# How Should Autonomy be Defined in Medical Negligence Cases?

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##

## Introduction

In modern law medical paternalism no longer rules.[[1]](#footnote-1) Respect for patient autonomy is now a fundamental principle of both medical law and bioethics.[[2]](#footnote-2) Guidance issued to healthcare professionals emphasises the importance of respecting this value.[[3]](#footnote-3) As a result of these developments there have been suggestions that the law of clinical negligence should be developed so as to recognise diminished autonomy as a form of actionable damage in this area of tort law.[[4]](#footnote-4) But in order for the tort of negligence to recognise this new interest, it is first necessary to determine how autonomy should be understood in this context. The purpose of this article is to shed light on this issue and arrive at a suitable definition of the concept.

Before proceeding, however, it is important to emphasise that there is scope for disagreement regarding whether autonomy ought to be given the prominence that it currently enjoys in the medico-legal literature. For example, there has been some criticism that that the focus on protecting autonomy has resulted in other ethical principles being overlooked.[[5]](#footnote-5) However, the correctness of this view and whether lost autonomy *should* be recognised as a form of damage in medical negligence claims is outside the scope of this article and, indeed, is the subject of a forthcoming paper by the author.

This article will begin by providing some background as to how lost autonomy has come to be seen as a potential new form of damage in negligence. The second part of this article will then outline the main conceptions of autonomy in moral philosophy. The proceeding sections will then discuss which version of autonomy is the most philosophically and legally coherent. The final conclusion will be that if English law is to recognise autonomy as an interest protected by the tort of negligence, it is the liberal conception (or ‘current desire’ version) that provides the most appropriate definition.

## Autonomy as a Form of Damage in English Clinical Negligence Cases

Before discovering which definition of autonomy is preferable to adopt in claims for medical negligence, it is necessary to provide some background as to why it has been suggested that medical negligence adopt such a course. Traditionally, the tort of negligence has not perceived autonomy per se as a form of damage that should be compensated. Instead, it has protected autonomy indirectly by safeguarding interests in, among others things, bodily integrity and property.[[6]](#footnote-6) Despite this, in two important cases the damages awarded (and thus the damage suffered) cannot be reconciled with traditional principles and so it could be argued that the better interpretation of these decisions is that they compensate the respective claimants for their diminished autonomy.

In *Rees v Darlington Memorial NHS Trust*,[[7]](#footnote-7) the claimant, Ms Rees, was severely visually disabled. She feared that her poor sight would prevent her from being able to care for a child and so underwent a sterilisation, which was negligently performed by the defendant hospital. As a result she gave birth to a healthy son.

Her claim for the costs associated with raising the child and, if this should be refused, the extra costs she would incur from raising a healthy child attributable to her disability was unsuccessful in the House of Lords. The majority decided to follow an earlier decision, which held that the costs of raising a healthy child were irrecoverable.[[8]](#footnote-8) Yet they held that since the claimant was a victim of a legal wrong which had denied her the opportunity to live in the way she had planned, she should receive a ‘conventional award’ of £15,000. Lord Bingham justified this on the basis that the mother had ‘been denied, through the negligence of another, the opportunity to live her life in the way that she wished and planned.’[[9]](#footnote-9) This has been interpreted by some commentators as an attempt to compensate the Ms Rees for her lost autonomy. Nolan, for example, has stated that the case ‘amounts to recognition of diminished autonomy as a form of actionable damage.’[[10]](#footnote-10)

The second case is *Chester v Afshar*.[[11]](#footnote-11) The claimant, Miss Chester, suffered from back pain so visited the defendant consultant, Mr Afshar, who recommended surgery. In breach of his duty of care he failed to warn her about a small risk (1-2 per cent) of cauda equina syndrome (paralysis) inherent in the operation. This risk would be present no matter how expertly the operation was performed and liable to occur at random. Based on this (lack of) advice, Miss Chester underwent the procedure and, although the surgery itself was not carelessly performed, she suffered from the syndrome.

Miss Chester admitted that she could not say that she would never have undergone the operation even if she had been warned of the risks (if this had been the case she would have easily been able to show that Mr Afshar’s carelessness in failing to warn her of the risks had caused her injury). Instead, she said that she would not have had the procedure at the time that she did but would have instead wanted to discuss the matter with others and explore alternatives. She conceded that she may have chosen to have the surgery on a different day in the future. As a result of this concession, it was arguable that she could not show that Mr Afshar’s carelessness in failing to warn her of the risks had actually caused the syndrome because it might have occurred anyway: Mr Afshar’s carelessness had not increased her risks of suffering from cauda equina syndrome.

