

# The Essex Autonomy Project



## CONSENT IN HISTORY, THEORY AND PRACTICE

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### *Introduction*

This report is a guide to consent and some of the key debates concerning its history, theory and use in practice. It touches upon a broad range of human activities and relationships in which consent features—from the political to sexual to economic—whilst focusing in particular on consent in health and social care. There are two main sections: firstly, a genealogy of consent, encompassing its history in the ancient, medieval and modern world; and secondly, a legal and philosophical account of consent in contemporary practice, including discussion of what kinds of information, competence and social relationships it requires and an account of various rationales for seeking consent.

### *The History of Consent*

At its simplest, to consent is to give permission or reach agreement for some activity to occur. Clearly, in this wide sense, consenting has always been part of human social life, predating more formal apparatus or conventions of consent, such as research participation forms, voting booths, or medical regulations. Nonetheless, grasping the manifold changes in how, why, and

for what consent has been sought from people is important if we are to understand what is distinctive about current practice and theory concerning consent. This report provides an aerial view of this history, spanning a number of kinds of consent and different domains where it became significant, rather than focusing upon a single context, such as medical or political consent. While this makes our story more complex, it helps reveal how changes in disparate consent practices foreshadow and impact one another.<sup>1</sup>

### *Originating and Permissive Consent*

An important distinction, which should help us navigate this history, identifies two main kinds of consent: originating and permissive. When it is permissive, consent acts as a waiver, ensuring that an act that would otherwise commit some wrong does not do so. For instance, when operating upon an ill but competent patient, the surgeon's actions can count as ethically and legally benign (instead of being invasive battery) in light of the permissive consent of the patient. Thus, in relation to background laws, rights, values or reasons, then consent can act as a *waiver*, legitimising actions that would otherwise count as wrongful. But consent can also be originating: introducing, altering and endorsing parts of this background itself. For

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<sup>1</sup> In narrating the history of consent, we have tried to avoid both anachronism and an overcautiously narrow history. If from the outset we adopt a stringent modern conception of what consent involves, the danger is that we shall be led to ignore many historical resources that prefigure and are able to illuminate our current practices. In this, we are wary of concluding with Robert Veatch that the "history of consent reveals that it is a relatively recent phenomena," even if contemporary consent practices take a distinctive form. Robert Veatch, 'Abandoning Informed Consent,' *Hastings Center Report* 25:2 (1995), p. 5. (Others who claim that consent is properly a very recent concept include N.W. Kour and A. Rauff, 'Informed Patient Consent—Historical Perspective and a Clinician's View,' *Singapore Medical Journal* 33 (1992), pp. 44-6; and P. Nelson-Marten and B.A. Rich, 'A Historical Perspective of Informed Consent in Clinical Practice and Research,' *Seminars in Oncology Nursing* 15 (1999), pp. 81-8.)

But equally, it is important that we not too readily suppose that the texts and practices of the past must directly reflect or speak to contemporary attitudes to consent. For although consent is the notion guiding *our* inquiry, it would be anachronistic to frame much of the history we are concerned with as a self-conscious contribution to a tradition which attempts to articulate, develop, champion or oppose any such enduring idea. Indeed, we often learn most from the past when we see how it remains somewhat alien to us, rather than being readily assimilable to modern attitudes. In short, the goal is to combine historical sensitivity with an account that will retain contemporary relevance. For more on this perennial problem in the history of ideas, see the salutary remarks in Quentin Skinner, 'Meaning and Understanding in the History of Ideas,' *History and Theory* 8:1 (1969), pp. 3-53.

instance, we might think that the authority of a state's statute law originates in the consent of its citizens, or that new ethical and legal rights and responsibilities associated with the social role of being married are grounded in the consent of those marrying. In sum, permissive consent legitimises specific actions in relation to some background norms, whereas originating consent can confer or withdraw legitimacy from some of these norms themselves. During the historical discussion to follow, we shall range over both permissive and originating consent, since they remain mutually illuminating, before concentrating on the permissive consent integral to much contemporary professional practice.<sup>2</sup>

### *The Ancient World*

Consent, in its now-familiar forms, was less integral to the medical practice, politics and law of most ancient societies than it is taken to be in the majority of places today. But nascent kinds of consent – albeit often communal and recognised as having more *de facto* than *de jure* authority – were by no means absent. Despite widespread relations of domination, from imperialism to deep-seated patriarchy, consent-seeking begins to take a hold in relation to a number of activities. This section addresses some of this fractious early history of consent in civil law, medicine and politics, starting with some religious roots of the notion.

