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Achieving Relational Justice for Doctor and Patient

Jake Lewis

Abstract

*A court will always seek to secure the moral rights of the patient. A doctor is negligent where failing to take reasonable care to ensure a patient is aware of any material risk to a treatment, or of any reasonable alternative or variant treatment. An effective duty of care is one that does justice to both parties. The standard of care through which justice is expressed is of fundamental importance. Relational justice comprises three factors of a doctor's choice. Used prescriptively, this vindicates efficacy. This article first illustrates the particular patient test as the only compatible legal standard with the tripartite choice analysis. The present 'double standard' posited in *Montgomery* evidences the lexical absurdity of attempting to characterize the third factor of moral credit, before the prior two: The range and conditions of choice. Moral credit exists in correlation with the co-dependent values of consent and autonomy, which comprise the patient's right. This article aims to align the law with the prospective responsibility of the doctor. A modified duty of care, standard of care, and a new defence at law of moral credit achieve this. However, adjustment requires time. This article further proposes a compromise through reinterpretation of the present law to facilitate full departure through judicial or statutory authority.*

Introduction

The court in *Montgomery* necessitated a legal obligation by propounding the moral right of the patient.¹ Two legal standards, the reasonable patient and the particular patient, were proffered.² Yet only the former sees practical use. This article proposes a theory of Relational Justice. By securing justification in relation to the context of the duty of care, from both doctor and the patient, the subjective standard is demonstrated as optimal. Preference for an objective standard is explained as a consequence of mischaracterizing factors pertinent to doctoral responsibility as limiting the patient's right. Relational justice is secured normatively through alignment of the legal duty and right with the proposed moral framework.

Part one of this article demonstrates the core shortcomings of 'Social Justice', an attractive theory that rejects tort law's pursuit of objective patterns of resource distribution, favouring instead justifications to agents in relation to the reasons for those distributions.³ Moral responsibility is expressed in two factors of choice, range and

¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [87], [93]

² *Ibid* [87]

³ Emmanuel Voyiakis, 'Rights, Social Justice and Responsibility in The Law of Tort' [2012] UNSWLJ 453

conditions, to justify to the responsible agent that particular distribution.⁴ Yet, ‘Social Justice’ fails to accommodate both parties to a duty of care in medical negligence.⁵ The full moral dimensions of a patient’s legal right are furthermore rejected on applying this theory.⁶ This necessitates a third category of factor of choice called ‘moral credit.’ The right of the patient imbues the steps necessary to realize that right with a distinct moral quality. In this context, it represents a doctor’s attempt to vindicate the patient’s right.⁷ Analysis of each standard of care presented in *Montgomery*, in light of Relational Justice, produces an alternative justification for arriving at the particular patient test.

Part two demonstrates the normative consequence of ‘lexical priority’ generated by the attempted application of the two legal standards. In two cases subsequent to *Montgomery*, the court when given two standards of care will lexically prioritise, and develop first, the objective and less justifiable standard.

This generates what one may deem a ‘principle of negligible materiality’. Part three unpacks the notion of moral credit. The neutral impact of an imported doctrine of informed consent is shown to give rise to a highly libertarian conception of autonomy. This is revealed, as with its alternative in Kantian Ethics to be unsatisfactory. Part four makes the positive case for relational autonomy, as being both practically valuable and accommodating of Relational Justice.

This article concludes with proposed amendments to the GMC patient consent guideline.⁸ It acknowledges the ideal reforms to the duty of care, standard of care, and an appropriate defence grounded in moral credit. Implementation will be difficult. A compromise is to read into the existing law, and added to the GMC legal annex.

1) The Road to Justice

A Coroner Report suggests in practice, there exists a ‘presumption’ in favour of less costly procedures that needs to be rebutted.⁹ This runs counter to the ruling in *Montgomery*, whereby a doctor would be negligent for failing to make the patient aware of variant treatments.¹⁰ Both secure particular distributions of resources in face of a given externality; the former in spite of the moral right of the patient, the latter in spite of strained financial conditions. Social Justice as proposed by Voyiakis reconciles this dichotomy by looking to the reasons for a distribution in the ‘social structure’.¹¹ This

4 Ibid 459

5 Ibid 449

6 Ibid 456

7 Allan Beever ‘Corrective Justice and Personal Responsibility in Tort Law’ [2008] OJLS 475, 487-489

8 General Medical Council ‘Patients and Doctors Making Decisions Together’ [2008]

9 Andrew Walker, ‘Report to Prevent Future Deaths: Kristian Jaworski’ (2016) <https://www.judiciary.gov.uk/wp-content/uploads/2016/04/Jaworski-2016-0125.pdf> Accessed 12th May 2016 [5]

10 *Montgomery* (no 1) [87]

11 Ibid Voyiakis (no 3) [453]

allows the aforementioned externalities to contextualize the performance of a duty and standard of care.