The majority of the House of Lords, however, found in Miss Chester’s favour. They held that even though the claimant could not establish that the defendant had *caused* her back pain under traditional rules, a departure from conventional causation principles was justified because her right to make her own decision about her treatment had been interfered with. Lord Steyn laid emphasis on Miss Chester’s ‘right of autonomy and dignity,’[[12]](#footnote-12) saying it ‘can and ought to be vindicated by a narrow and modest departure from traditional causation principles.’[[13]](#footnote-13) This indicates that, as Devaney has noted, ‘the primary concern of the majority…was to ensure that patient autonomy is respected’[[14]](#footnote-14) and several academics have perceived the *real* damage (as opposed to that pleaded) in this case to be the interference with Miss Chester’s autonomy.[[15]](#footnote-15) Green, for examples, describes it as a ‘loss of autonomy case.’[[16]](#footnote-16)

Given that these cases are hard to reconcile with conventional negligence rules that a claimant must establish that the defendant owed them a duty of care and the breach of that duty caused them actionable damage,[[17]](#footnote-17) it is arguable that a more principled understanding of these decisions is to perceive them as compensating the claimants for their lost autonomy. As a result, there have been a number of suggestions that lost autonomy per se is now, or should be, recognised as a form of damage in negligence.[[18]](#footnote-18) Chico states that these decisions ‘demonstrate substantial congruity’[[19]](#footnote-19) as in both cases the House of Lords ‘was motivated to provide a remedy for the victim of medical negligence on the basis that there had been an interference with the patient’s autonomy.’[[20]](#footnote-20) Although the above judgments are infused with recognition of the importance of autonomy, there is very little discussion of what is meant by the concept in the cases themselves. How, then, should autonomy be defined in medical negligence claims? The answer to this question will be the focus of the rest of this article.

## What is Autonomy?

 ‘Autonomy’ literally means self-determination[[21]](#footnote-21) and a person will be autonomous if they can choose and act on their own decisions.[[22]](#footnote-22) Beyond this, there are divergences in opinion about what being autonomous might entail. Coggon has provided a useful taxonomy of the three main different conceptions of autonomy utilised in legal discussions. He describes these theories as: ideal desire autonomy; current desire autonomy; and best desire autonomy.[[23]](#footnote-23) Each of these might demand different courses of action and so an understanding of this philosophical concept is required in order to fully determine how it will be recognised by the tort of negligence.

### *Ideal Desire Autonomy*

Ideal desire autonomy is influenced by the work of Immanuel Kant.[[24]](#footnote-24) It reflects what a person *should* want and, according to Coggon, this is measured ‘by reference to some purportedly universal or objective standard of values.’[[25]](#footnote-25) He states that this theory:

…requires agents to consider their reason for acting, and only to pursue a course of action if it could be made a universal law. That is, if it could be a successful maxim for all agents to follow. Therefore, if a person chooses to act in a way that is incompatible with a universalisable theory, that person is not acting autonomously.[[26]](#footnote-26)

According to this definition, certain conduct may never be capable of being autonomous if it does not comply with Kantian values (i.e. if one cannot rationally will one’s actions to be a binding universal law that everyone should follow) or is otherwise objectively morally bad. For example, Kant maintained that his ethical system prohibited lying (even to save someone’s life) and suicide.[[27]](#footnote-27) If he was correct about this then lying or committing suicide cannot be autonomous acts. This would be so even if someone wanted to do these things. This notion of autonomy is therefore not based on an individual’s actual preferences but on what they (supposedly) *should* want.

### *Current Desire Autonomy*

Current desire autonomy, on the other hand, reflects an individual’s ‘immediate inclinations.’[[28]](#footnote-28) It does not require a high level of reflection and need not be consistent with the person’s values or ultimate goals.[[29]](#footnote-29) This conception of autonomy is influenced by the work of John Stuart Mill, who stated: ‘The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.’[[30]](#footnote-30) Mill did not require people’s self-regarding actions to be consistent with any set of rules or long-term goals. Instead, people can do as they please – in other words, fulfil their current desires – provided they do not cause harm to others.

