].
601 ibid [77].
602 ibid [90].
603 Although not relating to information disclosure, the significance of holding certain basic beliefs is also clearly evident in the law dealing with the mental capacity to consent to treatment. See: *Re MB* [1997] EWCA Civ 3093 [3]; *Trust A v H (an adult patient)* [2006] EWHC 1230 (Fam), [2006] 5 WLUK 706 [23].
604 *Chatterton v Gerson* [1981] QB 432, 443. Pugh himself draws this distinction in the English legal context: Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (2020) 165.
605 See *Appleton v Garrett* (1997) 34 BMLR 23 and *R v Williams* [1923] 1 KB 340 respectively.
606 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430. Note in this regard, how *Montgomery* has expanded the number of factors that are deemed significant even within this one category. As will be examined in Chapter 6, under the previous standard a doctor generally needed only to disclose those risks that one responsible body of medical opinion would deem necessary.

## IV. Limitations

To realistically assess how the principle of autonomy influences the application of specific legal mechanisms to the problems posed by the use of AI, one must also be candid about the limitations involved in the operation of this principle. This is necessary in spite of the suggestions by some academics that considerations of autonomy do, or ought to, predominate in medical law's reasoning. For instance, Heywood and Miola have stated that:

> The approach taken by the Supreme Court [in *Montgomery v Lanarkshire Health Board*] is the same as that adopted by the House of Lords in *Chester v Afshar* and indeed the High Court of Australia in *Rogers v Whitaker*. This entails identifying the purpose of the law as being the protection of autonomy and assessing the current legal regime to see if it meets that aim. In all three of these cases a majority of judges found that it did not and so modified the law adequately to protect autonomy (…) Future courts should look at the approach of the House of Lords and now Supreme Court, and consider cases in the same way: does the current law adequately protect patient autonomy and, if not, what needs to be changed to allow it to do so?[607]

There are two significant limitations that such an approach seems to ignore, but which are deemed important to recognise in subsequent chapters. On the one hand, we have elaborated on the fact that legal principles are liable to conflict with other principles and values. The more general demands of the law are not necessarily coherent and commensurate and cannot be brought under just one head, such as autonomy.

In particular, as we move to consider individual mechanisms, the normative demands of these rules cannot be discounted. If a rule has enough weight, or if the consequences of departing from it would be sufficiently dire, then the best legal argument may be that it ought to be upheld, even if this is to the chagrin of the autonomy principle. This is especially true in the private law context, where the relevant informed consent obligations will be seen to be overwhelmingly located. Here it has been noted that a tendency to use wider societal and political reasoning is restricted by

607 Heywood and Miola, 'The Changing Face of Pre-operative Medical Disclosure: Placing the Patient at the Heart of the Matter' (2017) 133((Apr)) Law Quarterly Review p. 296, 320.

institutional factors. These encompass: a need to give considerable priority to legal documentary forms, a convention of placing greater emphasis on consistency and doctrinal stability and the recognised need of doing justice to both parties.[608]

It is surely correct that if AI threatens the specified aspects of a patient's autonomy, especially in a wide-ranging or grave manner, then this provides an impetus for examining the legal situation in light of the underlying principle. But the limits imposed by the nature of specific rules and other principles remain. These conflicts must be assessed in each individual scenario, framed at least in part in terms of the considerations and arguments offered here.

## *V. Conclusion*

In conclusion, this chapter has maintained that UK medical law incorporates a conception of autonomy that bears a multitude of forceful affinities to the outlined procedural approach. This represents one cogent normative specification of an open-ended jural concept and enables autonomy to be used as a legal principle in the following analysis of specific legal mechanisms. The autonomy principle demands that an autonomous decision-making process has taken place. This includes the exercise of basic rational, cognitive capabilities, as well as a reflection of one's own, personal commitments. It also means that the patient must be protected from outside interferences and have their decision-making ability facilitated by relevant actors – especially through the provision of information in the medical context. Lastly, it must also be acknowledged that this principle is not the sole goal of the law. A principle will conflict with different norms and with consequentialist forms of reasoning and its application in individual circumstances must always be tempered by the limitations that these considerations legitimately impose.

608 Robertson in Robertson and Tang, *The Goals of Private Law* (2009) 269-279.

# Chapter 5: Autonomy in U.S. law

Within the United States considerations of patient autonomy have a long-established history, both at the state and the federal level. Through the judicial reshaping of its inherited doctrines, the U.S. was perhaps the first common law jurisdiction to develop a legally significant understanding of patient autonomy in medical decision making. To unpick the meaning that can be attributed to this understanding, this chapter follows the mode of analysis adopted in the British context, determining: within what confines the autonomy concept ought to be considered, what function and substantive content can be attributed to it and what limiting factors deserve particular attention.[609]

## *I. Scope*

The first point of call is to circumscribe the boundaries within which the relevant understanding of autonomy is to be found in the positive legal order of the U.S. and, specifically, California. When doing this one cannot ignore the fact that '[t]he law governing American health care arises from an unruly mix of state and federal agencies and from a jumble of statutes and common law doctrines conceived, in the main, without medical care in mind'.[610] Such fragmentation of healthcare law raises some difficulties in demarcating the area of inquiry; difficulties that are compounded by the lack of a single institution that, *via* its treatment of the autonomy concept, could provide an authoritative statement on the relevance of these different legal materials.[611] Questions touching on patient self-determination arise

609 As in the English context, I do not restrict my analysis based on any particular terminology, given that terms such as 'autonomy', 'self-determination' and 'bodily integrity' are often used interchangeably to denote similar substantive concerns. See for example: *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833, 857 and *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1188-1189. It is the substance of these concerns that directs the enquiry.

610 Bloche, 'The Invention of Health Law' (2003) 91(1) California Law Review p. 247, 249-250.

611 A similar fragmentation existed in England and Wales. Yet we saw there how the United Kingdom's Supreme Court signalled the relevance of disparate components

against the backdrop of a federal system that encompasses over 50 jurisdictions with divided institutional competencies on pertinent constitutional, statutory and common law issues.

## A. Jurisdictional scope

Due to the fragmented nature of the United States' common law, a selection was made in the introduction to focus on the tort law of California. Yet, this does not mean that the operation of a legal concept, which informs more specific mechanisms, must be restricted to an analysis of one state alone. It is a well-established feature of legal reasoning in the U.S. that general principles are laid down corresponding to 'the general average of the results reached by the courts of various states'.[612] In this way the judge or scholar 'aims at finding the best solution of a problem on the footing of examples from many jurisdictions [and they] will tend to concentrate on recent trends'.[613] If autonomy is a 'general principle' in these senses, then our analysis should engage with the more disparate legal landscape of the U.S.

This does not require a comprehensive, detailed accounting of each jurisdiction, however. Rather, prominent trends in federal and cross-state case law will be relevant to some aspects of our analysis. Most especially to the determination of the conceptual scope of autonomy, which delineates the outer boundary of a broad consensus, and to the function of the autonomy concept, which is the dimension that draws on the aforementioned commonality in legal reasoning. In so far as the specific substance

---

by using them to shape the construction of its understanding of autonomy. By contrast, the United States Supreme Court stated *Cruzan by Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 277-278: 'State courts have available to them for decision a number of sources – state constitutions, statutes, and common law – which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did'. This usefully highlights the formal position in America, which prevents the Supreme Court from performing a similar signalling role, but it will also be seen *infra* how the legal reasoning of the Supreme Court is indirectly influenced by the materials that were formally dismissed in *Cruzan*.

612 Goodhart, 'Case Law in England and America' (1930) 15(2) Cornell Law Review p. 173. Note that here I do not use the term 'principle' in the sense of a legal norm, which was elaborated in the previous chapter and will be drawn upon again below.

613 Cross, *Precedent in English Law* (Third Edition 1979) 18. This type of reasoning will be elaborated upon when considering autonomy's function *infra*.

of the autonomy principle and the limitations that are imposed on it are concerned, the focus must, first and foremost, be on California's law, which may offer its own, distinct specifications for each.

Beginning then with the question of whether autonomy is a concept for which a coherent approach is sought across the jurisdictional boundaries of U.S. law – spanning different state and federal courts – this must be affirmed beyond doubt.[614] In relation to individual autonomy, one might even say that the approaches of different legal actors are particularly interwoven.[615] This is evidenced by the U.S. Supreme Court's early recognition of the common law's formative role in the value's conception. So that in 1891, when considering whether a plaintiff seeking damages could be forced to undergo a surgical examination, it was found:

> No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.[616]

---

614 For some examples of scholars approaching the topic in this way: Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95(2) The Yale Law Journal p. 219; Appelbaum, Lidz and Meisel, *Informed consent: Legal theory and clinical practice* (Second Edition 2001) pt II; Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (2010) chapter 2; Faden, King and Beauchamp, *A History and Theory of Informed Consent* (1986) chapter 2.

615 'Constitutional development is often broadly rooted in common law principles; in [medical privacy cases] the public law is somewhat in advance of the private': Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95(2) The Yale Law Journal p. 219, 277. In a non-medical context, Bloustein has argued forcefully for the recognition of a connection between tortious and constitutional understandings of privacy, stating that 'there is a common thread of principle and an identical interest or social value which runs through the tort cases as well as the other forms of legal protection of privacy': Bloustein in Schoeman, *Philosophical Dimensions of Privacy* (2009) 181.