Amongst early religious texts, one significant episode foregrounding consent is the Biblical story of the covenant between Yahweh and the Israelites established at Mount Sinai.<sup>3</sup>

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<sup>2</sup> Our historical survey also straddles another important distinction, which it may help to flag from the outset, namely between implicit and explicit consent. Thus, we shall examine consent that is tacitly as well as expressly given, rather than merely focusing upon the sort of clearly articulated consent that comes out of formal agreements or institutionalised consent procedures. Explicit consent, whether that is signing a contract of employment, or dropping a ballot ball into an urn, is only one kind; and in some circumstances, implicit consent, such as rolling up your sleeve for an injection, or ordering from the restaurant menu without first agreeing a price with the waiter, can be more appropriate.

<sup>3</sup> Yahweh tells the Israelites, “if you obey me fully and keep my covenant, then out of all nations you will be my treasured possession,” and when Moses gives this message to the elders, “the people all responded together, ‘We will do everything the LORD has said.’” See Exodus 19:5-8 (New International Version).

Commentators have claimed that the Jewish people are depicted as affirming divine authority in entering this covenant.<sup>4</sup> Whereas divine commands had previously only been promulgated to them, consent is now sought and given for some new aspect to the Israelites' relationship to Yahweh.<sup>5</sup>

In the vocabulary set out above, the Mosaic covenant involves originating consent. This consent alters the character of the authority held over the Israelites because they *bind themselves* to religious laws rather than simply respecting or yielding to them. Admittedly, we are still far from individual consent as conceived in the modern liberal tradition. The Jews give collective rather than individual consent, which Moses secures only through consulting with the elders as representatives of the people. Furthermore, although God asks for the Jews' agreement to the covenant, and they continue to reaffirm it, there is clearly no scope for negotiation over its terms or the limits of divine sovereignty. Nevertheless, this account signals an important recognition that consent can legitimate authority in a distinctive fashion.<sup>6</sup>

Originating consent also features in other areas of ancient life, albeit most often heavily circumscribed. Take consent to political authority, for example. In Mesopotamia, India and Sparta, the use of popular assemblies balanced monarchical power; and, more radically, Cleisthenes' reforms of 507 BCE introduced direct democracy to Athens. Yet, even in the

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<sup>4</sup> See David Johnston, 'A History of Consent in Western Thought,' *The Ethics of Consent: Theory and Practice*, F. Miller and A. Wertheimer (eds.)(Oxford: Oxford University Press, 2009), 26. Kenneth Seeskin provides a more extended account of the place of autonomy with respect to the relation between God and the Israelites in the Biblical narrative, arguing that it is "the foundation of a moral tradition that upholds freedom and the importance of agreement by mutual consent. Briefly put, God in not Pharaoh. Rather than impose positive law on people who have no choice but to accept it, God asks Israel to commit itself to a law that represents the highest expression of its own convictions." *Autonomy in Jewish Philosophy* (Cambridge: Cambridge University Press, 2001), 29.

<sup>5</sup> This covenant is subsequently reaffirmed instead of being an isolated episode. For instance, see Deuteronomy 29:12-5 (New International Version): "You are standing here in order to enter into a covenant with the LORD your God, a covenant the LORD is making with you this day and sealing with an oath, to confirm you this day as his people, that he may be your God as he promised you and as he swore to your fathers, Abraham, Isaac and Jacob."

<sup>6</sup> For a modern bioethical account of consent which employs the concept of covenant, see Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), 5, 37.

highly unusual Athenian situation, where the consent of the governed came to perform an integral function in establishing political legitimacy, there were some serious limits upon this principle. The clear majority of people were disenfranchised, with slavery rife, women marginalised, citizenship typically denied to those with non-Athenian parentage, and all these groups excluded from political participation. Thus, only the consent of the few mattered.