This account of autonomy has been advocated by Jonathan Glover, who stated ‘I override your autonomy only where I take a decision on your behalf which goes against what you actually do want, not where the decision goes against what you would want if you were more knowledgeable or more intelligent.’[[31]](#footnote-31) A person’s actions will be autonomous if, provided the person is competent to make the decision and it is free and informed, such choices reflect their desires.[[32]](#footnote-32)

### *Best Desire Autonomy*

In contrast, best desire autonomy states that a decision will be autonomous if it reflects a person’s overall desires given their values, even if it runs contrary to their immediate desire.[[33]](#footnote-33) This theory of autonomy has been proposed by Harry Frankfurt[[34]](#footnote-34) and Gerald Dworkin.[[35]](#footnote-35) The latter stated: ‘Autonomy cannot be located on the level of first-order considerations, but in the second-order judgments we make concerning first-order considerations.’[[36]](#footnote-36) An action will only be autonomous if a person’s first-order desires (their immediate wants) are endorsed by their second-order desires (their long-term goals or values).[[37]](#footnote-37) An example of respecting this type of autonomy would be preventing someone from eating cake if their long-term goal is to lose weight because their desire to eat cake only reflects their current desire rather than their ‘best’ desire.

### *Relational Autonomy*

Before contemplating which of these definitions of autonomy is most cogent, it is worth pausing to consider another version of autonomy that is known as relational autonomy.[[38]](#footnote-38) This theory is critical of the above accounts as they fail to ‘recognise the inherently social nature of human beings.’[[39]](#footnote-39) It maintains that there is a need to think of autonomy as a ‘characteristic of agents who are emotional, embodied, desiring, creative, and feeling, as well as rational creatures’[[40]](#footnote-40) and recognise that agents are ‘psychically and internally differentiated and socially differentiated from others.’[[41]](#footnote-41)

Relational autonomy was developed by feminist theorists and communitarians who believe that other definitions ‘would wrongly attribute autonomy to those whose restricted socialisation and oppressive life conditions pressure them into internalising oppressive values and norms.’[[42]](#footnote-42) Feminist critiques maintain that given that traditional accounts of autonomy do not recognise the ‘value of relations of dependency’[[43]](#footnote-43) they are seen as ‘masculinist conceptions.’[[44]](#footnote-44) Those who accept a relational account of autonomy would not perceive, for example, that a woman who had an internalised belief that her role was to be subservient to her husband was autonomous even if that is what she wished to do.

However, this paper will not be considering this version of autonomy separately from the accounts discussed above. This is because most nuanced accounts of autonomy do not deny that people are, for example, emotional, creative and reliant on other people. It is a simple statement of the obvious that they are. As Raz states: ‘Autonomy is possible only within a framework of constraints. The completely autonomous person is an impossibility The ideal of the perfect existentialist with no fixed biological and social nature who creates himself as he goes along is an incoherent dream.’[[45]](#footnote-45) As a result, the concerns of communitarians and feminists can be accommodated within Coggon’s tripartite classification. As an example, the feminist belief that a woman who has an internalised belief that her role was to be subservient to her husband is not autonomous could be reconciled with ideal desire autonomy by maintaining that women *should* desire to be treated as equals with men and not accept passive roles.

It is therefore difficult to disagree with Fineman’s conclusion that ‘Although we all operate within societal and cultural constraints, we can determine directions and decide to take one path rather than another.’[[46]](#footnote-46) Given this, and despite the fact that relational critiques of autonomy provide a valuable examination of the influence of social constraints on individuals, it will not be considered as a separate account in the following discussion.

## Which Conception of Autonomy is Preferable in the Medical Negligence Context?

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### *Philosophical Coherence*

The three conceptions of autonomy mentioned above will often have the same outcome.[[47]](#footnote-47) If a person was suffering from a disease and currently had a desire to be cured, it is consistent with their values to be cured, and there is an objective rule that it is good for them to be cured then their decision to be cured will be autonomous under all three theories.

However, the theories can conflict. Objective values, second-order desires, and current preferences do not necessarily coincide. An individual might desire to commit suicide at the moment but this may conflict with their long-term goals or with a set of Kantian rules. Which version of autonomy, then, should be favoured for the purposes of recognising an interest in autonomy in medical negligence claims? The rest of this section will explain why the current desire view of autonomy is the preferable definition to adopt

First, best desire and ideal desire autonomy contain a number of logical defects. With regards to best desire autonomy, it could be argued that if a person’s first-order desires need to be endorsed in order to be autonomous then the same conditions should apply to a person’s second order desires. This could lead to an infinite regress of endorsements, making it implausible that endorsement should be a prerequisite in order for a choice to be an autonomous one. After all, why not require that one’s second-order desires are endorsed by one’s third-order desires and so on?[[48]](#footnote-48) As Watson has argued, ‘Since second-order volitions are themselves simply desires, to add them to the context of conflict is just to increase the number of contenders; it is not to give a special place to any of those in contention.’[[49]](#footnote-49)