616 *Union Pac. R. Co. v. Botsford* (1891) 141 U.S. 250, 251-253. Following Sunstein, one may see the common law as functioning as a baseline for constitutional reasoning in this area. Whereby 'courts used common law principles to define the judicial role in public law cases', e.g. 'finding coercion only in cases of government infringement of common law rights': Sunstein, *After the Rights Revolution: Reconceiving the Regulatory State* (1993) 210-220. For a wider application of this theory to the modern Supreme Court see especially: Shell, 'Contracts in the Modern Supreme Court' (1993) 81(2) California Law Review p. 431 and Farber and Frickey, 'In the Shadow of the Legislature: The Common Law in the Age of the New Public Law' (1991) 89(4) Michigan Law Review p. 875.

This guiding role of the common law in constitutional reasoning has become more prominent as the court has been obliged to deal with the more nuanced aspects of medical decision making. For example, when *Cruzan v. Director, Missouri Department of Health* considered the compatibility of restrictions on end-of-life decision making with the Due Process Clause of the 14th Amendment, several judges dwelt extensively on the common law's respect for self-determination and its requirements of informed consent.[617] And again, in a very different situation in *NIFLA v. Becerra* – considering the imposition of disclosure obligations on primary care clinics – all members of the Court explicitly recognised the legitimacy of imposing informed consent requirements on health care providers where this served to facilitate medical decision-making and patient self-determination.[618] The majority appeared particularly content to defer to the common law in this area. They highlighted its long-established role, before rejecting the manner in which California sought to extend the scope of informed consent to justify its statute.[619]

Ample instances can also be found where state courts have referenced the importance attributed to autonomy in the federal and state constitutions, whether or not these were directly in point. The New Jersey Supreme court in *Matter of Conroy* prefaced its purely common law analysis of the right to decline life-sustaining treatment, with an exposition of the Constitutional privacy right, as elaborated in *Griswold v. Connecticut* and *Roe v. Wade*.[620] Faced with a similar case the California Court of Appeal held that '[t]he right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy', citing both the state and the federal constitution, but only after having already inferred similar rights from the State's common law and statute.[621]

---

617 For example, Chief Justice Rehnquist, delivering the opinion of the Court: *Cruzan by Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 267-278. See also Justice Brennan, with whom Justice Marshall and Justice Blackmun joined, dissenting: ibid 305-306.

618 *National Institute of Family and Life Advocates v. Becerra* (2018) 138 S.Ct. 2361. See Justice Thomas delivering the opinion of the Court: ibid 2373-2375. See also: Justice Breyer for the dissenting justices: ibid 2385-2386.

619 ibid 2373-2374. In part this rejection seemed to turn on the fact that the disclosure fell outside the situations where disclosure had traditionally been mandated. See also the minorities' criticism of such reasoning: ibid 2386.

620 *Matter of Conroy* (1985) 98 N.J. 321, 348.

621 *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 195. See also: *Thor v. Superior Court* where the California Supreme Court supported its proposition that 'the right

Perhaps the most significant impact of the constitutional recognition of autonomy interests on common law reasoning has been seen in the realm of so-called wrongful birth claims.[622] These are negligence actions where parents seek damages after they have not been properly informed about, or there has been a misdiagnosis of, a foetus' condition that would have caused the parents not to continue the pregnancy to birth. The indirect and yet substantial influence of *Roe v. Wade*[623] on the recognition of these purely private law claims, prior to its recent overturning in *Dobbs v. Jackson Women's Health Organization*,[624] has been noted by courts and commentators alike.[625] Whereas 'public policy' militated against the recognition of this cause of action before *Roe*,[626] courts considering wrongful birth claims after that decision argued that it brought about a shift in their background considerations, favouring the facilitation and protection of women's autonomy.[627]

---

to refuse medical treatment is equally "basic and fundamental" and integral to the concept of informed consent' *inter alia* by reference to the aforementioned U.S. Supreme Court case of *Cruzan*: *Thor v. Superior Court* (1993) 5 Cal.4th 725, 735-736.

622 One can also compare the impact of *Griswold v. Connecticut* (1965) 381 U.S. 479 on the legal recognition of wrongful conception claims: *Custodio v. Bauer* (1967) 251 Cal.App.2d 303, 317-318; *Troppi v. Scarf* (1971) 31 Mich.App. 240, 253-254.

623 *Roe v. Wade* (1973) 410 U.S. 113.

624 *Dobbs v. Jackson Women's Health Organization* (2022) 597 U.S. 215.

625 In addition to the cases *infra*, see: Haqq, 'The Impact of Roe on Prenatal Tort Litigation: On the Public Policy of Unexpected Children' (2020) 13(1) Journal of Tort Law p. 81; Harris, 'Statutory Prohibitions on Wrongful Birth Claims & Their Dangerous Effects on Parents' (2014) 34(2) Boston College Journal of Law & Social Justice p. 365, 374; Gold, 'An Equality Approach to Wrongful Birth Statutes' (1996) 65(3) Fordham Law Review p. 1005, 1015.

626 *Gleitman v. Cosgrove* (1967) 49 N.J. 22.

627 Whether this view of *Roe v. Wade* was ever correct is another question. The court in *Roe* stated: 'The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the point where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician': *Roe v. Wade* (1973) 410 U.S. 113, 165-166. For a critical analysis see *Daly, 'Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey' (1995) 45(1) American University Law Review p. 77*. Daly argues that *Roe* and its progeny afforded primacy over the abortion decision to the medical professional, not the woman. Siegel and Greenhouse have made a similar point referring to *Roe*: 'the Court explained and justified its holding in language that depicted doctors as the responsible and authoritative decisionmakers, with women as patients subject

In *Robak v. U.S.* it was mused that 'State courts have been quick to accept wrongful birth as a cause of action since *Roe v. Wade*, because it is not a significant departure from previous tort law'[628] and, significantly, because a similarity to other medical malpractice actions was not marred by 'political and moral questions concerning abortions [that] the Supreme Court has already settled'.[629] In *Smith v. Cote* the Supreme Court of New Hampshire conceded that 'we believe that *Roe* is controlling; we do not hold that our decision would be the same in its absence', adding later: 'we are bound by the law that protects a woman's right to choose to terminate her pregnancy'.[630] In California the Supreme court – while not appealing directly to *Roe* – cited with approval such out-of-state actions (including, but not limited to, *Robak*) and apparently conceded the validity of wrongful birth actions on the strength of their authority and on the basis of two rulings of the Court of Appeal.[631] In this manner, the primacy that the U.S. Supreme Court afforded to the ability to make abortion decisions has clearly permeated state courts' reasoning in accepting a novel type of negligence claim, even if it is difficult to see how a concrete constitutional argument could have been constructed to require its creation or maintenance.[632]

This leads one to the final aspect of the intertwined nature of autonomy-related reasoning in the U.S. Namely, that in many cases dealing with the

---

to their guidance (…) the Court figured the doctor as the agent responsible for abortion decisions and the criteria guiding those decisions as medical': Siegel and Greenhouse, *Before Roe v. Wade: Voices that Shaped the Abortion Debate Before the Supreme Court's Ruling* (2010) 255. This made *Roe* a surprising basis for mandating private law causes of actions against physicians who are performing their constitutionally mandated role: controlling the abortion decision.

628 *Robak v. U.S.* (7th Cir. 1981) 658 F.2d 471, 476.

629 ibid 476.

630 *Smith v. Cote* (1986) 128 N.H. 231, 239-242.

631 *Turpin v. Sortini* (1982) 31 Cal.3d 220, 225-227. This approach was described and affirmed in: *Foy v. Greenblott* (1983) 141 Cal.App.3d 1, 8.

632 Arguments to this effect were rejected in: *Hickman v. Group Health Plan, Inc.* (Minn. 1986) 396 N.W.2d 10, 13-15; *Edmonds by James v. Western Pennsylvania Hosp. Radiology Associates of Western Pennsylvania P.C.* (Pa. Super. Ct. 1992) 414 Pa.Super. 567, 575-576; *Dansby v. Thomas Jefferson University Hosp.* (Pa. Super. Ct. 1993) 424 Pa.Super. 549, 553-555. See also Kelley's analysis, which emphasises 'Refusal to recognize a cause of action for wrongful birth (…) does not constitute governmental interference with the woman's right to contraception or abortion. The Constitution does not require state courts to grant tort recovery for private interference with the exercise of constitutional rights': Kelley, 'Wrongful Life, Wrongful Birth, and Justice in Tort Law' (1979) Fall(4) Washington University Law Quarterly p. 919, 959.

concept, courts applying state law have also drawn generously upon the judicial pronouncements of their sister jurisdictions to determine what patient autonomy means and requires. Some decisions that are frequently cited, and often cited together, in the area of informed consent law span the following states: *Schloendorff v. Society of New York Hospital* (a decision of the Court of Appeals of New York Court),[633] *Salgo v. Leland* (The California Court of Appeal for the First District),[634] *Canterbury v. Spence* (a federal decision, applying the law of the District of Columbia),[635] *Natanson v. Kline* (the Supreme Court of Kansas)[636] and *Cobbs v. Grant* (the Supreme Court of California).[637]