The intellectual climate was similarly mixed. Aristotle singles out what he sees as the “most important principle – to ensure that the number of those who wish the constitution to be maintained is greater than that of those who do not,” but this is primarily for pragmatic reasons of political stability rather than legitimacy.<sup>7</sup> Aristotle’s mentor Plato was even less receptive to the need for political consent. For him, the function of political community was educative: political institutions should shape the populace rather than be shaped by it. Authority was to reside with the wise, who acted on the independent demands of justice, rather than legitimacy flowing from the consent of the people.

Greek society remained ambivalent regarding originating consent in politics and political theory, and these tensions are mirrored in attitudes towards permissive consent in medical practice. For instance, the works of the *Corpus Hippocraticum* advocate beneficence as the guiding value for physicians without discussing the consent of patients.<sup>8</sup> This suggests that consent was a marginal issue for Hippocratic doctors, though it does not prove that it was not typically sought. In their advice on disclosing information, the Hippocratic texts reinforce

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<sup>7</sup> Aristotle, *The Politics*, trans. T.A. Sinclair and revised by T.J. Saunders (London: Penguin, 1981), bk. V ch. ix (1309b). He also places a similar emphasis upon voluntary commercial exchange as something that binds the *polis*, but insofar as he connects this form of reciprocity with justice, there seems to be a more sanguine view here about the normative significance of consensual relations. See Aristotle, *Nicomachean Ethics*, trans. C. Rowe (Oxford: Oxford University Press, 2002), bk. V ch. v (1132b20).

<sup>8</sup> For further discussion, see Ruth Faden and Thomas Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986), 60-3.

this sense that consent is peripheral, recommending “concealing most things from the patient, while you are attending to him.”<sup>9</sup>

The Hippocratic approach to medicine was only one amongst many, and, despite its later prominence, it is unclear how widespread it was in ancient Greece. Other approaches to the role of physicians were rather more liberal when it came to patient choice and less keyed to beneficence. For example, although forbidden by Hippocratic principles, some doctors did help people commit suicide.<sup>10</sup> So too, Plato’s texts describe a Greek practice of attempting to impart details of diagnoses and solicit consent in some medical treatments of free men.<sup>11</sup> But systematic concern with informing, enabling and respecting patient decision-making is not in evidence.

Civil law was more fertile ground for a recognisable conception of individual consent. In particular, Roman law of contract provided a sophisticated set of tools enabling consensual agreements to be made legally enforceable.<sup>12</sup> One advantage of the Roman legal apparatus was that it allowed for highly flexible consensual arrangements to be formalised in contract. But even more importantly, it also established common conditions for informal contracts, such as sales. David Johnston outlines the significance of the guarantees and efficiencies this brought with it:

the consensual contract of sale, which was governed by standardized terms [...] was crucial to the development of commerce on a large scale and, more generally, to the development of a society in which it gradually became the norm for rights and obligations to be created and transferred via consensual transactions.<sup>13</sup>

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<sup>9</sup> Selections from the Hippocratic Corpus, *Decorum*, XVI, in W.H.S. Jones, trans., *Hippocrates*, 4 vols (Cambridge, Mass.: Harvard University Press, 1923-31), 2:297 quoted in Faden and Beauchamp, *A History and Theory of Informed Consent*, 61 .

<sup>10</sup> Faden and Beauchamp, *A History and Theory of Informed Consent*, 62.

<sup>11</sup> On this, see P. Dalla-Vorgia, J. Lascaratos, P. Skiadas and T. Garanis-Papadatos, ‘Is Consent in Medicine a Concept Only of Modern Times?’ *Journal of Medical Ethics* 27: 1 (2001), 59–61.

<sup>12</sup> See the excellent discussion in Johnston, ‘A History of Consent in Western Thought,’ 39-41.

<sup>13</sup> *ibid.* 41.