Additionally, it is unclear why second-order desires are any more authentic than first-order ones. As Thalberg has stated, best desire autonomy:

…assume[s] that when you ascend to the second level, you discover the real person and what she or he really wants…why grant that a second-order attitude must always be more genuinely his, more representative of what he genuinely wants, than those you run into at ground level? Perhaps his higher attitude is only a cowardly second thought which gnaws at him.[[50]](#footnote-50)

Similarly, there are problems with the theoretical basis of ideal desire autonomy. Being based on the work of Immanuel Kant, it suffers from the problems associated with his philosophy. According to most versions of the ideal desire version of autonomy one will be autonomous if one’s decisions can be logically universalised. Yet, as Joshua Greene has pointed out, there are a number of actions that cannot be universalised under this theory: ‘Take, for example, being fashionable. Universal fashionableness is self-undermining [If everyone is fashionable then no one is]. Nevertheless, we don’t think that being fashionable is immoral.’[[51]](#footnote-51) Besides, given that Kant himself used his theory to argue that slavery was morally justified but that masturbation was not, it can be seen as nothing more than an *ex post facto* rationalisation for the gut feelings that he already held.[[52]](#footnote-52) It is doubtful that it provides a sound basis on which to determine whether an action is moral – let alone autonomous – or not.

Even if a non-Kantian version of ideal desire autonomy is adopted, this account of autonomy still raises a number of difficulties. As Christman, citing the work of Isiah Berlin,[[53]](#footnote-53) has argued, this version of autonomy would allow people ignore the actual wishes of others in order to do what their ‘rational’ selves should want.[[54]](#footnote-54) Indeed, this is a fundamental logical problem with adopting ideal desire and best desire accounts of autonomy, as both theories 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 – the restriction of a person’s choices ‘allegedly in the recipients’ own best interests.’[[55]](#footnote-55) Given this, ideal desire and best desire definitions of autonomy fail to provide convincing accounts of autonomy. It is illogical that a given action – say, preventing someone from committing suicide – can described as be both paternalistic and respectful of autonomy *at the same time*, as it can under those two interpretations. To define the overriding of a competent person’s choices as a way of respecting their wishes is an abuse of language. It is more cogent to describe actions enforcing best desire and ideal desire autonomy as paternalistic and consider the circumstances when (if ever) paternalism is justified. The current desire version of autonomy is therefore the most philosophically coherent understanding of the concept.

### *Legal Coherence*

Whatever the philosophical shortcomings of the other accounts of autonomy, and even if the above analysis is erroneous, there is another reason why the tort of negligence should perceive autonomy as matching the current desire definition of the concept. Adopting a different account of autonomy would mean that different theories of autonomy would be used in different branches of the law, thus damaging its coherence. For it is the current desire version of autonomy is one that the courts presently use in a number of contexts. As McLean states, ‘Irrespective of those philosophical approaches which seek to make autonomy a richer concept, it is the decision-making aspect of autonomy that dominates in law.’[[56]](#footnote-56)

The evidence for this is overwhelming. In a case on the ‘right to die’ the European Court of Human Rights declared that:

…the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or *morally harmful* or dangerous nature for the individual concerned.[[57]](#footnote-57)

If morally harmful decisions are deemed to be autonomous, then this definition of autonomy cannot refer to ideal desire autonomy as that theory requires actions to be ‘moral’ in order to be autonomous.

Furthermore, in criminal law it has been held that injecting oneself with a syringe of heroin is an autonomous act that breaks the chain of causation for the offence of unlawful act manslaughter.[[58]](#footnote-58) Lord Bingham stated that ‘informed adults of sound mind are treated as autonomous beings able to make their own decisions.’[[59]](#footnote-59) Given that injecting oneself with heroin is contrary to most people’s higher-level desires and is not particularly morally praiseworthy, this appears to be an implicit endorsement of the current desire version autonomy.

There is also evidence that the current desire version of autonomy is used in the tort of battery. In the influential case of *Re T (Adult: Refusal of Treatment)*[[60]](#footnote-60)Lord Donaldson MR stated:

…the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent. That his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his capacity to decide.[[61]](#footnote-61)

If a right to choose one’s treatment exists even if the reasons for that choice are irrational or non-existent then this cannot possibly reflect ideal desire or best desire theories of autonomy as the former (usually) requires decisions to be rational and the latter requires the reasons for them to be consistent with one’s long-term wishes or values (thereby requiring *some* reasons for them to be given). The view that a person is free to make unwise self-regarding choices provided they have capacity to do so is also reflected in section 1 of the Mental Capacity Act 2005.