Voyiakis' social justice proposes an agent is morally responsible for the violation of another agent's legal right.¹² The social structure is an account of the 'web of facts', as with society, and tort law itself.¹³ Here, social justice is achieved where no agent could reasonably reject the principles that assign that agent their particular place within the basic structure, and hold each *responsible* for the ways in which he or she interacts with others.¹⁴

Without a means of identifying which facts are relevant, the social structure fully obscures all responsibility. Scanlon offers a solution through the concept of a 'lens of choice'. Viewing the social structure through a particular lens allows one to discern and separate factors relevant to that lens.¹⁵ Voyiakis proposes moral responsibility exists when viewed through two different lenses: where there are a range of choices available to the agent, and where the conditions for making that choice are not *prejudicial* to responsibility.¹⁶

Voyiakis implies external factors occlude moral responsibility. Yet, the satisfaction of the patient's moral right is an 'obligation',¹⁷ wholly gratuitous and separate to the law, and therefore not incurring responsibility in the moral sense.¹⁸ This is incorrect in the medical context. Failure to meet the moral right of the patient incurs moral responsibility due to the nature of the consequences produced.¹⁹ Accordingly, the present 'lens' reduces the patient (and his rights) to factors of the doctor's choices. The steps requisite to achieve the patient's moral right cannot be within 'range', as this would be the only viable choice, and ergo, no choice at all. Similarly, a patient's moral right cannot be a condition of choice itself, as it would incorporate all factors necessary to vindicate that moral right, thereby making the right conclusive of the choice. Corrective justice sees this a simple problem; the patient has a moral right, in this context represented by consent and autonomy, which ought to correlatively be vindicated.²⁰ Looking to meet the moral right of the patient ought to be considered a 'morally praiseworthy' action. Praiseworthiness can be illustrated in four elements.²¹

- 1) Act B exemplifies a moral rule.
- 2) Act B performed voluntarily.

12 Voyiakis (no 3) 457

13 Ibid 456

14 Ibid 455

15 T. M. Scanlon 'What we owe to each other' (HUP 2000)

16 Voyiakis (no 3) 459

17 Ibid 456 Begonias Analogy

18 Beever (no 7) 478

19 Voyiakis (no 3) 467, 'button in a factory' analogy.

20 Sandy Steel 'Private Law and Justice' [2013] OJLS 607, 609-610

21 Elizabeth Beardsley 'Moral Worth and Moral Credit' [1957] The Philosophical Review 306. These 4 elements are known as the P1 criteria

- 3) Act B is not performed in ignorance of relevant facts.
- 4) Act B was committed as direct result of, in that situation, a 'good' desire.

Within the context of a medical negligence claim, 'Act B' is the choice of the doctor to disclose material risks to a patient. This will be shown to distinguish praiseworthy activity from institutionally requisite activity. Voluntariness and full effective knowledge will be assumed respectively. Element 4 of P1 ought to be presumed by virtue of a doctor's beneficence and their training in Bio-ethics.²² This article assumes that causation is present, as with all elements of liability bar the standard of care. The natural corollary is that within medical negligence; responsibility should be conclusive of liability in order to realize a patient's rights.

Moral Credit reflects the positive duty to seek to meet the right of the patient subject to the mitigating factors that correlatively arise in its pursuit.²³ It is only upon satisfaction of the test for moral praiseworthiness, that mitigating factors are capable of acquiring 'creditability'. 'Credit-worthiness' is ratified by a separate standard which qualifies these mitigating factors known as the P2 criteria.²⁴ As 'right' is a pluralism, the P2 criteria will be assumed to be satisfied for the purposes of analysing legal standards of care, and unpacked in part 3. This features as a third organizing factor of choice.²⁵ A doctor ought to be responsible, and ergo liable in negligence where the range of choice is sufficient, the conditions of choice are not inhibitory, and the choice is not in accordance or in pursuit of the patient's moral right.

Assumptions

I assume an appropriate 'range' is binary choice to disclose or not to disclose, and ideal 'condition', the absence of any non-patient inhibitory factors. P 2-4 are satisfied presumptively. I will assume that in light of the p1 and b1 factors (B corresponding to an equivalently valued 'blameworthiness) the choice of the doctor to disclose information is a morally neutral action. If doing so 'pursues the right of the patient', it will be considered a morally praiseworthy action and gain moral worth.

Moral credit is not a resource to be distributed freely. To state 'the doctor is morally credited with a disclosure' where that disclosure exists as a direct consequence of a duty, is to incorrectly attribute credit for the outcome to the doctor, and not the institutional practice.²⁶ Moral credit is inextricable from personal experience, and therefore can only be distributed according to what that doctor deserves.²⁷ 'Institutional Credit' will denote what accrues where one does not pursue the right of the patient, but

22 Ibid 321, the desires normatively stemming from the role of a doctor are in that circumstance, 'good'.

23 Ibid 314, A separate standard renders credit distinguishable from worth

24 section 3.

25 Beever (no 7) 488, 489

26 Ibid 486

27 Ibid 488, 489

nonetheless meets the legal standard of care for liability.²⁸ Where a doctor seeks to meet the legal duty and standard of care for liability, that choice cannot be considered praiseworthy, and thereby acquire moral worth.

The P1 criteria as outlined above are a necessary pre-condition to moral credit. Where the doctor does not attempt to vindicate a moral right, and thus does not satisfy the P1 criteria, factors that nonetheless arise in vindication of that right are indistinguishable from normal, external factors. The relevant factors of responsibility can only first exist within ‘range’ and ‘conditions’. Similarly, when the duty and standard are adjusted to reflect the right itself, formerly morally worthy factors become indistinguishable from those external factors. These formerly morally worthy factors now filter into ‘range’ and ‘conditions’. Moral credit becomes impossible to acquire. Therefore, where ‘institutional credit’ is acquired, and where the duty reflects the right accurately, moral credit will cease to operate.