After the fall of the Western empire, there was a waning of the influence of the Roman system of contract law, along with the confidence in individual consent in the civic sphere which it expressed. But the attitude towards consent expressed by the Roman jurists has had a long afterlife, resurfacing through their influence on later thinkers and institutions, particularly in canon law.<sup>14</sup>

Consent, as we have seen, does sometimes feature in ancient religion, politics, medicine and law. But, on the whole, features common to ancient societies militated against it achieving the ubiquity it now has. For instance, the close-knit communities of classical antiquity, with their more heavily circumscribed sets of social roles and expectations than most modern societies, were thereby less hospitable to the ideal of universal self-determination. In contrast to liberal modernity, no great weight was given to personal autonomy, a protected private sphere, or respect for individual deliberation for its own sake. Only when dealing with the powerful is consent likely to appear upon the horizon: the collective consent of the citizenry becomes significant when they can topple the current political regime; and the permissive consent of the patient becomes important when he can see that the doctor goes without pay. Nevertheless, we have seen traces of the idea that voluntary agreement can confer kinds of legitimacy, and these begin to lay the groundwork for later, more radical conceptions of the relation between consent and authority.

### *Middle Ages*

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<sup>14</sup> For instance, this influence is especially pronounced on canonists of the so-called twelfth century renaissance, and subsequently the tradition of civic republicanism. For a broader account of the impact of Roman thought on modern conceptions of freedom, see Quentin Skinner, *Liberty Before Liberalism* (Cambridge: Cambridge University Press, 1997).

Christianity was the reigning intellectual influence upon much European medieval thought, and this remains true of attitudes towards consent. We can see this particularly clearly with regards to political authority. At the end of the fourth century, Augustine had a theological conception of such authority, which took the institution of the state to be legitimate insofar as it embodies the divinely ordained natural order (*ordo naturalis*). Fundamentally, political governance for Augustine is “control of the wicked within the bounds of a certain earthly peace,” which arises due to a need to keep our sinfulness in check.<sup>15</sup> Neither the individual nor collective will of citizens grants the state its power to coerce, but rather the divine intellect. Some eight centuries later, that other towering figure of medieval Christian thought, Thomas Aquinas, can be found supporting a similar conclusion.<sup>16</sup> Thomas takes the government of just rulers to be legitimated by the natural law, which has divine origin, and not the consent of the governed. Admittedly, he does go further than Augustine when in the *Summa* he gives a limited role to popular consent, through advocating electing leaders from the populace at large alongside the monarch and the aristocracy.<sup>17</sup> However, this is foremost a pragmatic recommendation, which safeguards against tyrannous rule, rather than an attempt to champion consensual self-determination for its own sake.

The theocratic visions of political authority found in Augustine and Thomas, which deny an crucial place to consenting citizens, does not however completely dominate the medieval landscape.<sup>18</sup> Duns Scotus, for example, claims that political authority stems from “the common consent and election of the community,” whether that consent be directed towards

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<sup>15</sup> *De Genesi ad Litteram* 9.9.14 quoted in Robert Markus, *Saeculum: History and Society in the Theology of St. Augustine* (Cambridge: Cambridge university Press, 1970), 96.

<sup>16</sup> For commentary on his discussion of consent as it relates to agency more broadly, see Judith Barad, ‘Aquinas on Faith and the Consent/Assent Distinction,’ *Journal of the History of Philosophy* 24: 3 (1986), 311-321.

<sup>17</sup> Thomas Aquinas, *Summa Theologiae*, 1-2, q. 105, a. 1. For an open-access edition, see *The Summa Theologica of St. Thomas Aquinas* trans. Fathers of the English Dominican Province (1920) [Available: <http://www.newadvent.org/summa/>]

<sup>18</sup> For a brief survey of competing medieval positions, see Brian Tierney, ‘Hierarchy, Consent, and the “Western Tradition,”’ *Political Theory* 15:4 (1987), 646-652.

an hereditary monarch or held in a democracy.<sup>19</sup> Similarly, his early fourteenth century contemporary Herveus Natalis also emphasised political consent. He took it that the authority of rulers to oblige their subjects must come, “only through consent of the people,” since violence cannot establish a right, and yet presents the only other potential source of obligation.<sup>20</sup> Thus, we find conflicting currents of thought concerning the significance of originating political consent, and we shall see how these debates come to a head in violent revolutionary struggles in later centuries.