A comparable trend is also identifiable in specific applications of autonomy arguments, such as the right to die. In this field Meisel has elaborated how the decisions of the Supreme Court of New Jersey, including *Matter of Quinlan,*[638] *In re Conroy*[639] and *Matter of Jobes,*[640] have played an important role in shaping a consensus in this area of the law, which holds across States and which has been reinforced by the United States Supreme Court's influence.[641] At the same time, prominent decisions from

633 *Schloendorff v. Society of New York Hospital* (1914) 211 N.Y. 125.
634 *Salgo v. Leland Stanford Jr. University Bd. of Trustees* (1957) 154 Cal.App.2d 560.
635 *Canterbury v. Spence* (D.C. Cir. 1972) 464 F.2d 772.
636 *Natanson v. Kline* (1960) 186 Kan. 393.
637 *Arato v. Avedon* provides a straightforward example of such reasoning, citing all of the aforementioned cases: *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1183, fn. 5.
638 *Matter of Quinlan* (1976) 70 N.J. 10.
639 *Matter of Conroy* (1985) 98 N.J. 321.
640 *Matter of Jobes* (1987) 108 N.J. 394.
641 Meisel, 'The Right to Die: A Case Study in American Lawmaking' (1996) 3(1) European Journal of Health Law p. 49. Meisel elaborates on courts' and lawyers' process of decision-making: 'Almost without exception, when deciding its first right-to-die case, each court has felt compelled to recount the development of the law in other states even though the law of other states is not binding precedent on courts outside that state' and '[lawyers advising clients] try to obtain a composite picture of the law across the US to determine if there is any uniformity or at least a majority position': ibid 59-60. He also traces the influence of these cases on other jurisdictions, such as Pennsylvania, ibid 61. Lastly, regarding the role of the United States Supreme Court he comments: 'The role played by the United States Supreme Court in the development of the right to die in American law has been dramatic, but late in coming. By the time the Court entered the arena, the consensus was very well developed. However, the action by the Supreme Court has helped to solidify and ultimately extend the reach of the consensus": ibid 63.

other states – such as *In Re Gardner*,[642] *Satz v. Perlmutter*,[643] *Superintendent of Belchertown v. Saikewicz*[644] and *Rasmussen v. Fleming*[645] – have also contributed materially to the legal understanding of autonomy in this context.[646]

All in all, given these interrelations, it appears that an exposition of legal reasoning with the autonomy concept is not restricted to one state jurisdiction, but can (and partially must) be situated in this wider context, to give a fair accounting of its meaning and significance.

## B. Conceptual scope

The remainder of this section establishes the outer bounds of this broad consensus by illustrating how the U.S. courts have considered autonomy in connexion with medical decision making.

As a rule, this has not proceeded by explicitly delineating autonomy as a health law concept. Much the opposite: both state and federal courts have been more open than their transatlantic counterparts in associating patient autonomy with understandings of agency and liberty drawn from other areas of law. For instance, in an interesting point of contrast with the British position, American courts and commentators have relied substantially on the duties owed in fiduciary and commercial relationships to supplement considerations of individual agency and to define a physician's informational responsibilities.[647] Similarly, the freedom afforded to patients

642 *In re Gardner* (Me. 1987) 534 A.2d 947.

643 *Satz v. Perlmutter* (Fla. 1980) 379 So.2d 359.

644 *Superintendent of Belchertown State School v. Saikewicz* (1977) 373 Mass. 728.

645 *Rasmussen by Mitchell v. Fleming* (1987) 154 Ariz. 207.

646 *Thor v. Superior Court* refers to these and many more cases, interspersing them with analyses of the already mentioned informed consent case law, to reach such conclusions as 'Because health care decisions intrinsically concern one's subjective sense of well-being, this right of personal autonomy does not turn on the wisdom, i.e., medical rationality, of the individual's choice': *Thor v. Superior Court* (1993) 5 Cal.4th 725, 734-737. In *Robak v. U.S.* the 7th Circuit of the U.S. Court of Appeals stated that 'In the absence of any direct precedent from the state involved, a federal court applying state law should consider decisions of its sister states on the same issue': *Robak v. U.S.* (7th Cir. 1981) 658 F.2d 471, 475.

647 *Bowman v. McPheeters* (1947) 77 Cal.App.2d 795, 800-801; *Berkey v. Anderson* (1969) 1 Cal.App.3d 790, 804-805; *Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 128-134. Cf. also *National Institute of Family and Life Advocates v. Becerra* (2018) 138 S.Ct. 2361, 2374, where the majority placed physician's informa-

in their healthcare decisions is often described merely as one aspect of a more general liberty interest or even supplanted in specific circumstances by other rights, such as the right to make family decisions.[648]

Going forward, the impacts of such broader doctrines will be considered when they impinge on the role of an independent conception of medical autonomy. But there is no indication that they eclipse the possibility of an independent notion of patient autonomy in the first place. Two less conspicuous modes of reasoning in the American courts betray their recognition of the unique normative demands that the health law background places on their assessments of patient autonomy.

The first type of reasoning consists of the courts' reference to the distinct nature of medical decision making, which then *implicitly* shapes the operation of patient autonomy. Both state and federal courts have proved sensitive to the unique circumstances, moral weight and personal significance of medical decisions and this has shaped their legal consideration of patient self-determination. The Californian Supreme Court has had occasion to be particularly explicit in this respect, emphasising that '[a]lthough an aspect of personal autonomy, the conditions for the exercise of the patient's right of self-decision presuppose a therapeutic focus'[649] and elsewhere '[medical ethics] is a necessary component and complement of [patient autonomy] and should serve to enhance rather than constrict the individual's ability to resolve a medical decision in his or her best overall interests'.[650] Clearly,

---

tional duties squarely in the context of other professional relationships. Schultz has stated that 'The duty to disclose for purposes of informed consent is a specific instance of such a fiduciary duty, yet, for several reasons, a generic fiduciary duty to disclose sometimes more effectively vindicates patient interests in autonomy than do narrower duties that have crystallised under ordinary rules of medical consent'. This exemplifies Schultz's analysis of fiduciary obligations as both one influence on the realisation of patient choice in other causes of action and as a cause of action, furthering this end, in its own right: Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95(2) The Yale Law Journal p. 219, 259-264.

648 See the opinion of the U.S. Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833, 884: 'The doctor-patient relation does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy'.

649 *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1188-1189. To be noted are also the connection to moral ideals drawn in the decision and the emphasis of the 'overall medical context': ibid 1185.

650 *Thor v. Superior Court* (1993) 5 Cal.4th 725, 743. Further expressions of this view, and concomitant practical consequences, were also expressed: 'Given the well- and long-established legal and philosophical underpinnings of the principle of

the Court believed that the doctor's obligations to ensure the patient's informed consent is concerned with a particular conception of an individual's autonomy, which is primarily at stake in healthcare decision making, and it explicitly recognised that medical ethics have a positive role to play in shaping the legal understanding of that conception.

Such reasoning is not unique to California. The Supreme Court of Maine identified the special importance of the concept of personal autonomy 'in the realm of medical care' in *In Re Gardner*, rooting it in the common law doctrine of informed consent, as well as in political and bioethical analyses of patient refusal to continue life-sustaining care.[651] In the New Jersey case of *Hummel v. Reiss* the dissenting Justice Handler insisted that the relevant clinical decision 'clearly involved not only complicated medical judgements about the condition of both [the mother] and the fetus, but also difficult moral questions involved in weighing the value of the mother's life against the potential life of the child. (…) Because the decision involved profound moral and personal issues, it was one that only [the mother] could make'.[652]

A similar tenor emerges from many voices in the U.S. Supreme Court.[653] In *Cruzan*, the dissenting Justice Brennan, picked up on the personal and moral dimensions of the medical decision-making process: '[t]he right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own

---

self-determination, as well as the broad consensus that it fully embraces all aspect of medical decisionmaking by the competent adult, we conclude as a general proposition that a physician has no duty to treat an individual who declines medical intervention' ibid 738. See also *Conservatorship of Drabick*, which stated: 'Under California law, however, human beings are not the passive subjects of medical technology. The line of decisions beginning with *Cobbs v. Grant* and continuing with *Barber*, *Bartling*, and *Bouvia* compel this conclusion. These cases recognize that medical care decisions must be guided by the individual patient's interests and values. Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals': *Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 208.

651 *In Re Gardner* (Me. 1987) 534 A.2d 947, 950-951.

652 *Hummel v. Reiss* (1992) 129 N.J. 118.

653 It is only mentioned indirectly in the text *infra* but *Roe v. Wade* provided some support for an understanding of a broad medical autonomy interest. In this respect, Daly provides an analysis of how the women in that case and its progeny were treated primarily as medical patients, rather than as people with more complex individual and social circumstances: Daly, 'Reconsidering Abortion Law' (1995) 45(1) American University Law Review p. 77. This was bolstered by an expansive definition of 'health' in the companion case of *Doe v. Bolton*: ibid 88.

values and to make a personal decision whether to subject oneself to the intrusion'.[654] The challenged rule was seen as particularly objectionable, due to the fact that it allowed for the transformation of 'human beings into passive subjects of medical technology'.[655] Justice O'Connor (giving a concurring judgment) also referred both to the patient's 'deeply personal decision to reject medical treatment', and their 'interest in directing [their] medical care', implicitly distinguishing it from the 'freedom of personal choice in matters of … family life'.[656] In this manner, the Justices in *Cruzan* emphasised the distinctive way in which medical decisions could be highly personal, engage an individual's values and render them vulnerable to atypical forms of external interference.