Standards

Montgomery considers a range of standards. The first is the *Bolam* test, mitigated by the *Bolitho* test. This held that a doctor would be liable for the non-disclosure of a risk only where a reasonable body of medical opinion could not be found to evidence that practice,²⁹ and where supplied, such evidence must qualify as ‘logical.’³⁰ The scope of the standard is mitigated by ‘logic’. This is however noted as lacking efficacy, as liability most often is found where there is internal inconsistency in the reasoning of medical opinion.³¹ Questions of ‘resources’ similarly characterize the wider defensive practice over the doctor’s choice.³²

Departure is necessitated by how under both *Bolam*, and *Bolitho*’s modification, the doctor’s choice to disclose is perpetually morally frustrated. *Bolam* ties liability to an opinion. This occupies ‘conditions’ of choice, as an opinion fluctuates and anticipating such fluctuations constitute an inhibitory circumstance. Where this inhibits moral responsibility, and liability is nonetheless found, this is morally unjustifiable to the doctor. Similarly, *Bolitho* ties that 3rd party opinion to the institution of medical practice. This occupies ‘range’ as institutional practice is less conducive to deviation in choice. Where this inhibits moral responsibility, through logically constraining available choices, but the doctor is nonetheless liable, this also cannot be justified to the doctor.

Recognition of the third dividing factor of moral credit is a key motivation for the

28 Ibid

29 *Bolam v Friern Hospital Management Committee* [1957] WLR 582, 587

30 *Bolitho v Hackney Health Authority* [1998] AC 232, 241-242

31 Rachael Mulheron ‘Trumping Bolam: a critical legal analysis of Bolitho’s “gloss”’ [2010] CLJ 609, 637-638

32 Ibid 623-624

subsequent court's departures.³³ The doctor conversely is bound to respect the choice of other doctors, and not the patient. Liability under the *Bolam* test cannot be justified to the patient within 'Relational Justice', as the choice of another agent is pursued over the right of the patient.

The second is 'the reasonable patient in the circumstances.'³⁴ Liability of the doctor is assessed in relation to what an objective patient would deem material.³⁵ However, the reasonable patient is practically unknowable.³⁶ As the law itself is a condition of choice,³⁷ this would fully occlude responsibility. This is not justifiable to the doctor as liability cannot be determined by reference to the social structure. The objective standard therefore could only accumulate substance through litigation where the doctor could not be held morally responsible; which in light of 'Relational Justice' is costly and unnecessary.³⁸

The understanding of a reasonable patient could be based on an informational survey.³⁹ However, available studies are insufficiently reliable, subject to study design issues, reporting biases, and the ages of the data collected.⁴⁰ Until appropriate studies are carried out, there exists deep uncertainty for the doctor in determining the legal conception of a reasonable patient.⁴¹ This occludes the 'conditions' of the doctor's choice, and liability cannot be justified to the doctor under 'Relational Justice'. Once the reasonable patient is established, moral credit still pertains only to the particular claimant.⁴² As a result, the doctor in fielding responsibilities to a legal fiction will only gain institutional credit. This cannot be justified to the patient, whose personal right is not pursued.

The particular patient test comes the closest to representing alignment. This standard is extracted from that in *Rogers and Whitaker*, which originally combined it with a reasonable patient test. It reads; 'a risk is material ... If the medical practitioner is, or should be reasonably aware, that the particular patient, if warned of the risk, would be likely to attach significance to this risk.'⁴³ Unlike the reasonable patient, the particular patient is 'knowable.' In order to exculpate the duty, the doctor is forced to "take his duty's precise content from the needs, concerns, and circumstances of the individual patient."⁴⁴ Moral credit accrues automatically to the law-abiding doctor. One cannot

33 *Montgomery (no 1)* [58]

34 *Ibid* [64]; *Pearce v United Bristol Healthcare NHS Trust* (1998) WL 1044056, 5

35 *ibid*

36 Margaret Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law' [1987] 7 LS 169, 182

37 *Voyiakis (no 3)* 464

38 NHS Litigation Authority 'Reports and Accounts' (2014/2015) HC 293 [29]

39 Alasdair Maclean (2005) 'Giving The Reasonable Patient a Voice: Informational Disclosure and The Relevance of Empirical Evidence, MLI Vol 7 1, 18

40 *Ibid* 23

41 Brazier (no 36) 182

42 Steele (no 20)

43 *Rogers v Whitaker* (1992) 175 CLR 479, 490 (High Court Australia)

44 *Montgomery (no 1)* [73]

adhere to this standard, and not seek to vindicate the right of that patient, as it accounts for patient subjectivity. Institutional Credit is rendered a non-factor as the particular patient standard reflects the right of the patient; necessarily, exculpation solely lies in inhibited choice.

2) Subsequent Cases to Montgomery.

Where do the factors pertinent to doctor/patient interaction filter in determining the responsibility of the doctor? If categorized under moral credit, with the patient's right, then this affects the threshold of where moral credit acquires.⁴⁵ If it is part of the conditions of choice of the doctor to disclose, it determines preliminarily when the doctor is capable of being morally credited.