No one-sided picture emerges of medical practice either. Paternalism is voiced by physicians such as Henri de Mondeville, in the late thirteenth century, who states that “patients [...] should obey their surgeons implicitly in everything appertaining to their cure.”<sup>21</sup> He has no compunction in recommending that, in the service of recovery, doctors lie about the rosy prospects for their patient; and this hardly provides a promising basis for consensual interaction. While he does caution about coerced treatment, this is rooted primarily in reputational worries and concern for the effectiveness of treatments so administered.<sup>22</sup>

Despite this seeming ethical indifference to medical consent, there are points when it gets put to familiar uses. We can see this through looking to a recurring nascent consent ritual, which was devised by doctors as a means to protect themselves from undue sanction. The first record of its use is in the late sixth century, when Byzantine physicians were hesitant to operate on the gravely ill Emperor Justin II lest they be held responsible for his death. Although he promised that they would not be punished, they reportedly asked that the

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<sup>19</sup> John Duns Scotus, ‘Opus Oxoniense’ in *Opera Omnia* (Paris: L. Vives, 1895), IV, d. 15, q. 2, n. 6.

<sup>20</sup> Herveus Natalis, *De Iurisdictione*, L. Hodl (ed.) (Munich: M. Hueber, 1959), 15 quoted in Tierney, ‘Hierarchy, Consent and the “Western Tradition,”’ 649.

<sup>21</sup> Henri de Mondeville, ‘On the Morals and Etiquette of Surgeons,’ as entitled and reprinted in S.J. Reiser, A.J. Dyck, and W. J. Curran (eds.), *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (Cambridge, MA: MIT Press, 1977), 15 quoted in Faden and Beauchamp, *A History and Theory of Informed Consent*, 63.

<sup>22</sup> We might think that coercion being a threat to the doctor’s reputation is itself indicative of wider ethical unease about non-consensual treatment, but this remains speculation.

Emperor personally hand them the scalpel as an explicit sign of his willingness to be operated upon.<sup>23</sup> In contemporary medicine, consent has been said to be a ‘flak jacket’ for liability, and foreshadowing this later function, consent here acts as a hauberk of sorts, which aims to protect the consent-seeker and not simply consent-giver.<sup>24</sup>

Church marital law of the High Middle Ages provides us with an even clearer demonstration that consent was becoming an important civic notion. Papal reforms begun in the twelfth century made the free consent of bride and bridegroom both necessary and sufficient conditions for marriage (barring clear impediments like consanguinity and bigamy). Before this, oftentimes the family, master and even feudal lord of the married couple were parties to the marriage. William of Pagula outlines the new conditions:

Marriage is contracted by consent alone (*solo consensu*) through words in the present tense, as when a man says: ‘I take you to be my wife,’ or the woman says: ‘I take you to be my man or husband.’<sup>25</sup>

Thus, on the reformed conception of marriage, not even a priest or religious ritual are required, but simply consent.<sup>26</sup> To be authoritative, this consent had to be freely given, and the Church was far from toothless in ensuring this. Besides annulment, there was the threat of withdrawing sacraments from those impeding or compelling another’s consent, such that “a

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<sup>23</sup> This account is provided by John of Ephesus, *Historia Ecclesiastica, Volume III* (Louvain: E W Brooks, 1964), 91-6.

<sup>24</sup> Significantly, this scalpel-handing ritual is recorded numerous times in the following centuries, and not merely for powerful patients. Indeed, it is so widespread as to attract criticism from the author of *Miracles of St Artemios* for allowing surgeons to disclaim responsibility for their mistakes. For more on this consent ritual, see Dalla-Vorgia et al., ‘Is Consent in Medicine a Concept Only of Modern Times?’, 60.

<sup>25</sup> William Paull, *Oculus Sacerdotis*, MS BL Royal 8. B. XV, fo. 141 quoted in David d’Avray, *Medieval Marriage: Symbolism and Society* (Oxford: Oxford University Press, 2005), 130.