Finally, there is the example of *Chester v Afshar* (discussed earlier). Mr Afshar’s actions were arguably perfectly justified under a best desire or ideal desire version of autonomy as it would be irrational and not in Miss Chester’s long-term interests to refuse such an operation when it carried such small risks. Yet it was accepted that he *did* interfere with her *autonomy* and so this is further evidence that the law uses the current desire version of autonomy rather than the ideal desire or best desire versions.

Now the fact that a particular definition of autonomy represents the status quo is not, in itself, enough to ensure that it should be maintained. After all, many things that once represented the status quo in law – for instance, the condoning of marital rape – are now considered reprehensible.[[62]](#footnote-62) The common law is ‘capable of evolving in the light of changing social, economic and cultural developments’[[63]](#footnote-63) and so could theoretically evolve to reflect a different definition of autonomy. It may be that other branches of the law, such as the tort of battery, should be changed to reflect a more accurate interpretation of the concept. This would mean that it would be open for the tort of negligence to adopt the ideal desire or best desire theories.

Leaving aside the philosophical problems with those two accounts, such a utopian vision would require a radical re-writing of the entire law of tort. Even if a different definition of autonomy was more plausible it would be the triumph of hope over experience to believe that judges would countenance such a drastic transformation of the law in this area.[[64]](#footnote-64) Furthermore, it would be inconsistent to accept different definitions of the same concept within different areas of the law (never mind within such closely related areas of the law as the tort of battery and the tort of negligence).

It is for this reason that it is hard to accept Chico’s argument in favour of the tort of negligence recognising an interest in autonomy. In her compelling book *Genomic Negligence* Chico argues that ‘English negligence law could be imbued with a specific recognition of the interest in autonomy as a means of recognising…novel genomic claims [i.e. novel tort claims arising as a result of advances in genetic technologies].’[[65]](#footnote-65) Her theory rests on a concept of autonomy ‘imbued with substantive or value rationality and procedural rationality’[[66]](#footnote-66) because ‘it allows some objective evaluation of what autonomy consists in which makes legal recognition of the interest more likely.’[[67]](#footnote-67) In other words, Chico adopts a theory approximate to the ideal desire definition of autonomy. What form might such ideal desires take? Chico states that the English negligence system already ‘holds an intrinsic notion of value’[[68]](#footnote-68) that could pour content into this rationality-based version of autonomy, namely ‘the position of the ordinary or reasonable person’[[69]](#footnote-69) could be used to determine what is rational in the same way that it is ‘used as a measure of reasonableness.’[[70]](#footnote-70)

However, while it is true that the idea of the reasonable person is well-developed in other aspects of negligence law and that this conception of autonomy might constrain the number of claims in negligence for this type of damage and thus be more acceptable to judges,[[71]](#footnote-71) it suffers from the same problems associated with ideal desire autonomy that have been outlined above. For example, no ordinary or reasonable person would refuse a blood transfusion because such procedures are ungodly. Doing so would be archetypal unreasonable behaviour. And yet respect for autonomy means we permit such unwise choices by allowing Jehovah’s Witnesses (and others) treated in such a manner to bring actions in trespass.[[72]](#footnote-72) Similarly, mentally competent pregnant women are entitled to refuse to undergo a caesarean section even when doing so will endanger their life and that of their unborn child.[[73]](#footnote-73) If autonomy is based upon what the ordinary or reasonable person deems acceptable then such decisions would not be capable of being autonomous ones. Accepting that choices have to be approved by the ordinary person would result in different definitions of autonomy existing in the tort of battery and the tort of negligence (with the former perceiving a refusal of life-saving blood transfusions and caesarean sections as autonomous behaviour but the latter not). This would undermine the coherence of the law. [[74]](#footnote-74)\*

Nonetheless, it may be countered that judges take advantage of the equivocal nature of autonomy and utilise all three conceptions in their judgments.[[75]](#footnote-75) Judges might *explicitly say* that there need not be any reasons given for a decision in trespass to the person cases, but they may, as Coggon has argued, *implicitly* require that such decisions be rational.[[76]](#footnote-76) One example he cites is the case of *Ms T*[[77]](#footnote-77) where the refusal of a blood transfusion by a patient was overruled because she lacked mental capacity. The reason for Ms T’s refusal was that she believed her blood to be evil and this was held by the judge hearing the case to be an indication that she lacked capacity. Coggon believes that this case provides evidence that in some circumstances judges require a decision to be rational before they will allow a patient to exercise their autonomy. If this is correct it may mean that current desire autonomy is not the only correct legal definition of autonomy and that negligence law could adopt the best or ideal desire versions.