As the 'particularities' of each patient influence doctor/patient discourse, the normative consequences of pursuing the former line of analysis are devastating to the rights of the particular patient.⁴⁶

Mrs A

This case concerned 'Mrs A', who sought damages for the breach of duty of care of her obstetrician to disclose the risk of an unbalanced chromosome, leaving the child with severe disabilities.⁴⁷ Her argument was that the risk of chromosomal abnormality was material, and should have been disclosed.⁴⁸

The particular patient aspect of the test saw 'Mrs A' characterized by an earlier statement regarding a test for Downs Syndrome.⁴⁹ The court concluded from this that the numerical risk factor retrieved from this test constituted what the patient would deem an immaterial risk and applied it to like conditions.⁵⁰ The case can be faulted for failing to consider the evidence supplied by Mrs A as a condition under which the doctor's choice was made. This does not imply that the doctor is not morally responsible for disclosure by virtue of this evidence being an inhibitory condition. To suggest so is a non sequitur, ignoring how the patient had requested such information in the first place.⁵¹ Considering the right of the patient in lexical priority to the responsibility of the doctor resulted in a 'reasonable' patient standard being generated; only institutional credit can be afforded to the agent pursuing a legally fictitious standard.

45 Beever (no 7) 489

46 Vilhjálmur Arnason and Stefán Hjörleifsson 'The Person in The State of Sickness' [2016] CQHE 209, 216-217

47 Mrs A v East Kent Hospitals University NHS Foundation Trust [2015] EWHC 1038, (2015) WL 1651409 [2]

48 Ibid [4]

49 Ibid [62]

50 Ibid [69]

51 Ibid [61], as inferred from 'We agreed'

The first standard falls in priority to the second. The court found contrary to the notion that ‘one cannot reduce a risk to percentages.’⁵² The 1:1000 risk by the reasonable patient standard was considered ‘negligible’ and the doctor does not need to disclose it.⁵³ This may be identified as an emerging principle of ‘negligible materiality’.⁵⁴

Tasmin

This case concerned management of a child’s delivery at a particular time, 10:30, and the alleged failure of a doctor to recommend a caesarean section.⁵⁵

This case appears to resolve the first limb in relation to the character of the claimant as in *A v East Kent*. Any evidential gaps go not towards characterizing responsibility, but are filtered into generating an objective standard. They are anxious parents,⁵⁶ and the patient herself has limited English skills.⁵⁷

Instead of determining these as conditions for the doctor’s choice not to offer alternative treatment, the court characterized the patient as “[a person] who placed trust in the professionals” and “tended to accept what was being recommended.”⁵⁸ The moral right of the patient is diminished in place of the doctor’s responsibility to that right on the basis of external characteristics. A vulnerable patient whose rights are defined by their vulnerabilities will under this judgment be incapable of arguing their right has not been met. Consequently, the doctor can only gain institutional credit, and this cannot be justified to the patient. The absurdity of lexical priority is far more egregious here. The relative power difference of the two parties manifests in the quality of their evidence,⁵⁹ and their starting point of knowledge in medicine.⁶⁰

The second limb is ‘harmonised’ with obstetric practice RCOG 2001 guidelines, but fails to make mention of the 2008 GMC guidelines on consent.⁶¹ Following *A v East Kent* Jay J concluded that a risk of 1;1000 was “too low to be material”.⁶² To achieve this, he relegates the relevant phrase from *Montgomery* to defining the border between materiality and immateriality.⁶³ Negligible materiality is as under the reasonable patient test, insufficient to recognize the right of the patient, and merely capable of distributing institutional credit.

52 *Montgomery* (no 1) [89]

53 *Mrs A* (no 47), [84], [95]

54 *Ibid* [69], [84], [95], [96]

55 *Mahima Begum Tasmin v Barts Health NHS Trust* [2015] EWHC 3135, (2015) WL 665521 [5]– [17]

56 *Ibid* [60]

57 *Ibid* [8], [42]

58 *Ibid* [62]

59 *Ibid* [35], where Justice Jay expresses doubt that any parent could give reliable evidence.

60 *Ibid* [47]

61 *Ibid* [116]

62 *Ibid* [118]

63 *Ibid*

A corpus of law in departure from *Montgomery* is emerging. Though, the ‘principle of negligible materiality’ is likely to be curtailed on appeal, one cannot ignore how the rights of the patient are being brought subject to older, and more specific clinical documents. The correct order of reasoning can be secured through sole application of the particular patient test.

3) The Right

Having established the particular patient standard as ideal, the analysis is not complete until the substance of the right of the patient is identified. This can be achieved through unpacking the notion of moral credit.

The P2 Criteria are as follows.⁶⁴

- A) Act B has positive moral worth if P1 is satisfied.
- B) X’s situation at the time of performing B included a preponderance of known circumstances which are reasonably judged to be unfavourable to the performance of B.

In exchange for the significant latitude offered by a responsibility analysis and lens of choice, by accounting for ‘mitigating circumstances’ in relation to the range and conditions of choice, the purpose of moral credit is to encourage pursuit of the right of the patient by pressing the doctor to operate beyond their existing professional responsibilities. Credit determining factors must be on a different, but not exclusive scale to those that affect moral worth so as to be categorized under the range and conditions of choice of the doctor.⁶⁵ But credit determining factors must also not be indirectly causative of the morally creditable act (Act B).⁶⁶

I determine a direct causal connection in a manner unique to Relational Justice. Only those factors which are capable of affecting the range or conditions of the doctor’s choice will constitute the minimum requisite difficulty. The mitigating circumstances may be fully occlusive of responsibility once accommodated by the first two elements. These factors offer the defence of ‘pursuing patient right’ in perpetuity, and cannot be justified to the patient.