<sup>26</sup> We should note that much of the impetus for placing free consent at the heart of marriage was to shore up its status as indissoluble: because you have freely consented to this relationship, then you have bound yourself to it in perpetuity. For more on this, see d’Avray, *Medieval Marriage*, ch. 2. In short, consenting forsakes the right to future objection. Thus, for marriage so understood, the authority of consent is limited along another dimension, since mutual consent cannot be a sufficient condition of divorce (as it was in classical Roman law).

father, for example, might be denied absolution on his deathbed if his will disinherited a daughter refusing to marry as he directed.”<sup>27</sup>

Consent’s increased importance within social institutions such as marriage reflected broader cultural changes in the twelfth and late eleventh centuries, which some scholars have called ‘the discovery of the individual.’<sup>28</sup> For instance, there is a burgeoning interest in psychological inner life, and the ethical significance of a person’s intentions and emotions as opposed to merely their acts alone.<sup>29</sup> Furthermore, with “the shift from subject to citizen,” the individual acquires firmer legal and political status.<sup>30</sup> Individuality’s exalted place in modernity, which provided such a fertile environment for individual consent to take root, owes much to these developments and their later intensification throughout periods such as the Italian Renaissance of the fifteenth century.<sup>31</sup>

### *Modernity*

The modern political landscape has been transformed by demands for popular sovereignty understood in terms of the consent of the governed. The English Civil War of the mid-

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<sup>27</sup> John Noonan, ‘Power to Choose,’ *Viator* 4 (1973), 434.

<sup>28</sup> For instance, see the classic study of the same name: Colin Morris, *The Discovery of the Individual 1050-1200* (Toronto: University of Toronto Press, 1972). The extent of the novelty of developments in this period has been disputed, and a survey of the relevant debates can be found in Leidulf Melve, “‘The Revolt of the Medievalists.’” *Directions in Recent Research on the Twelfth-Century Renaissance*, *Journal of Medieval History* 32:3 (2006), pp. 231-252.

<sup>29</sup> Peter Abelard is the most important figure in effecting the later change. See his ‘Ethics’ in *Ethical Writings* trans. Paul Vincent Spade (Indiana: Hackett Publishing, 1995).

<sup>30</sup> Other developments in this rise of individuality are those in art, where there is “the emergence of the individual both as author and as hero of twelfth-century poetry and romance;” and regarding religious life and interiority, with “a new concern with self-discovery and psychological self-examination, an increased sensitivity to the boundary between self and other, and an optimism about the capacity of the individual for achievement.” Caroline Walker Bynum, ‘Did the Twelfth Century Discover the Individual?’ *Jesus as Mother: Studies in the Spirituality of the High Middle Ages* (Berkeley: University of California Press, 1982), 83. Bynum also notes an important difference that separates this time from modern celebrations of individuality: whereas we now tend to think of individuals as unique, and that this constitutes much of their value, those in the twelfth century generally regard individuals as essentially the same, since they were thought to be made in the image of God.

<sup>31</sup> We should sound a cautionary note here, underlining the continued importance of strong social ties in both the twelfth and fifteenth century Europe, which would have been far from the atomised liberal societies of late capitalism. For more on the former, see ‘Did the Twelfth Century Discover the Individual?’ 85f. and for more on the latter, see William J. Connell (ed.), *Society and Individual in Renaissance Florence* (Berkeley: University of California Press, 2002).

seventeenth century illustrates the growing reaction to autocratic rule, counterposing the divine right of kings with the authority of a parliament based upon popular custom and consent. Sir Edward Coke put the case early and directly in a 1621 speech in parliament:

When the kinge sayes he can not allowe our liberties of right, this strikes at the roote. Wee serve here for thousands and tenn thousands.<sup>32</sup>

But even the influential monarchist arguments of Thomas Hobbes accept that sovereign authority derives from a covenant based upon the individual consent of each man.<sup>33</sup> Hobbes simply recommends monarchy as the best outcome of such a covenant.<sup>34</sup>

The American Revolutionary War also shows how political consent is coming to occupy centre stage. The *Declaration of Independence* makes direct reference to consent, stating: “Governments are instituted among Men, deriving their just powers from the consent of the governed.” John Locke’s arguments concerning consent in his *Two Treatises of Government* likely influenced the document.<sup>35</sup> In particular, against Hobbes, his defence of a right to revolution under conditions where a government has broken its consensual contract with the people would have been attractive to the colonists. Despite Locke being bolder than Hobbes on this count, they both agree that government by consent, based upon a social contract, is compatible with monarchy and other undemocratic political forms.