But this this argument is not beyond reproach. Even if we accept that judges use all three definitions of autonomy in different circumstances this certainly does not mean that all they are equally valid or representative of the law. Traditional common law reasoning states that the decisions of the higher courts are binding on those of lower courts.[[78]](#footnote-78) Many authoritative judgments have confirmed that the law reflects the position stated above by Lord Donaldson MR above.[[79]](#footnote-79) If the occasional first instance decision departs from this by, say, requiring a decision to be rational, it is merely an example of judges misapplying the law. As such, this criticism does not refute the argument that current desire version of autonomy is the most representative of the legal status quo at present: cases contrary to this view are per incuriam and inconsistent with binding authorities. Given the common law’s concern with consistency and that the current approach towards any expansion of liability in negligence is that developments should be incremental based upon previous decisions,[[80]](#footnote-80) it is likely that if lost autonomy is accepted as a form of damage in negligence then it will be the current desire version of autonomy that will be utilised.

## Conclusion

The purpose of this paper has been to determine how English tort law might define the concept of autonomy in medical negligence claims. It has been argued that if autonomy is to be recognised as a form of damage protected by negligence then it is the ‘current desire’ version of the concept that is most likely to be used as it does not suffer from the philosophical problems of other definitions and is the most consistent with the current jurisprudence in related areas of tort law. Whether such claims should be successful is an entirely separate question. However, it is hoped that having a sound definition of the concept of autonomy will make arriving at the answer to it somewhat easier.