Consent

Dolgin characterizes the development of consent much in the same terms as Jackson; a ‘zeitgeist shift’ has seen a move from ‘familial and hierarchical relationships’, to a

64 Beardsley (no 21) 318

65 Ibid 314

66 Ibid 322

‘market based’ one.⁶⁷ This is consistent with the ‘axis’ of consent presented by Hurd. As we move to one end of the axis, so too does the boundary at which moral credit accrues.⁶⁸ Treatment without consent constitutes a battery.⁶⁹ To this end, the doctrine is more fundamental in mitigating professional deference.⁷⁰ The informed consent doctrine was a shift from a negative obligation, to a positive one. A doctor was required to obtain ‘intelligent consent.’⁷¹ This requires necessarily, information to be disclosed.⁷² The court in *Montgomery* also was subject to this shift. In its analysis of *Rogers v Whitaker*, the ‘double standard’ is admonished. However, there is paradoxically a focus on the lone patient.⁷³

This informed the court’s analysis of *Sidaway*, favouring Scarman’s ‘starting point as rights’ analysis.⁷⁴ Furthermore, the staunchest opposition to Informed Consent is contextualized: The act of disclosure is rationalized as not retaining the same type of skill as seen in treatment under the *Bolam* test.⁷⁵ The position in *Chester* marked this evolution from doctor to patient-centric reasoning. The duty to disclose has at its heart ‘the right of the patient’,⁷⁶ which necessitated a ‘modest departure’ from existing principles of causation.⁷⁷ On an unequivocal rejection of the majority decision in *Sidaway* and a vindication of the position in *Chester*,⁷⁸ the “citadel” of *Bolam*’s medical paternalism had been captured.⁷⁹ But what was left in its wake?

Autonomy

Consent is derived in power from an underlying right to individual autonomy.⁸⁰ Through implementation of informed consent, the court presumes that the patient’s right is secured. Unfortunately, this betrays a limited understanding of patient autonomy. The underlying ‘right’ cannot be vindicated automatically.⁸¹

This is visible in the ratio of *Montgomery*. The court alludes to a ‘discussion’, but the nature of the duty comprises none of this.⁸² *Montgomery*’s court paid lip service to

67 Janet L Dolgin, ‘Development of Informed Consent’ [2015] CQHE 97, 100; Rupert Jackson ‘The Professions’ [2015] PN 122, 131

68 HM Hurd ‘Moral Magic of Consent (1996) 2 LT 121, Consent’s valuation can be at its most libertarian purely a state of mind.

69 *Salgo v Leland Stanford Junior University Board of Trustees* (1957) PR 317 (US)

70 *F v West Berkshire HA* [1990] 2 AC 1, [1989] 2 WLR 1025, 44,45

71 *Salgo* (no 69)

72 Tom L. Beauchamp, ‘Informed Consent: Its history, meaning and present challenges’ [2011] CQHE 20 515, 518

73 *Montgomery* (no 1) [74]

74 *Sidaway v Board of Governors of the Bethlehem Royal Hospital* [1985] AC 871, 885-886

75 *Montgomery* (no 1) [85]

76 *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC (Lord Hope) [86]

77 *Ibid* (Lord Steyn) [24]

78 *Montgomery* (no 1) [84]

79 *Jackson* (no 67)

80 Roger Brownsword ‘The Cult of Consent: Fixation and Fallacy (2004) 15 KLJ 223, 255

81 Beauchamp (no 72)

82 *Montgomery* (no 1) [103]

notions of ‘dialogue’. The doctor is only bound to ensure the patient understands the ‘seriousness’ and the pros and cons of any particular treatment.⁸³ The duty itself prioritises ‘awareness.’⁸⁴

There is a distinction to be made between ‘awareness’ and ‘understanding’. The former preserves a liberal conception of patient autonomy.⁸⁵ An inexorable loss of understanding occurs when that information moves from the doctor to the patient.⁸⁶ Reducing this loss is ‘difficult’ and thereby creditworthy. It is necessary to look to alternative conceptions of autonomy and their ‘creditworthiness’ in relation to the concept currently protected. The following criteria will be used:

- 1) Are there mitigating circumstances to the doctor’s choice so as to accrue moral credit?
- 2) Are these circumstances normatively encapsulated within the existing obligations of the doctor?⁸⁷
- 3) Do these circumstances occlude responsibility of the doctor once the right is assumed as the standard?
 - a) Is there a range of choices available to the doctor?
 - b) What are the conditions in which the choice of the doctor is made?

A) Self Determination/Positive Liberal Autonomy

An ‘unfair pastiche’ of Liberty describes that of ‘self-determination’;⁸⁸ A Millian concept, unshackled from the complementary harm principle, which otherwise brings autonomy beneath some societal considerations.⁸⁹ By recognizing the patient as the master of their body, one can vindicate their positive liberal autonomy.⁹⁰ This necessitates an air of value pluralism, whereby the patient irrespective of any objective justification for their decision might have the final say.⁹¹ This is roundly criticised for its deference to a binary consideration of capacity and its reliance on the recognized doctrine of consent; where one has the capacity, the rules that determine when one has consented dictates whether autonomy has been secured.⁹²

1) Are there mitigating circumstances to this choice so as to accrue moral credit?