Even the U.S. Supreme Court majority in *Planned Parenthood v. Casey* – which preferred to rest its principal, now overturned, holding on a familial conception of liberty – repeatedly integrated *Roe v. Wade*'s relation to medical treatment into its reasoning.[657] Initially it was critically observed that the case may be read 'as a rule (whether or not mistaken) of personal autonomy and bodily integrity with doctrinal affinity to cases recognising limits on governmental power to mandate medical treatment or to bar

654 *Cruzan by Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 309-310.

655 ibid 325. The Justices were also explicit that there can be no distinction between different types of medical treatment: ibid 306-307. Cf. *Thor v. Superior Court* finding much the same: 'both courts and commentators generally reject attempts to draw distinctions between, for example, "ordinary" and "extraordinary" procedures, or "terminal" and "nonterminal" conditions, or "withholding" and "withdrawing" life-sustaining treatment. (…) Rather, effectuating the patient's freedom of choice remains the ultimate arbiter': *Thor v. Superior Court* (1993) 5 Cal.4th 725, 736-737.

656 *Cruzan by Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 289-291, citing *Cleveland Bd. of Educ. v. LaFleur* (1974) 414 U.S. 632, 639-640. This distinction can be gleaned from the fact that Justice O'Connor found that this freedom could 'also' (i.e. in addition to the patient's interest in directing his medical care) be in play where proxies, who are often family members, take decisions for the patient: *Cruzan by Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 289-291.

657 Although the *Dobbs* majority overruled *Roe* and *Casey* because it deemed abortion to be 'sharply' distinguishable on the basis of the critical moral question involved, it referenced the relevant constitutional case law against enforced medical procedures without apparent disapproval. Nor would a medical autonomy concept possess the 'high level of generality' that the majority apparently found objectionable: *Dobbs v. Jackson Women's Health Organization* (2022) 597 U.S. 215, 256-257. Citing the same case law, the dissenting opinion is more explicit in championing constitutional protections of bodily integrity and restrictions on the government's ability to interfere with medical decisions: ibid 379.

its rejection'.[658] In spite of this negative introduction, the majority could not avoid associating *Roe* with the right to terminate medical treatment in its broader analysis.[659] They recognised that a doctor's informational requirements in assisting the abortion decision were, as far as the Constitution was concerned, set by reference to the general requirements imposed on clinical procedures.[660] Justice Blackmun (concurring in part) likewise categorised abortions as relating primarily to decisions of 'reproduction and family planning'.[661] Nevertheless, his analysis of women's right to bodily integrity focused on analogies with surgical interventions and emphasised the connection between pregnancy, its health consequences and risks – factors that feature prominently in the law of informed consent and which frame abortion as a matter of medical decision making.[662] Although *Casey* rejected the medical context (and especially the doctor-patient relationship) as *the* basis for a woman's freedom to end her pregnancy, it was still recognised as an important facet of that freedom, making legally significant contributions.

Such a partial invocation of medical autonomy was also evident in the case of *NIFLA v. Becerra*. Here the Supreme Court adjudged upon a regulation of the California legislature that sought to promote the decision-making capabilities of, especially low-income, women by inter alia requiring the disclosure of publicly funded abortion services to them. This focused the Court's reasoning on the relationship between healthcare provider and patient, with Justice Thomas adopting with approval the quotation from *Wollschlaeger v. Governor of Florida* that '[d]octors help patients make

658 Ultimately it is clear that there was a preference for the right being categorised as the familial type, see: *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833, 884.

659 ibid 858-859.

660 ibid 859, citing *inter alia*: *Matter of Quinlan* (1976) 70 N.J. 10.

661 *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833, 927-928.

662 ibid 926-927. He also noted: 'Just as the Due Process Clause protects the deeply personal decision of the individual to refuse medical treatment, it also must protect the deeply personal decision to obtain medical treatment, including a woman's decision to terminate a pregnancy', positing a broader understanding of medical autonomy, which includes a positive dimension: ibid 927, fn. 3. But see also Spindelman's criticism of such reasoning: Spindelman, 'Are the Similarities between a Woman's Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling' (1996) 29(3) University of Michigan Journal of Law Reform p. 775, 814, fn. 151.

deeply personal decisions and their candor is crucial'.[663] Indeed the full quotation from *Wollschlaeger* demonstrates the distinct significance that the Court has attributed to the facilitation of autonomous healthcare decisions in a free speech context:

> Health-related information is more important than most topics because it affects matters of life and death. Doctors help patients make deeply personal decisions, and their candor is crucial. If anything, the doctor-patient relationship provides more justification for free speech, not less.[664]

However, the outcome of *Becerra* – an indication that California's notice requirement would be subject to, and not survive, strict scrutiny – suggests that the facilitation of personal decisions by the patients was not a decisive influence on the majority's reasoning.[665]

The dissenting minority's approach therefore also warrants consideration. Their support of the notice requirement, as well as their analysis, arguably represented a more sincere attempt to accommodate the normative demands of health care and the patient-doctor interaction. Justice Breyer relied on the Court's distinct jurisprudence on the regulation of the medical profession[666] and the bioethical concerns raised by the case (speech involving 'health, differing moral values and differing points of view').[667] Moreover, he went on to explicitly critique the majority's reliance on a narrow conception of 'medical procedure' as lacking 'moral, practical, and legal force', given the need to obtain the patients' informed consent and the 'health considerations' that would favour disclosure in this instance.[668]

These cases showcase the acknowledgements of state and federal courts that, in the final analysis, the demands of individual autonomy take a

663 Although he then appears to categorise this as a broader aspect of professional relations: *National Institute of Family and Life Advocates v. Becerra* (2018) 138 S.Ct. 2361, 2374-2375.

664 *Wollschlaeger v. Governor, Florida* (11th Cir. 2017) 848 F.3d 1293, 1328. This is difficult to reconcile with the manner in which the majority in *Becerra* then appeared to categorise the patient-doctor interaction as a normal aspect of professional relations: ibid 2374-2375.

665 Montanez, 'Pregnant and Scared: How NIFLA v. Becerra Avoids Protecting Women's Reproductive Autonomy' (2019) 56(3) San Diego Law Review p. 829, 849-851.

666 *National Institute of Family and Life Advocates v. Becerra* (2018) 138 S.Ct. 2361, 2382-2383.

667 ibid 2383.

668 ibid 2386.

unique shape where individuals make healthcare decisions. This is so regardless of whether the concept is partially subsumed under more abstract or related interests.

The second type of consideration reinforces this impression by focussing on the courts' selection of precedent for their analogical reasoning. This reveals a tendency to ascertain the value of autonomy by reference to a class of cases dealing with medical care and medical decision making, even if this is not made explicit and sometimes even at the expense of circumventing purported limitations on their reasoning.

A telling illustration of this is provided by the U.S. Supreme Court's approach in *Gonzales v. Carhart*. Here the majority relied on the balancing between personal autonomy and state interest that was undertaken *Washington v. Glucksberg* [669] (an assisted suicide case) to judge on the legality of a restriction on abortion.[670] It has been argued that such an analogy was possible primarily because both scenarios involved 'a medical procedure that necessarily implicates a life interest, though arguably different life interests, and uncertainty'[671] and, one might hasten to add, therefore also involves fundamental questions of patient autonomy. On the strength of this analogy the Supreme Court upheld a regulation that would have been much more problematic from the perspective of a narrower consideration of the Court's abortion case law or a broader doctrinal lens that focused on the demands of the right of privacy, considered under a standard of strict scrutiny.[672]

More generally, numerous examples of federal and state cases have already been adduced that draw analogies ranging from cases of informed consent, to those dealing with the refusal of medical treatment and those focussing on reproductive freedom.[673] These forms of legal argumentation

669 *Washington v. Glucksberg* (1997) 521 U.S. 702.

670 *Gonzales v. Carhart* (2007) 550 U.S. 124, 156-160.

671 Coyle, 'Gonzales v. Carhart: Justice Kennedy at the Intersection of Life Interests, Medical Practice and Government Regulations Comment' (2008) 27(2) Temple Journal of Science, Technology & Environmental Law p. 291, 309.

672 ibid 311-313. See also the dissenting Justices Ginsburg, Stevens, Souter and Breyer in *Gonzales v. Carhart* (2007) 550 U.S. 124, 171-174.

673 For example, Meisel has stated that informed consent law 'does not automatically decide right-to-die cases. However, courts have generally held that the law of informed consent stands for the proposition and reflects the principle that competent patients have a right of self-determination in medical matters': Meisel, 'The Right to Die: A Case Study in American Lawmaking' (1996) 3(1) European Journal of Health Law p. 49, 60.

highlight a unique understanding of autonomy *in medical decision making*. Within these bounds it seems possible to identify a coherent and relatively rich concept that can serve as a normative standard according to which the law's application to medical AI should be measured.