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 *Chester v Afshar* [2005] 1 AC 134 at 143 per Lord Steyn. [↑](#footnote-ref-1)
2. See John Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge & Kegan Paul, 1985), John Christman, ‘Constructing the Inner Citadel: Recent Work on the Concept of Autonomy’ (1988) 99 *Ethics* 109, Søren Holm, ‘Autonomy’ in Ruth Chadwick (Ed.), *Encyclopaedia of Applied Ethics Volume 1* (San Diego: Academic Press, 1998) and Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* 7th Edn. (Oxford: Oxford University Press, 2013). [↑](#footnote-ref-2)
3. See General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (London: GMC 2008). [↑](#footnote-ref-3)
4. See Kumaralingam Amirthalingham, ‘Causation and the Gist of Negligence’ (2005) 62 *Cambridge Law Journal* 64 (2005) 32, Donal Nolan, ‘New Forms of Damage in Negligence’ (2007) 70 *Modern Law Review* 79, Nicolette Priaulx, *The Harm Paradox: Tort Law and the Unwanted Child in the Era of Choice* (Abingdon: Routledge-Cavendish, 2007) 9, Victoria Chico, *Genomic Negligence: An Interest in Autonomy as the Basis for Novel Negligence Claims Generated by Genetic Technology* (Abingdon:Routledge-Cavendish, 2011) 134, Tamsyn Clark and Donal Nolan ‘A Critique of *Chester v Afshar*’ (2014) 34 *Oxford Journal of Legal Studies* 659. [↑](#footnote-ref-4)
5. See Margaret Brazier, ‘Do No Harm – Do Patients Have Responsibilities Too?’ (2006) 65 *Cambridge Law Journal* 397. [↑](#footnote-ref-5)
6. See *Perrett v Collins* [1999] PNLR 77 and *Marc Rich & Co v Bishop Rock Marine Co* [1996] AC 211. [↑](#footnote-ref-6)
7. [2004] 1 AC 309. [↑](#footnote-ref-7)
8. *McFarlane v Tayside Health Board* [2000] 2 AC 59. [↑](#footnote-ref-8)
9. *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309 at 317 per Lord Bingham. [↑](#footnote-ref-9)
10. Nolan ‘New Forms of Damage in Negligence’, 80. [↑](#footnote-ref-10)
11. [2005] 1 AC 134. [↑](#footnote-ref-11)
12. Ibid. at 146 [↑](#footnote-ref-12)
13. Ibid [↑](#footnote-ref-13)
14. Sarah Devaney ‘Autonomy Rules Ok’ (2005) 13 *Medical Law Review* 102, 107. [↑](#footnote-ref-14)
15. See Amirthalingham, ‘Causation and the Gist of Negligence’, David Pearce and Roger Halson, ‘Damages for Breach of Contract: Compensation, Restitution and Vindication’ (2008) 28 *Oxford Journal of Legal Studies* 73, John Murphy and Christian Witting, *Street on Torts* 13th Edn. (Oxford: Oxford University Press, 2013) 159. Clark and Nolan maintain that the damage pleaded was Miss Chester’s personal injury but that a better solution would have been to compensate her for her lost autonomy (‘A Critique of *Chester v Afshar*’). [↑](#footnote-ref-15)
16. Sarah Green, *Causation in Negligence* (Oxford: Hart Publishing, 2015) ch 7. [↑](#footnote-ref-16)
17. *Gregg v Scott* [2005] 1 AC 176 at 226 per Baroness Hale. [↑](#footnote-ref-17)
18. See n 4 above. [↑](#footnote-ref-18)
19. Victoria Chico, ‘Wrongful Conception: Policy, Inconsistency and the Conventional Award’ (2007) 8 *Medical Law International* 139, 154. [↑](#footnote-ref-19)
20. Ibid [↑](#footnote-ref-20)
21. Holm, ‘Autonomy’ 267. [↑](#footnote-ref-21)
22. Peter Singer, *Practical Ethics*. 3rd Edn. (Cambridge: Cambridge University Press, 2011) 84. [↑](#footnote-ref-22)
23. John Coggon, ‘Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?’ (2007) 15 *Health Care Analysis* 234, 240. [↑](#footnote-ref-23)
24. Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals* (tr: Thomas Abbott) in Allen Wood (Ed.), *Basic Writings of Kant* (New York: The Modern Library, 2001) 143. See also Onora O’Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press 2002). [↑](#footnote-ref-24)
25. Coggon, ‘Varied and Principled Understandings of Autonomy’ 240. [↑](#footnote-ref-25)
26. Ibid., 240-241. [↑](#footnote-ref-26)
27. Immanuel Kant, *Grounding for the Metaphysics of Morals* (Indianapolis: Hackett, 1993) 422. [↑](#footnote-ref-27)
28. Coggon, ‘Varied and Principled Understandings of Autonomy’ 240. [↑](#footnote-ref-28)
29. Ibid [↑](#footnote-ref-29)
30. John Stuart Mill, ‘On Liberty’ in John Gray (Ed.), *On Liberty and Other Essays* (Oxford: Oxford University Press, 1991) 14. [↑](#footnote-ref-30)
31. Jonathan Glover, *Causing Death and Saving Lives* (London: Penguin, 1977) 77. [↑](#footnote-ref-31)
32. See Mental Capacity Act 2005. [↑](#footnote-ref-32)
33. Coggon, ‘Varied and Principled Understandings of Autonomy’ 240. [↑](#footnote-ref-33)
34. See Harry Frankfurt, ‘Freedom of the Will and the Concept of a Person’ (1971) 68 *Journal of Philosophy* 5. [↑](#footnote-ref-34)
35. See Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988). [↑](#footnote-ref-35)
36. Gerald Dworkin, ‘Autonomy and Behaviour Control’ (1976) 6 *The Hastings Centre Report* 23, 25. [↑](#footnote-ref-36)