83 Ibid [90]

84 Ibid [87]

85 Alasdair Maclean ‘Magic Myths and Fairy Tales: Consent and the Relationship between Law and Ethics’ in Freeman (ed), *Law and Bio Ethics: Current Legal Issues Volume 2* (OUP, Oxford 2008) [113]

86 Ibid

87 That which falls within existing obligations accrues institutional credit.

88 Charles Foster ‘Autonomy in The Medico-Legal Courtroom: A Principle Fit for Purpose?’ [2014] *MLR* 48, 50

89 Ibid

90 John Coggon ‘Autonomy, liberty and Medical Decision Making’ [2011] *CLJ* 523, 535

91 Ibid 523, 543

92 Foster (no 88) 48, 58

The difficulties faced in choosing to pursue the right are minimal. Disclosing information itself can be considered a mitigating circumstance. Deference to consent, to allow informed decision making, poses its own difficulties. A doctor must have an awareness of the desire of the patient, and be willing to disclose information until that patient is satisfied to decide.

2) Are these circumstances normatively encapsulated within the existing obligations of the doctor?

The disclosure of information is broadly institutionally recognized. As there is no definite ‘particularized’ field of information required, a standard form based on the facts of the injury or medical condition would be applied.⁹³ Awareness renders the doctor instrumental to the patient’s wishes. The doctor can only obtain institutional credit; seeking to manifest a choice of the patient without pursuing their full understanding, whether or not this is achievable, is not pursuing a patient’s right, but their consent.⁹⁴

3) Do these circumstances occlude responsibility of the doctor once the right is assumed as the standard?

a) Is there a range of choices available to the doctor?

There is no obligation on the doctor to challenge the decision of the patient to consent, or to understand the patient’s reason for consenting. This is true even where the doctor may know a risk or alternative treatment that may change the patient’s decision. A range of decisions is not occluded; as doctoral discretion is determinative of materiality.

b) What are the conditions in which the choice of the doctor is made?

A requirement to merely provide mutual awareness sees a limited quality of information disclosed. Due to mutual awareness, there are two possible amounts of information that will be required. First, the doctor may seek to disclose all possible treatments, options and alternatives as a hollow materiality requirement paints everything as significant. The informational burden fully occludes a doctor’s moral responsibility, irrespective of liability, and thus cannot be justified to the doctor. Alternatively, and much more likely, the doctor will defer to existing mechanisms of informed consent acquisition through a standard form. The notion of an underpinning right, as illustrated above, comes to a vanishing point, and cannot be justified to the patient.

B) Kantian Prudential Reasoning

93 GMC (no 8) [49] – [50]

94 Montgomery (no 1) (Lady Hale) [108]

Taylor sets two core requirements that constitute his conception of Kantian autonomy.⁹⁵ First, that it is ultimately motivated by pure practical reason, which in turn is motivated by universal objective reasons.⁹⁶ Secondly, that scope exists for subjectivity and self-authorship within pursuit of the objective good.⁹⁷

Imperfect duties of virtue require particular actions and omissions to attain the particular end, allowing 'latitude', or in a sense, choice. Twin imperfect duties of virtue, namely self-perfection and beneficence, satisfy this requirement.⁹⁸ There is no necessary external impact, and the moral ends both pursue are universal, objective goods.⁹⁹ As with mathematical formulae, these are proffered to be discoverable facts, and are conclusions that will inexorably be reached by all.¹⁰⁰ Thus the first criterion is satisfied. Self-perfection requires development of the patient's natural capacities, whilst Beneficence requires the patient to further the ends of the doctor. It allows the agent to choose how and to what extent both are met, thus satisfying the second, subjectivity criterion.¹⁰¹ This is to be distinguished from 'pure phenomenon' in instilling personal desires and choices with moral significance.¹⁰²

1) Are there mitigating circumstances to this choice so as to accrue moral credit?

Two major difficulties arise in the attempt to satisfy the right of the patient. The doctor is required to enter into a dialogue to ascertain the life-plan of that particular patient. Secondly, the doctor is forced to identify which information is likely to further the capacity of the patient, thereby enabling their attempt at self-perfection.

2) Are these circumstances normatively encapsulated within the existing obligations of the doctor?

This goes far beyond the initial requirements of the doctor.¹⁰³ Extensive dialogue is required to first ensure that the doctor understands the patient's life plan, and secondly to secure that the patient fully understands the treatments proposed.

3) Do these circumstances occlude responsibility of the doctor once the right is assumed as the standard?

a) Is there a range of choices available to the doctor?

95 Robert Taylor 'Kantian Personal Autonomy' [2005] Political Theory, Vol. 33, No. 5 602, 611-612

96 Ibid

97 Ibid

98 Ibid 613

99 Ian Brassington, 'The Concept of Autonomy and Its Role in Kantian Ethics' (2012) 21 CQHE, 166, 168

100 Ibid

101 Taylor (no 95) 614

102 Brassington (no 99) 171

103 Montgomery (no 1) [87]

The two difficulties cannot be resolved without fully compromising the moral responsibility of the doctor. The objective nature of the overarching concepts is circumstantially capable of occluding a range of choice. One is forced to abide the moral force of the patient's decision insofar as the subjective elements involved are immediately and transparently presented (thus rendering it objective).

b) What are the conditions in which the doctor's choice is made?

The information requirement is far too onerous. A life-plan is all encompassing, and touches all possible treatments and alternatives doctor can conceive. This cannot be justified to the patient, whose end may never reasonably be met, nor can it be justified to the doctor whom may be held liable in spite of the enormity of the task. Furthermore, a true understanding of the broader implications of each treatment on said life plan, necessary to increase the 'capacities' of every patient, can never truly be achieved. It requires absolute empathy on the doctor's behalf, to fully understand not just what a patient might feel, but what that particular agent might consider significant in light of that.