## II. Function

With the UK background in mind, the function of autonomy in American law can be arrived at *via* a less circuitous route than was pursued there. The American courts' use of terminology with respect to self-determination is broadly similar to that employed in the UK, with it being described as a right,[674] a value,[675] and a principle.[676]

Taking these in order, it is relatively clear that autonomy cannot be seen as an independent right afforded to individual patients. In spite of the occasional rhetorical flourish, it has been correctly stated that within American law 'autonomy has never been recognized as a legally protectable interest'.[677] Broadly this insight can be based on a similar mode of reasoning as was utilised in the previous chapter: autonomy is only vindicated partially and imperfectly through remedies aimed primarily at related interests.[678] For the U.S. this reasoning can be bolstered further by considering the rights-landscape into which autonomy interests had to be integrated, which evinces a strong antipathy towards positive rights.[679]

674 *Canterbury v. Spence* (D.C. Cir. 1972) 464 F.2d 772, 784.

675 *In re Gardner* (Me. 1987) 534 A.2d 947, 950.

676 There are 'well- and long-established legal and philosophical underpinnings of the principle of self-determination': *Thor v. Superior Court* (1993) 5 Cal.4th 725, 738.

677 Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95(2) The Yale Law Journal p. 219, 219.

678 ibid 276. See also the discussion *infra* regarding the ability of the autonomy principle to ground an action directly.

679 ibid 277; see also: Currie, 'Positive and Negative Constitutional Rights' (1986) 53(3) The University of Chicago Law Review p. 864. The latter also places the constitutional jurisprudence in a wider common law context: ibid 866-867, fn. 13. Writing specifically in relation to *Cruzan*, Spindelman has further noted that this case 'did not hold that a competent individual has a common law or constitutional right to obtain any form of medical treatment she wishes. Therefore, in light of the limitations lower courts have placed on the right to informed consent, there is no basis for the position that anyone, including the terminally ill, has a common law right, much less a Fourteenth Amendment liberty interest, to receive medical assistance from a doctor to commit suicide. Any claim to the contrary would constitute a vast

In California specifically, this difficulty is exemplified by the fact that the autonomy interests under the constitutional right to privacy are stated negatively: 'interests in making intimate personal decisions or conducting personal activities without observation, intrusion, or interference'. Furthermore, even these negative interests are restricted, as they protect '*certain intimate and personal decisions* from government interference' and they do not 'create any *unbridled* right of personal freedom of action that may be vindicated in lawsuits against either government agencies or private persons or entities'.[680]

Conversely, it is almost banal to claim that patient autonomy is a value that has influenced the American legal system. The view of the concept as something of value is embodied in numerous legislative and judicial pronouncements that endeavour to translate its moral ideal into concrete norms.[681] Yet, a purely extra-legal, policy-based form of reasoning is hardly a satisfactory explanation for the considerable influence that we have already begun to see the autonomy concept exert upon U.S. law.

This naturally leaves us to consider again whether autonomy could be conceived of as a legal principle. Recall in this regard that, under the theories adopted in the previous chapter, a principle is identifiable by reference to a number of factors, including a (perceived) positive value and a level of generality. On the basis of the case law already examined, both of these criteria appear to be straightforwardly fulfilled. Autonomy has shaped multifaceted areas of the law and evidently is considered an important goal to pursue. What has not been sufficiently established, is the concept's manner of interacting with other norms and with forms of consequentialist

---

departure from the Supreme Court's past jurisprudence that has never held that a competent individual has an affirmative constitutional right to obtain medical treatment': Spindelman, 'Are the Similarities between a Woman's Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling' (1996) 29(3) University of Michigan Journal of Law Reform p. 775, 813-814.

680 *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1, 35-36 (emphasis added).

681 See e.g. *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1184-1185, commenting on the interaction between the moral ideal of patient autonomy and the derived legal standards. See also: California Probate Code section 4650, subdivision (b): 'Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of *protecting individual autonomy*, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person' (emphasis added).

reasoning, as well as the typical functions that these interactions perform within the legal system.

That the interest in autonomy interacts with other principles is well-illustrated by the constitutional jurisprudence that, as the previous section has shown, utilises the common law's understanding of this concept. Here the courts have consistently referred to the need to evaluate patient autonomy by reference to other fundamental interests – above all the 'protection of life'.[682] Autonomy protection is balanced against other deeply held, legally recognisable commitments. Given the close relationship to the constitutional right to privacy, and the analysis demanded there – which considers a particular facet of the interest and entails a deference to state justification[683] – this line of jurisprudence can also be understood to stand for the proposition that the realisation of autonomy must sometimes yield to rule-specific considerations.

To examine a less constrained relationship with conflicting principles, one should further consider the application of autonomy alongside other general norms of the common law. Such an application can be identified, for example, in the way the courts have carved out an emergency exception to the necessity of obtaining patient consent. They have limited the protection afforded to patient autonomy to the extent that there is a sufficiently serious danger to the patient's health and life.[684] By balancing the principles of beneficence and autonomy, they have carved out an exception that is a matter of degree, requiring an assessment of the patient's interest in making their own decision and the gravity of the danger that must be addressed.[685]

682 '[T]his Court's post-Roe decisions accord with Roe's view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims': *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833, 835.

683 *People v. Privitera* (1979) 23 Cal.3d 697, 703-705.

684 *Conte v. Girard Orthopaedic Surgeons Medical Group, Inc.* (2003) 107 Cal.App.4th 1260, 1268.

685 In *Burchell v. Faculty Physicians & Surgeons of Loma Linda University School of Medicine* the gravity of the risk to the patient did not qualify the procedure as an emergency intervention – 'it would be a stretch to characterize a "low risk" associated with taking a more conservative approach, or "speculation" about possible risks, as evidence of an emergency, requiring the surgeon to act despite a lack of express consent Jury was within reason to find that there was no life-or health-threatening situation that justified Barker's decision to perform an operation substantially beyond the scope of Burchell's express consent': *Burchell v. Faculty Physicians & Surgeons of Loma Linda University School of Medicine* (2020) 54 Cal.App.5th 515, 525.

A blanket approach, whereby the autonomy interest of a class of individuals is uniformly judged to be outweighed by a principle of beneficence, can also be found in the common law. Specifically in the rule that minors are not generally able to consent to medical treatment.[686] The purpose of this rule 'was to protect the health and welfare of minors, safeguarding them from the potential overreaching of third parties or the improvidence of their own immature decisionmaking'.[687] Across these precedents one can therefore see that patient autonomy has been weighted alongside other legal principles to reach a concrete determination.

Similarly, the requisite kind of interaction between autonomy and consequentialist reasoning is well-supported by precedent. A seminal Californian case, *Cobbs v. Grant*, exemplified this aspect in considering whether battery or negligence ought to be the legal mechanism by which the common law protects a patient's interest in informed decision making. It was held that:

> Although this is a close question, either prong of which is supportable by authority, the trend appears to be towards categorizing failure to obtain informed consent as negligence. That this result now appears with growing frequency is of more than academic interest; it reflects an appreciation of the several significant consequences of favoring negligence over a battery theory[688]

*Inter alia* these consequences included the availability of punitive damages under a battery cause of action, which may not be covered by a physician's malpractice insurance, and factors implicitly related to the propagation of an unjustified number of claims – including the longer limitation period under the tort of battery and the ease with which the other requirements of the requisite action could be fulfilled.[689]

Moreover, where these consequential concerns have been deemed inapplicable, or to lack the same force, the courts have been prepared to opt for the stronger protection of patient autonomy under battery.[690] Similarly, where the autonomy violation at stake is perceived to be more important, this also supports a stronger form of protection, regardless of the

686 *Bonner v. Moran* (D.C. Cir. 1941) 126 F.2d 121, 122-123.
687 *American Academy of Pediatrics v. Lungren* (1997) 16 Cal.4th 307, 314-315.
688 *Cobbs v. Grant* (1972) 8 Cal.3d 229, 240.
689 ibid 240.
690 *Rains v. Superior Court* (1984) 150 Cal.App.3d 933, 942.

consequential considerations.[691] In sum, the Californian courts exhibit a pattern of reasoning with the autonomy concept that is consistent with its classification as a legal principle. Its influence is dependent on its relative weight *vis-à-vis* countervailing considerations that can be found in principle and/or in consequentialist argumentation.

With this established, one can turn to examine the additional, hallmark roles that principles can play within jurisdictions. Namely, justification of existing norms, instituting norm change, aiding interpretation, generating new norms, creating exceptions to rules and grounding actions directly. Before exemplifying autonomy's ability to function in most of these capacities, it is worth dealing briefly with the last function. For, it has already been considered that autonomy is not conceived of as a right in California and the U.S. Rather, the protection of the concept has been achieved through its insertion into established causes of action and, in Chapter 7, it will be seen how the requirements of such actions limit any ability to claim for autonomy violations *per se*. Let us therefore focus on the remaining roles.