Contemporary liberal states do rest upon representative democracy, whereby individual consent is taken to legitimate political institutions, primarily through the election of political officeholders. Limits to the authority consent can bestow are usually fixed by a set of

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<sup>32</sup> Wallace Notestein, Frances Relf and Hartley Simpson (eds.), *Commons Debates, 1621* (New Haven: Yale University Press, 1935), V, 240 quoted in Charles Howard McIlwain, *Constitutionalism: Ancient and Modern* (Ithaca: Cornell University Press, 1940), 116.

<sup>33</sup> Thomas Hobbes, *Leviathan: The Matter, Forme and Power of a Common Wealth Ecclesiasticall and Civil*, Richard Tuck (ed.) (Cambridge: Cambridge University Press, 1990 [1651]).

<sup>34</sup> This is both striking and symptomatic in two respects: firstly, consent has supplanted the divine right of kings in the arguments of an advocate of absolute monarchy, and not merely an opponent of it; and furthermore, this consent is thought as individual rather than granted by an estate or whole segment of society. Originating consent, as it recognisable in contemporary political theory and practice, begins to take form here.

<sup>35</sup> John Locke, *Two Treatises of Government* (Cambridge: Cambridge University Press, 1988 [1689]).

inalienable rights of citizens, enshrined in the state's constitution, which cannot be overturned merely by the will of the majority. Critics of consent-based representative democracy, such as Jean-Jacques Rousseau and Karl Marx, have argued that it wrongly presupposes that a people can alienate and divide their sovereignty.<sup>36</sup> In other words, they claim it is mistaken to think that individuals, by their consent, can transfer their collective authority over their lives to others meant to represent them.<sup>37</sup> Despite this suspicion of parliamentarianism, the broader principle that popular consent is the source of political legitimacy has become firmly entrenched in the domestic political cultures of most developed capitalist nations.

The rise of originating consent in politics has been accompanied by permissive consent becoming more widespread and formalised in civil matters. In English medical law, one significant case was *Slater v. Baker and Stapleton* in 1767, where surgeons reset a femoral fracture (in an experimental device) without the patient's consent and without giving him sufficient prior warning.<sup>38</sup> Since it was customary amongst physicians to obtain consent, then the judge ruled that in failing to do so then the surgeons were remiss.<sup>39</sup> Informed consent meeting contemporary standards was not demanded, only that a patient be told of the procedure so they could "take courage," but it is significant that the courts recognised that

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<sup>36</sup> Jean-Jacques Rousseau, 'On The Social Contract,' in *Basic Political Writings* trans. Donald A. Cress (Indianapolis: Hackett Publishing, 1987), 2.I-II, 153-5.

<sup>37</sup> Contemporary critics of modern parliamentary democracy have also focussed upon consent as a mechanism for abrogating political authority to representatives. For instance, Peter Hallward has recently recommended that we think of the popular will as "a matter of material power and active empowerment, before it is a matter of representation, authority or legitimacy." Peter Hallward, 'The Will of the People: Notes Towards A Dialectical Voluntarism,' *Radical Philosophy* 155 (2009), 22. More radically still, Alain Badiou has criticised the formalism of political regimes of individual consent: "I must tell you I absolutely do not respect universal suffrage in itself; it depends on what it does."<sup>37</sup> Alain Badiou, *The Meaning of Sarkozy*, trans. David Fernbach (London: Verso, 2008), 32.

<sup>38</sup> *Slater v Baker & Stapleton* 95 Eng. 860, 2 Wils. KB 359 (1767).

<sup>39</sup> This appeal to professional standards, in looking to customary practice, is echoed in the so-called 'Bolam test,' which requires skilled practitioners to meet the requirements of a responsible body of professional opinion. See *Bolam v Friern Hospital Management Committee* 1 WLR 583 (1957) and for its application to consent, see *Sidaway v Bethlem Royal Hospital Governors* AC 871 (1985). We shall return to Bolam later in the report.

some legal duties to respect treatment decisions were imposed by the established practice of seeking medical consent.<sup>40</sup>