Finally, the most troubling aspect arises. The nature of the dual notions of beneficence and self-perfection only demands objective imperfect duties of virtue to be present in some minimal capacity.¹⁰⁴ Thus, a patient is incapable of deferring entirely the doctor in an autonomous fashion due to minimal beneficence, and incapable of autonomously acting counter to the life plan, once a life plan is established in the mind of the doctor. These are not uncommon scenarios, whereby agitation and indecision are characteristics typical of a vulnerable patient.¹⁰⁵ Accordingly, this cannot be justified to that patient.

4) The Positive Case for Relational Autonomy

Relational autonomy is more a school of thought than a concrete notion.¹⁰⁶ It suffers its own ontology, struggling to meet the predictability of other forms of autonomy. Nonetheless, it appears a natural conclusion that in light in the principles of justice, a person is fundamentally relational.¹⁰⁷ Relational autonomy is an attempt to vindicate patient-centred care. Patient-cantered care admonishes relationality by grounding autonomy in a person's life.¹⁰⁸ It more broadly reflects the current GMC guidelines,¹⁰⁹

104 Taylor (no 95) 616, one must be 'minimally responsive' to those objective ends.

105 Rob Heywood and Kevin Williams 'Patient Perceptions On the Consent Process' [2008] 2 PN 102, 115. Disconnect between consent and information provision can generate seemingly inconsistent patient activity.

106 Andrea Westlund 'Rethinking Relational Autonomy' [2009] Hypatia Volume 24. No 4, 26

107 John Christman 'Relational Autonomy, Liberal Individualism, And The Social Constitution of Selves' [2003] IJPAT 143

108 Ibid

109 GMC (no 8) [7]- [8]

but goes beyond it by proposing, “shared decision making shaped by the whole structure of society.”¹¹⁰

Autonomy Skills and Objectivity

The process of ‘enabling’ is the key most element to the obligation of the doctor; it represents an almost symbiotic relationship whereby the doctor seeks to identify the goals of the patient, their values, their priorities, and take a decision backed by the patient, jointly.¹¹¹ Indeed, theories that assume moral principles or values possess validity independent of a person’s judgement are perfectionist.¹¹² This is demonstrably faulty in that it insulates that independent standard from the authentic and free choice to reject that standard.¹¹³ Relational autonomy can be said to necessarily support a plurality of values as with self-determination, but not in the same fashion. It supports a notion that any social dynamic is amenable to autonomous activity, making no such distinction of perfection.¹¹⁴

Instead, Christman argues that one is autonomous only when the conditions supporting one’s self-imposed, authentic standards are supplied.¹¹⁵ This is an attempt to extricate an agent’s ‘authenticity and self-imposition’ from the very conditions those qualities validate. A patient is capable of freely rejecting external standards, but is by Christman’s view, incapable of rejecting their own self-imposed and authentic standards once said standards are established.

A person remains tied to that static self-imposition for as long as they deal with other agents. This would render the doctor instrumental to the purposes of creating those conditions, while ignoring the patient’s capacity to change. What must be accepted is that an agent’s capacity is a function of their social environment.¹¹⁶ The self-impositions therefrom must be dynamic. Without this assumption, one would be incapable of acting autonomously if a patient’s self-imposed conditions disagreed with their environment.

Westland’s theory departs in talking of autonomy of ‘choice and action’ as opposed to the more liberal autonomous qualifier of ‘will’. Focus is placed on identifying the very moment this necessary self-imposition emerges; when in a dialogue with other agents.¹¹⁷ The self-imposed, authentic standard is grounded in some value on the part

110 C Ells and others ‘Relational Autonomy as an Essential Component of Patient-Centered Care’ [2011] IJFAB Vol.4 (No.2) 79, 86

111 Health Foundation ‘Patient Centred Care’ [2016] 6

112 Christman (no 107) 151

113 Ibid 152

114 Ibid 158-159

115 Ibid 158

116 Alistair Wardrope ‘Liberal Individualism, Relational Autonomy, And The Social Dimension of Respect’ [2015] IJFAB 38, 41

117 Westlund (no 106) 36

of the patient.¹¹⁸ When prepared to engage in dialogue, the patient is capable of adjusting their self-imposed standard, utilizing the critique of the doctor to defend or adjust the value on which the standard is based.¹¹⁹ This new social dynamic presented by dialogue is also capable of supporting a plurality of values. Mere criticality is however insufficient to challenge the patient's values. In order to fully invest the doctor in the autonomy of the patient, their duty must consider a means of ascribing legitimacy to any challenge they pose to the values of the patient.¹²⁰ The patient accepts 'self-responsibility' in this disposition,¹²¹ to adjust or maintain the value when legitimately challenged by critique.¹²²

The intervention must be 'relationally situated.' This means there must be clarity as to the purpose of the intervention and there must be mutual investment in the outcome or wider scheme for that information's use.¹²³ An intervention must also be 'contextually sensitive', so as to not provoke or upset the patient unreasonably, and to tailor an intervention in such a manner as to maximize understanding.¹²⁴ The product of a successful, legitimate challenge can be viewed as a means to rehabilitation; 'enabling' a patient to recognize their own limitations or irrationalities.¹²⁵ Árnason's proposal that the doctor's purpose is to 'restore patient functioning', accommodates not just physical illness, but a realization of the patient's 'goals;' that which can only be facilitated by dialogue.¹²⁶