Regarding the function of justifying existing law, *Foy v. Greenblott* illustrates how patient self-determination has been drawn upon to perform just this role. California's Supreme Court considered, among other things, the extent to which a mental health facility was obligated to interfere in the reproductive decisions of an incompetent patient to prevent the birth of a child (in essence a type of wrongful birth claim). This obligation was suggested to entail a supervision of sexual contacts and the prescription of contraceptives, if necessary overriding the patient's wishes.[692] In deciding against the imposition of such a duty, the court referred to a range of statutes and case law, which were held to:

> express a public policy of maximizing patients' individual autonomy, reproductive choice, and rights of informed consent. Within the considerable range of discretion left to them, mental health professionals are expected to opt for the treatments and conditions of confinement least restrictive of patients' personal liberties. The threat of tort liability for insufficient vigilance in policing patients' sexual conduct and in second-guessing their reproductive decisions would effectively reverse these incentives and encourage mental hospitals to accord patients only

691 *Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 105-106.
692 *Foy v. Greenblott* (1983) 141 Cal.App.3d 1, 9-10.

> their minimum legal rights. Consequently, these aspects of respondents' conduct are not actionable.[693]

The *Foy* court thereby rejected a use of the autonomy concept to add to, or alter, existing norms in this instance, leading to an imposition of tort liability. However, it stated clearly that the legitimacy of a range of sources derived from their approximation to this ideal.[694]

Unlike in *Foy*, the dimensions of norm generation and alteration have played a significant role in many other contexts. One of these contexts is the development of the doctrine of valid consent and informed consent that will be discussed in-depth in Chapter 7. As will be examined there, the judiciary has been more than prepared to change existing standards to meet the demands of patient autonomy. Whether this takes the form of an innovation in the breach analysis of negligence – supplementing the reasonable defendant standard with the reasonable patient standard – or the imposition of a legal presumption regarding the medical professional's intention in battery – that substantial deviations from patient consent were intentional.

Accompanying the concept's use in rule creation, there has naturally also been a significant reliance on patient autonomy to interpret these novel norms. In *Truman v. Thomas* the Supreme court determined whether disclosure obligations applied to a situation that was not directly covered by precedent: where a procedure had been refused, rather than consented to. By appealing to patient autonomy – specifically to the fact that the significance of the information to patient decision making was the same in both scenarios[695] – it was held that the leading case (*Cobbs v. Grant*) clearly required the physician to advise the patient also in this situation.[696]

A similar role for the value can be found in statutory interpretation. For example, in *Daum v. Spinecare Medical Group, Inc.* the court paired an analysis of statutory disclosure requirements with the common law's analysis of a 'patient's right of self-decision' in order to determine the standard for the form and content of disclosure regarding the use of an

693 ibid 11-12.
694 Consider also *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1015-1016. Here the general right of a patient to control their medical treatment justified, but also exceeded, statutory provisions dealing with end-of-life treatment.
695 *Truman v. Thomas* (1980) 27 Cal.3d 285, 292-293.
696 ibid 292-293.

investigational device.[697] Such cases are indicative of the prominent role that autonomy has been able to play in the process of norm creation, alteration and interpretation in Californian law.[698]

Lastly, it remains to be shown that the concept is utilised to generate exceptions to rules. *Ballard v. Anderson* demonstrates such usage, but also that it is not always easy to distinguish from autonomy's role as an interpretative aid. The court determined that a minor's consent to a therapeutic abortion fell under a statute allowing for her to consent to 'medical and surgical care related to her pregnancy'.[699] This rule already had a restricted application, concerning 'a minor of any age, only if she is pregnant and unmarried and only for medical, hospital and surgical care related to her pregnancy'.[700] Yet, after asserting that a therapeutic abortion fell within the requirements of this rule, the court also found 'an additional limitation implicit in each of the medical emancipation statutes: the minor must be of sufficient maturity to give an informed consent to any treatment procedure'.[701] The Californian Supreme Court rested this insight on general considerations stemming from the informed consent doctrine and especially highlighted the minor's possession of a requisite understanding, which will be seen to constitute an important substantive element of California's autonomy principle. Ultimately, it can be noted that, once *Ballard* had interpreted a statutory provision to cover a certain situation, it then created an exception to this application by reference to characteristics that stemmed not from the rule itself, but rather from a concern for patient autonomy.

In summation, it is argued that the operationalisation of the autonomy concept in the U.S. and California fits well with a conceptualisation of it as a legal principle. It is neither just an abstract non-legal value, nor a concrete, assertable right. It is a general norm to which the law attributes importance, it has a certain mode of interacting with other norms and consequentialist forms of reasoning and it has a set of typical roles that the Californian common law has attributed to it.

---

697 *Daum v. SpineCare Medical Group, Inc.* (1997) 52 Cal.App.4th 1285, 1303-1305.

698 See also: *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1139-1140. Holding that the right to control medical care, specifically to refuse life-sustaining treatment, was wider than the one granted by statute – which was limited to a certain group of persons.

699 *Ballard v. Anderson* (1971) 4 Cal.3d 873, 882-883.

700 ibid 882-883.

701 ibid 883.

### III. Substantive content

We now turn to the meaning that, specifically California, has imbued patient autonomy with. Given the emphasis in the previous section on the legally determined function of the concept, it is important to give credence to its legal nature and to the role that the law has in the provision of a definition. Without more, one cannot simply take over the bioethical theory espoused in Chapter 3. Faced with the same challenge, we will turn to the same theory as was relied upon in the British analysis. This called for a distinction between autonomy's jural and its normative meaning.[702] That such a distinction is apposite emerges from the above analysis. It touched upon a number of jural reference points for autonomy and its analogues, but it did not indicate that these derive from an alignment with a particular philosophical position.[703]

As a consequence, our task is not to prove that the law has included any high-level, abstract theory within its precepts. Rather, it is to identify support in the legal material for the argument that the identified bioethical theory provides one viable, useful means of conceptualising its approach to patient autonomy. Again, it bears emphasising that this conceptualisation need not be uncontested, but it should be sufficiently strongly entrenched to play the requisite guiding role. Moreover, this also implies that the normative meaning of autonomy should provide sufficiently concrete indicators for the courts. Pugh's conceptualisation broadly fulfils these requirements. It lays down standards that find considerable support in the law and are concrete enough to provide guidance, while also leaving space for jural considerations to influence their specification.

The standards to be assessed in this way are: (1) a cognitive element, identifying autonomy by reference to a patient's engagement with rationality and reasons in their decision making (2) a reflective element, giving pride of place to the individual's own values, especially their long-established, defensible commitments (3) a practical element, referencing the positive and negative dimensions of freedom that shape an individual's ability to act – including a recognition that the patient's autonomy must be facilitated and that a certain kind of disconnect with the true state of

702 Balganesh and Parchomovsky, 'Structure and Value in the Common Law' (2015) 163(5) University of Pennsylvania Law Review p. 1241.

703 In California specifically, the reliance on such positions is extremely limited and haphazard. This is exemplified in *Thor v. Superior Court* (1993) 5 Cal.4th 725, 734-735; *People v. Privitera* (1979) 23 Cal.3d 697, 729, fn. 8.

affairs (a failure to hold decisionally necessary beliefs) is a particularly grave violation of autonomy.

## A. Rationality

The first standard of Pugh's theory identifies autonomous decision making with deliberation that follows the norms of theoretical rationality, at least to a minimal extent. This is arguably the most controversial aspect of his theory when considered from the perspective of Californian judicial pronouncements on medical decision making. As in the UK, the courts have rejected an explicit rationality requirement in their recognition of a patient's capacity to make autonomous decisions.

In this vein, Justice Arabian stated in *Thor v. Superior Court* that, since 'health care decisions intrinsically concern one's subjective sense of well-being, this right of personal autonomy does not turn on the wisdom, i.e., medical rationality, of the individual's choice'.[704] And, later in the same case, the Californian Supreme Court rejected a judicial intervention to assess a prisoner's capacity to make a rational choice because this 'tends to denigrate the principle of personal autonomy, substituting a species of legal paternalism for the medical paternalism the concept of informed consent seeks to eschew. "Rationality" is for the patient to determine'.[705]

Writing extra-judicially, Justice Arabian expanded upon this holding, explaining that requiring a rational decision-making ability of the patient, in addition to comprehension, would constitute a drastic and severe invasion into their personal autonomy.[706] Such statements are a paradigmatic example of the anti-paternalistic opposition to an association between autonomy and rationality.[707] Once this association is made, it is believed that it will give licence to a denial of decisional autonomy, effectively allowing professionals to overrule it.

However, the Californian manifestation of this concern relies on factors that appear to be, more properly, subsumable under the reflective component of decisional autonomy. The ability of an individual to pursue a

704 *Thor v. Superior Court* (1993) 5 Cal.4th 725, 736-737.
705 ibid 747-748.
706 Arabian, 'Informed Consent: From the Ambivalence of Arato to the Thunder of Thor' (1994) 10(3) Issues in Law & Medicine p. 261, 287.
707 Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (2020) 183.

subjective sense of well-being is not precluded by a relation of autonomous decisions to minimal standards of theoretical rationality – including the ability of inductive reasoning or a reliance on evidence in the formation of one's beliefs. This is the extent of Pugh's particular conception of rationality. *Pace* the above statement, such matters are not for the patient to determine and Justice Arabian recognised this. In the aforementioned peace of extra-judicial writing, he went on to state 'if the illness of a severely disturbed patient precludes his making a rational decision regarding treatment using only the information a reasonable person would require, then this level of information will not be sufficient to effectuate individual autonomy'.[708] An ability to use and reason with information, in a manner that allows one to direct one's decisions accordingly, is an element of autonomy.