37. Ibid [↑](#footnote-ref-37)
38. This notion of autonomy underpins Priaulx’s work in *The Harm Paradox*. [↑](#footnote-ref-38)
39. Jennifer Nedelsky, ‘Reconceiving Autonomy: Sources, Thoughts and Possibilities’ (1989) 1 *Yale Journal of Law and Feminism* 7, 8. [↑](#footnote-ref-39)
40. Catriona Mackenzie and Natalie Stoljar (Eds.), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford: Oxford University Press, 2000) 21. [↑](#footnote-ref-40)
41. Ibid. [↑](#footnote-ref-41)
42. John Christman, ‘Autonomy in Moral and Political Philosophy’ in E.N. Zalta (Ed.) *The Stanford Encyclopaedia of Philosophy* (Spring 2011 Edition) <http://plato.stanford.edu/archives/spr2011/entries/autonomy-moral/>. [↑](#footnote-ref-42)
43. Mackenzie and Stoljar, *Relational Autonomy* 8. [↑](#footnote-ref-43)
44. Ibid., 9. [↑](#footnote-ref-44)
45. Joseph Raz, ‘Liberalism, Autonomy, and the Politics of Neutral Concern’ (1982) 7 *Midwest Studies in Philosophy* 89, 112. [↑](#footnote-ref-45)
46. Martha Fineman, *The Autonomy Myth: A Theory of Dependency* (New York: The New Press, 2004) 304. See also Helen Reece, ‘Review Article – *The Autonomy Myth: A Theory of Dependency*’ (2008) 20 *Child and Family Law Quarterly* 109. [↑](#footnote-ref-46)
47. See Coggon, ‘Varied and Principled Understandings of Autonomy’ 244. [↑](#footnote-ref-47)
48. Irving Thalberg, ‘Hierarchical Analyses of Unfree Action’ (1978) 8 *Canadian Journal of Philosophy* 211, 219. [↑](#footnote-ref-48)
49. Gary Watson, ‘Free Agency’ (1975) 72 *The Journal of Philosophy* 205, 218. [↑](#footnote-ref-49)
50. Thalberg, ‘Hierarchical Analyses of Unfree Action’ 219-220. [↑](#footnote-ref-50)
51. Joshua Greene, *Moral Tribes: Emotion, Reason and the Gap Between Us and Them* (London: Atlantic Books, 2013) 332. [↑](#footnote-ref-51)
52. Ibid, 300. [↑](#footnote-ref-52)
53. Isaiah Berlin, *Four Essays on Liberty* (Oxford: Oxford University Press, 1969). [↑](#footnote-ref-53)
54. Christman, ‘Constructing the Inner Citadel’ 116. [↑](#footnote-ref-54)
55. Hetta Häyry, ‘Paternalism’ in Ruth Chadwick (Ed.), *Encyclopaedia of Applied Ethics Volume 1* (San Diego: Academic Press, 1998) 449. [↑](#footnote-ref-55)
56. Sheila McLean, *Autonomy, Consent and the Law* (Abingdon: Routledge-Cavendish, 2009) 19. [↑](#footnote-ref-56)
57. *Pretty v United Kingdom* (2002) 35 EHRR 1 at [62] (my emphasis). [↑](#footnote-ref-57)
58. *R v Kennedy (No 2)* [2008] 1 AC 269. [↑](#footnote-ref-58)
59. Ibid. at 275 per Lord Bingham. [↑](#footnote-ref-59)
60. [1993] Fam 95. [↑](#footnote-ref-60)
61. Ibid. at 112. [↑](#footnote-ref-61)
62. *R v R* [1992] 1 AC 599. [↑](#footnote-ref-62)
63. Ibid. at 616 per Lord Keith. [↑](#footnote-ref-63)
64. Since the cases of *Caparo v Dickman* [1990] 2 AC 605 and *Murphy v Brentwood District Council* [1991] 1 AC 398 the trend has been for the law in this area to develop incrementally. [↑](#footnote-ref-64)
65. Chico, *Genomic Negligence* 29. [↑](#footnote-ref-65)
66. Ibid, 42. [↑](#footnote-ref-66)
67. Ibid, 49. [↑](#footnote-ref-67)
68. Ibid, 57. [↑](#footnote-ref-68)
69. Ibid, 57 [↑](#footnote-ref-69)
70. Ibid, 57 [↑](#footnote-ref-70)
71. The trend in negligence has been to limit number of claims to avoid ‘opening the floodgates.’ See *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310. [↑](#footnote-ref-71)
72. See *Re T* (Adult: Refusal of Treatment) [1993] Fam 95 at 112. [↑](#footnote-ref-72)
73. See *St George’s NHS Healthcare Trust v S* [1998] 3 WLR 936. [↑](#footnote-ref-73)
74. \* It is worth mentioning that in a more recent article (published after this article was accepted for publication), Chico has written that ‘Despite the vague nature of autonomy in English medical law, in essence there seems to be a commitment to a content-neutral interpretation of the concept.’ I will take her view to be that as a matter of positive law, autonomy is content-neutral but that, normatively, she believes the law should adopt the ideal desire version for clinical negligence cases. Victoria Chico, ‘Requiring Genetic Knowledge: A Principled Case for Support’ (2015) *Legal Studies* (online advance access) doi: 10.1111/lest.12080. [↑](#footnote-ref-74)
75. Coggon ‘Varied and Principled Understandings of Autonomy’ 235. [↑](#footnote-ref-75)
76. Ibid, 247. See also Chico, *Genomic Negligence* 47. [↑](#footnote-ref-76)
77. *An NHS Trust v Ms T* [2004] EWHC 1279. [↑](#footnote-ref-77)
78. See Lord Oliver, ‘Judicial Legislation’ (1989) 2 *Leiden Journal of International Law* 1, 3. [↑](#footnote-ref-78)
79. See *Sidaway v Board of Governors of the Bethlam Royal Hospital and the Maudsley* [1984] 2 WLR 778 at904 per Lord Templeman and *Re MB* [1997] 2 FLR 426 at 432 per Butler-Sloss LJ. [↑](#footnote-ref-79)
80. See n 64 above. [↑](#footnote-ref-80)