Respect and Limitations

Adhering to a diachronic theory of respect entails that one should consider the autonomy of all individuals affected by a choice.¹²⁷ One should only argue that regard be had for the subsequent and contemporaneous patient's autonomy, not that one should seek to meet several instances of autonomy within one set of choices. Failing to do so compromises the duty to a particular patient at any given time.¹²⁸ This ensures that one seeks to change and adapt the conditions to each particular patient with regard to the relatively different conditions experienced by another patient. It should highlight an individual's right normatively and distinguish them from the doubtless to emerge 'general conditions' that threaten a homogenized approach to all patients of similar places in the social structure.¹²⁹ One can view the wider social impact on other agents

118 Ibid 37

119 This harnesses the power gap between the agents to the patient's benefit.

120 Westlund (no 106) 39

121 Montgomery (no 1) [81]

122 Westlund (no 106) 39

123 Ibid 40

124 Ibid

125 Health Foundation (no 111) Albeit more accurately described as 'rectifying weakness'.

126 Árnason (no 46)

127 Wardrope (no 116) 46

128 Ibid 57, to fail to do so compromises the 'consequential individualism' on which social respect norms are based.

129 Fails to abide 'relational situatedness' whereby a wider communitarian aim cannot be considered a legitimate challenge, as it would justify all interventions.

as being an extension of a patient's self-responsibility, and not a means for the doctor to engineer tensions or their own value commitments into the wider implications of their challenge.

Relational Autonomy can thus be described as:

'The right to social conditions that support an agent's critical development in relation to the conditions experienced by oneself and by other individuals.'

The Criteria

1) Are there mitigating circumstances to this choice so as to accrue moral credit?

The main difficulties facing the doctor are threefold. Firstly, identifying the initial priorities and conditions conducive to a patient's relational autonomy. Secondly, posing a legitimate challenge to the patient to instil critical development or trigger the sharing of responsibility. Thirdly, accounting for the effect that the altered conditions have on other patients, which triggers a re-identification of those agent's priorities.

2) Are these circumstances normatively encapsulated within the existing obligations of the doctor?

The mode of thinking employed goes beyond the existing GMC guidelines and legal standards.¹³⁰ It requires not awareness, but an interrogatory disposition which will vary in employment across different agents.

3) Do these circumstances occlude responsibility of the doctor once the right is assumed as the standard?

a) Is there a range of choices available to the doctor?

The doctor retains the minimum discretion necessary for their choice to hold moral weight in most circumstances. Even where the social conditions requisite for relational autonomy to be satisfied are so minimalistic that they could be said constitute no choice at all, a range of choices will still be supported. This is because a doctor can still choose to not utilize those conditions in a way that is critically stimulating, or legitimate.

Range will be occluded chiefly where it is impossible to create those social conditions required to support critical development. This will only be when such impossibility is immediately apparent to the doctor, as any effort undertaken to establish sufficiency of conditions presupposes a range of choice.

¹³⁰ GMC (no 8) [43] Doctors are told explicitly not to challenge a decision once made.

b) What are the conditions in which the doctor's choice was made?

Identifying the initial priorities requires the minimum of an agent engaging in a dialogue with the patient; they cannot be isolated.¹³¹ What is substantively uncovered is significant only in informing the doctor's advice to the patient. The quality and the amount of dialogue will differ from patient to patient. A patient that does not assume a dialogic disposition will fully occlude responsibility once the duty and standard reflect relational autonomy. What constitutes a legitimate challenge will be at a minimum of that already outlined.

Where a legitimate challenge is employed and the patient refuses to 'adjust their standard' through critical development, the patient will assume moral 'responsibility' for the outcome. The doctor cannot be held liable in light of this.

The effect of the challenge on other patients' autonomy may be far ranging. This necessitates a re-triggering of that initial dialogue and assessment with subsequent patients, and indeed that same patient.¹³² This is irrespective of existing knowledge or predictions, so as to necessitate a dialogue takes place. Meaningful dialogue is rendered conclusive of the duty, not the consequence of it.

5) Conclusion and Reforms

Montgomery represents regression, not consolidation. Adoption of the particular patient standard and a duty prioritizing relational autonomy is necessary to achieve 'Relational Justice.' Ideally, the duty of care should read:

'To take reasonable care to disclose risks or alternatives that a doctor could *reasonably discern from relational dialogue with a patient* as material.'

Consequently, Materiality should be established as:

'What the doctor is, or should reasonably be aware of through *relational dialogue* that the particular patient would attach significance to the risk.'

'Relational Dialogue' is to be understood as comprising the aims of relational autonomy, allowing the doctor to accrue moral credit lexically post factors affecting discussion. A broader defence of moral credit ought to exist until this standard is established. It subsumes the present one; a patient's mental health constitutes an inhibitory condition to choice, and therefore liability.¹³³ The new defence should read:

131 C Ells (no 110) 79, 82

132 Wardrope (no 116) 49

133 *Montgomery* (no 1) [88]

‘Where the doctor seeks to meet the right of the patient, but by inhibitory range or conditions cannot meet the standard, the doctor will not be liable.’

Legislative implementation is unlikely, as focus is on expanding available treatments.¹³⁴ Judicial support will be sparse when asked to depart the relative certainty of *Montgomery*. Necessarily, the present standard ought to be written into the legal annex of the 2008 GMC document on patient consent. The words ‘relational dialogue’ ought to be implied into this updated entry.¹³⁵ This serves to appropriately order the doctor’s and thereby the court’s analysis, allowing moral credit evidential force in absence of a defence.

134 Medical Innovation HL Bill (2015-16) 32
135 GMC (no 8) [33]- [40]