Consequently, while the courts clearly reject a thick conception of rationality, which would allow professionals to disregard personal commitments and idiosyncrasies (a matter we must return to in a moment in our consideration of the reflective component), this does not entail a commitment to the view that there is no theoretical component to decisional autonomy. Other statements indicate that just such a commitment has shaped the courts' standard understanding of medical decision making. For instance, in *Moore v. Regents University of California* the Supreme Court mused that:

> medical treatment decisions are made on the basis of proportionality—weighing the benefits to the patient against the risks to the patient. As another court has said, "the determination as to whether the burdens of treatment are worth enduring for any individual patient depends upon the facts unique in each case," and "the patient's interests and desires are the key ingredients of the decision-making process."[709]

Framed in these terms, there is no opposition between the patient's subjective assessment of their interest and an insistence on a (fairly minimal) rational process of decision making. The former is to be realised through the latter.

In other instances the courts have not been content to require only a modest degree of theoretical rationality in reasoning, but have made determinations that approximate to the more demanding rationality re-

708 Arabian, 'Informed Consent: From the Ambivalence of Arato to the Thunder of Thor' (1994) 10(3) Issues in Law & Medicine p. 261, 287.

709 *Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 130; citing: *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1018-1019.

quirement rejected in *Thor*. For example, in the already discussed case of *Ballard v. Anderson* the court created the requirement that a minor must possess a degree of understanding and maturity to be deemed capable of making the requisite autonomous decision.[710] More starkly still, in *Stewart v. Superior Court* the Court of Appeal found it necessary to clarify that the decision maker there was 'not an uneducated patient objecting to a procedure without explanation'.[711] Rather, they were a registered nurse who was able to point to alternative explanations for a diagnosis (engaging in inductive reasoning) and wished to receive a second opinion (seeking out further evidence on which to base a decision).[712]

In short, the aspects of decision making to which *Stewart* afforded particular respect have a strong affinity to the theoretical rationality standard. It thereby provides further support for the argument of this section. Yet, the court also did more than this. By referring to the patient's education and the professionally informed explanation provided for the decision, it intimated that a patient's choice would be granted more deference if it is of a certain intellectual calibre and/or aligns with an accepted body of opinion. To see why this particular pronouncement goes too far, and does not provide a basis for generalisation,[713] it is now important to assess the reflective dimension of autonomy.

## B. Individual reflection

The previous section showcased that one overriding concern in judicial appeals to self-determination was the ability of an individual to strike their own path – to determine what is valuable and direct their decisions accordingly. Under our theoretical approach this intuition was expanded upon. While an acceptance of certain basic values and desires was deemed necessary for any meaningful exercise of autonomy, it was essential to respect an

710 *Ballard v. Anderson* (1971) 4 Cal.3d 873, 883.

711 *Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 105-106. Similarly *Bouvia v. Superior Court* referenced the fact that the patient 'is intelligent, very mentally competent' and that they 'earned a college degree': *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1136.

712 *Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 105-106.

713 See in this regard both: *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1015 and *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 194. These cases implicitly reject the proposition that the right to make an autonomous medical decision is limited to a class of educated individuals.

individual's prerogative to weigh even these facets. It was further possible to identify a subset of an individual's commitments that were regarded as particularly intertwined with their personality and therefore central to their autonomy. Namely, acceptances and preferences that were long-lasting, cohered with the patient's wider character system and were resilient to challenge. Ascertaining the law's respect for the individual weighting of, even fundamental, interests and ascertaining whether it accords especial significance to the individual's acceptances or preferences on the basis of these factors will indicate that the law values autonomy *inter alia* for the kinds of reasons adduced under our concept.

In the first respect, Californian case law has repeatedly and emphatically asserted that it is for the individual alone to determine the proper balancing of their interests:

> The weighing of [disclosed] risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone. A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent.[714]

Moreover, deference has been accorded to the patient's evaluation even – or rather especially – where fundamental interests were recognised to be at stake. In judging on medical decisions that may cause the patient's death, California's Supreme Court held: 'Especially when the prognosis for full recovery from serious illness or incapacitation is dim, the relative balance of benefit and burden must lie within the patient's exclusive estimation: "That personal weighing of values is the essence of self-determination."'[715] Framed as an aspect of the reflective dimension – rather than a factor opposing a rationalist, procedural understanding of autonomy – this insight into the significance of individual evaluation can be readily subsumed under our theoretical conception.

*Barber v. Superior Court* provides a further elaboration of the courts' consideration of reflective autonomy. As in *Cobbs* and *Thor*, the court accepted that the patient has a paramount role in balancing the values and disvalues of a clinical decision for themselves. Yet, also in line with our

714 *Cobbs v. Grant* (1972) 8 Cal.3d 229, 243-244.

715 *Thor v. Superior Court* (1993) 5 Cal.4th 725, 739; citing *In re Gardner* (Me. 1987) 534 A.2d 947, 955.

theoretical analysis, the court referenced the necessity of adducing certain basic values, before leaving it to the patient to factor these into their own desires and beliefs:

> the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely, how long the treatment is likely to extend life and under what conditions. "[S]o long as a mere biological existence is *not considered the only value*, patients may want to take the nature of that additional life into account as well." (…)
> Of course the patient's interests and desires are the key ingredients of the decision making process.[716]

In this manner the courts have accepted that, even if there are fundamental values that must bear on relevant autonomous decisions, the attribution of importance to these is for the individual, not for the professional and not for the court.[717] Furthermore, it is the prerogative of the patient to define their own interests.

The next question that arises is whether the legal material also supports the view that, among this class of individual interests, it is especially a patient's deeper commitments – which are long-held, cohere with their character and which would be defended or defensible if challenged – that receive protection in the law. Such an approach is not without controversy. Judicial pronouncements, such as those above, are often framed in terms of an unconditional respect for a patient's assessment of their interest. Nevertheless, as has been discussed, the courts' treatment of the concept has not always been consistent and, even a strict adherence to this position, would not preclude a differentiation in terms of the seriousness of an intervention.

California's common law has had the opportunity to refer to the outlined kinds of factors under the negligence cause of action, the relevant aspects of which will be discussed in-depth in Chapter 7. For present purposes it is necessary to anticipate one forceful, rule-specific limitation that has been imposed on the law's ability to protect the reflective dimension of

716 *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1019 (emphasis added), citing: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 'Deciding to Forego Life-Sustaining Treatment: A report on the Ethical, Medical and Legal Issues in Treatment Decisions' (Washington, DC 1983) 32-39.

717 See also: *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 193; *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1140.

autonomy under this tort. Namely, by relying heavily on the figure of the reasonable patient in the causation stage of the analysis, the cases render it irrelevant what information the individual would have responded to on the basis of their own balancing of interests and their wider commitments.[718] All that is asked is: what information would a reasonable person in the patient's position have acted upon to avoid a relevant form of harm?

Crucially, there appears to be a subset of cases that are prepared to overcome these rule-specific limitations and to offer protection, if not to the finer aspects of the patient's weighting of their own interests, then at least to their deeply held commitments. In *Hernandez ex rel. Telles-Hernandez v. U.S.* a district court applying Californian law determined the issue of causation – here concerning whether the plaintiff would have opted for a caesarean section over a vaginal birth – by reference to the plaintiff's 'emphasis on prenatal care and her desire to deliver her baby without the use of medication'.[719] The individual mother's commitment to the health of her baby (above all other factors) was clearly an established one, as evidenced by her recourse to prenatal care, and a robust objective, as demonstrated by her decision not to take medication and endure substantial hardship in order to secure it.

A consideration of individual circumstances in the causation analysis, and a connection of this to the reflective element of autonomy was also on display in *Wilson v. Merritt*. Here the plaintiff was wheelchair-bound and suffered from adhesive capsulitis in his shoulder.[720] He was pursuing physical therapy options with some success before being recommended a manipulation under anaesthesia.[721] He claimed that his physician had not adequately informed him of the risks of this latter procedure, which in fact resulted in a torn rotator cuff and a fractured shoulder, and had he been so informed he would not have undergone the procedure and would not have suffered the damage.[722] The Court of Appeal, overturning the trial court's determination that the evidence was insufficient for the plaintiff to succeed on the causation element of their claim, held:

718 A somewhat comparable reliance is also placed on a patient's reasonableness in the breach stage, although for reasons to be explored in Chapter 7 there appears to be a greater degree of leeway for autonomy-based reasoning under this element.

719 *Hernandez ex rel. Telles-Hernandez v. U.S.* (N.D. Cal. 2009) 665 F.Supp.2d 1064, 1078-1079.

720 *Wilson v. Merritt* (2006) 142 Cal.App.4th 1125, 1129.

721 ibid 1138-1139.

722 ibid 1138.

> A jury reasonably could determine that an adult paraplegic who was suffering some problems with stiffness and flexibility, but was functional in his then current condition, who was seeing some improvement in his condition through physical therapy, who had suffered devastating damage from surgery in the past, and who was so concerned about the potential risks associated with the recommended procedure that he took his mother with him to question the medical doctor on the topic, would indeed turn down the opportunity for the procedure if informed that it could result in a loss of his remaining mobility due to a torn rotator cuff or a fractured bone.

This summation of the *Wilson* court's causation analysis showcases the remarkable extent to which it was prepared to rely on factors personal to the plaintiff and which, arguably, derived their normative significance from autonomy's reflective dimension. The patient's decision did not merely involve a balancing of interests. A subjective preference against a clinical intervention that could impair mobility was taken to be firmly anchored in the plaintiff's system of beliefs and desires, not least because of his history and the limited mobility he already possessed in light of a past surgical intervention. The robustness of this commitment was further evidenced by his questioning of the doctor and the wish to have another party present during the process.

Both *Hernandez* and *Wilson* highlight that individual motivations that are associated with an exercise of reflective autonomy have been treated as particularly significant and have been able to have a distinct impact on the reasoning of courts.[723]

It is further notable that in cases dealing with the right to die under constitutional privacy protections, Californian courts have felt it necessary to point to long-standing commitments of the patient. In this vein, *Barber v. Superior Court* asserted that a surrogate decision maker for an incapacitated person, should first consider their past wishes (if they were expressed).[724] This at least implies an acceptance of the continuity and coherence of character that underlies the coherentist interpretation of reflective autonomy.

723 See also the analysis in *Morgenroth v. Pacific Medical Center, Inc.* (1976) 54 Cal.App.3d 521, 534-535. The patient's fundamental interests in an active lifestyle were discussed as important factors, but were taken to support the disputed diagnostic intervention. It therefore did not allow for autonomy considerations to play an independent role.

724 *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1021.

More directly in point, in *Bouvia v. Superior Court* and *Bartling v. Superior Court* the judges identified a protracted pattern of behaviour, where the patient expressed the relevant preference – to die, rather than to go on living in their condition. This was used as a justification for their right to refuse medical treatment.[725] Such a pattern did not have to be unbroken,[726] but in both cases it was framed as a long-standing, robust commitment that was entirely consistent with the patient's wider beliefs (e.g. regarding the non-improvement or deterioration of their condition and the consequences of continued existence) and their desires.[727] So, in these instances too, the courts have indicated that the reflective dimension of autonomy influences the weight that the law will attribute to reasoning with the autonomy principle. This supports the conclusion that Californian common law operates with a conception of autonomy that includes this dimension.

### C. Positive and negative freedom

That the law includes ideas of positive and negative freedom (elements of the practical dimension of autonomy) is arguably the least contentious aspect to prove. The citation from *Union Pacific Railway Co. v. Botsford*, adduced under the first section of this chapter, bears testament to the esteem in which negative liberty is held under the common law: 'No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others'.[728] This sentiment has been reiterated in many settings, including the informed consent one.[729]

725 Respectively: *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1135-1136; *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 190-193.

726 '[T]he doctors and Glendale Adventist questioned Mr. Bartling's ability to make a meaningful decision because of his vacillation (…) The fact that Mr. Bartling periodically wavered from this posture because of severe depression or for any other reason does not justify the conclusion of Glendale Adventist and his treating physicians that his capacity to make such a decision was impaired to the point of legal incompetency': *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 192-193.

727 *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1143-1144; *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 191.

728 *Union Pac. R. Co. v. Botsford* (1891) 141 U.S. 250, 251-253.

729 'The purpose underlying the doctrine of informed consent is defeated somewhat if, after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and precluded

Moreover, when it comes to the positive freedom, it is particularly the informed consent context that has provided a framework for a legal understanding of this dimension to be developed and (partially) realised. With commendable clarity it was stated in *Cobbs v. Grant* 'the patient's consent to treatment, to be effective, must be an informed consent. And (…) the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process'.[730] Similarly it was stated in *Thor v. Superior Court* that 'Doctors have the responsibility to advise patients fully of those matters relevant and necessary to making a voluntary and intelligent choice'.[731] Under the Californian conception of autonomy it is thus beyond doubt that a patient's process of practical reasoning must be facilitated.

One may also point to more nuanced elaborations of this standard, whereby the necessity of assisting the patient in their decision-making process is emphasised and it is their need that serves as the relevant gauge. For instance, in *Daum v. SpineCare Medical Group, Inc.* it was stated that 'the medical profession must conform its methods of disclosure to the needs and understanding of patients'.[732] Likewise, certain conditions on the categories of information to be disclosed have been developed to maintain an effective facilitation of medical decision making.[733] The courts are mindful that the positive dimension of practical autonomy would be threatened not only by a deficit of information, but also by a flood of data that overwhelms the decision-making process. The appropriate, selected yardstick is the patient's ability to direct their actions effectively.

The final element of our theoretical approach that was found relevant to our analysis of AI, and which must be identified in U.S. law, is the recognition that the holding of certain true beliefs is a prerequisite for autonomous action in medicine. Without assisting the patient to acquire these beliefs, it is not possible for them to exercise their autonomy.

Although the common law does not explicitly address the necessity of holding such beliefs, their existence is acknowledged implicitly in its tiered

---

from foregoing all treatment whatsoever. We hold that the doctrine of informed consent—a doctrine borne of the common-law right to be free from nonconsensual physical invasions—permits an individual to refuse medical treatment': *Rasmussen by Mitchell v. Fleming* (1987) 154 Ariz. 207, 216.

730 *Cobbs v. Grant* (1972) 8 Cal.3d 229, 242.

731 *Thor v. Superior Court* (1993) 5 Cal.4th 725, 742-743.

732 *Daum v. SpineCare Medical Group, Inc.* (1997) 52 Cal.App.4th 1285, 1304-1305.

733 *Arato v. Avedon* (1993) 5 Cal.4th 1172, 1185-1186.

approach to information disclosure. Specifically, as will be seen in Chapter 7, the common law has asserted that a strong battery cause of action is appropriate where the patient has not given any consent at all. This situation exists *inter alia* where the patient lacks critical information about the procedure, such that the one which is in fact performed is 'substantially different'.[734] Here a necessary true belief was absent, the interference with the positive freedom of the patient was particularly grave and the legal response must be equally forceful. Lesser failures of facilitation are, by contrast, addressed under the aforementioned categories of negligence and are considered aspects of reasonable, rather than necessary, disclosure.

In sum, there are substantial grounds for concluding that our conception of procedural autonomy is present in California's common law and, to a significant extent, shapes the courts' reasoning with patient autonomy. This provides the basis for its application in our consideration of specific legal mechanisms.

### *IV. Limitations*

Alongside the force of the autonomy principle, whose form and content has been considered above, a legal analysis must also respect the normative and structural factors that provide countervailing impulses and limit a principle's relevance. It is self-evident that in a legal system one cannot argue in a vacuum.

This raises the issue of the strength of relevant restrictions. One may recall, for instance, the observation in the previous chapter that courts exhibit a particular reticence in the private law sphere to amend settled norms by reference to more abstract considerations, especially social and political objectives or values.[735] As we have not conceived of autonomy as a mere political, extra-legal value, this reticence should be somewhat less of a hindrance.

Nevertheless, it is worth recapitulating that many factors have a recognised potential to limit the realisation of the autonomy principle. These included: other principles, which in the medical context notoriously encapsulates maleficence, beneficence and justice,[736] specific rules and the

734 *Cobbs v. Grant* (1972) 8 Cal.3d 229, 239.
735 Robertson in Robertson and Tang, *The Goals of Private Law* (2009) 266.
736 Beauchamp and Childress, *Principles of Biomedical Ethics* (Fifth Edition 2001).

restrictions stemming from their underlying doctrine, and consequentialist reasoning. These all have the ability to impose severe restrictions on any argumentation with the autonomy principle.

In the final analysis, the issue remains that much is dependent on the relative weight or importance of considerations – including an assessment of the precise nature of the autonomy violations at issue – that have been particularised for a specific situation. The nature of the relationship between the autonomy principle and its limitations will therefore become fully apparent only in our detailed analysis in Chapter 7. Simultaneously, it should already be anticipated that the American courts, in spite of their use of powerful rhetoric and their ability to inspire significant developments, have arguably maintained a relatively stringent approach that is prepared to circumscribe autonomy's influence by reference to rule-specific factors.

## *V. Conclusion*

As indicated in the introduction of this thesis, the more fragmented nature of U.S. common law presents distinct challenges. These have emerged in the delineation of the autonomy concept. To provide a firm basis for argumentation it was not possible to restrict this analysis to just Californian common law. In particular, an examination of federal law and the law of other states provided insights into how the conception of autonomy was operationalised within legal reasoning, and within what scope.

Regarding the question of content, it was possible to focus on the Californian legal system. This presented the most relevant specification of a contestable concept for our subsequent, targeted analysis. Under this head we determined that, while there were some uncertainties and inconsistencies, substantial support could be found for the elements of procedural autonomy that were outlined in Part I. Moreover, here too the limitations on the deployment of this principle had to be taken seriously. As we will come to see in the next part, U.S. law clearly recognises the force of doctrinal and rule-specific restrictions on principled, autonomy-based argumentation.