Mental illness met with another approach; and through the early modern period, non-consensual detention and treatment was not typically taken to present a legal or ethical difficulty. Domestic care and confinement was commonplace, as it had been for millennia, and many others found themselves in prison or the workhouse, with there being only very limited provision for the mentally ill from some religious institutions throughout Europe.<sup>41</sup> In England, public financing of institutions introduced in 1808 led to a steady increase in patients, though private institutions, which had been operating since the Restoration, remained more populous into the mid-century.<sup>42</sup>

Asylum practices varied, with mechanical restraints being widespread until the 1840s, when a non-restraint movement blossomed, and the Lunacy Commission was mandated to conduct inspections requiring each use to be recorded and a rationale given. Medication without consent then became the so-called 'sheet anchor' for subduing disruptive patients, and arguably presented little or no advance, since the extensive use of powerful sedatives, such as opium, chloroform, ether and bromide, could be equally debilitating, shackling the mind and not merely the body.<sup>43</sup>

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<sup>40</sup> *Slater v Baker & Stapleton*, 362. For scepticism about the legal importance of this case, see Beauchamp and Faden, *A History and Theory of Informed Consent*, 116.

<sup>41</sup> On early modern history of confinement for madness, see Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), ch.5 and *Mind-For'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Penguin, 1987).

<sup>42</sup> For a magisterial study of consent in British psychiatric practice from this period onwards, see Phil Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1845* (London: Routledge, 1996).

<sup>43</sup> Physical restraint and seclusion did not simply disappear. Towards the end of the nineteenth-century, dissatisfaction with the side-effects and addictive properties of these sedatives prompted a return to forms of physical management of behaviour, such as 'wet packing' patients in sheets. However, concerns about abuses, arising from the knotty relation between punitive, custodial and therapeutic use of these techniques, removed them from the discretion of orderlies and required medical supervision for them. Now that they were understood as medical treatments, grounded in the authority of psychiatric expertise, then the effect was to legitimise them in the eyes of society at large despite their non-consensual application.

While forced medication was predominantly left to psychiatric discretion, procedures for detention and certification were formalised by the end of the 1880s, establishing legal oversight, based upon medical evidence, for non-consensual admittance to mental institutions. However, it was not until the Mental Health Act 1983 that conditions for psychiatric treatment without consent were clearly distinguished from those for detention.<sup>44</sup> But these conditions remain relatively weak, such that “consent of a patient shall not be required for any treatment given to him for the mental disorder from which he is suffering,” with the exception of psychosurgery and electroconvulsive therapy.<sup>45</sup> Furthermore, the Mental Capacity Act 2005 now also allows non-consensual treatment, on grounds of best interest, of those with ‘a disturbance of the mind or brain’ that seriously impairs their decision-making capacities.<sup>46</sup>

Research ethics, even more than medical and psychiatric issues, was the main driver of interest in consent in the twentieth century, primarily because of horrific abuses in human subjects research. Clinical research is often traced back to James Lind’s experiments to test scurvy remedies on British sailors in 1747, for which, from the little we know about it, there is no indication of consent-seeking.<sup>47</sup> Although concern with the consent of research participants was not totally absent prior to the last century, it was never sustained.<sup>48</sup> The first significant attempts to regulate consent in research appear in the early thirties in American

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<sup>44</sup> Compare parts II and IV of the Act on admission and consent to treatment. The distinction was also made in U.S. case law: see *Rennie v Klein* (1978) 462 F.Supp. 1131 (D.N.J); *Rogers v Okin* (1979) 478 F.Supp. 1342 (D.Mass); and *Rivers v Katz* (1986) 495 NE2d 337.

<sup>45</sup> See para.64 of the Act.

<sup>46</sup> We shall revisit the Mental Capacity Act in some detail below.

<sup>47</sup> Graham Sutton, ‘Putrid gums and ‘Dead Men’s Cloaths’: James Lind aboard the Salisbury,’ *Journal of the Royal Society of Medicine* (2003) 96, 605-8

<sup>48</sup> For what scant traces of it there is to be found, see Beauchamp and Faden, *A History and Theory of Informed Consent*, 152-3.

case law and the strict *Richtlinien* issued by Germany's Department of Health in 1931, both of which established a need for consent from subjects of medical experimentation.<sup>49</sup>

The German state, its new regulations notwithstanding, soon oversaw systematic medical experimentation of unmatched cruelty and brutality. Prisoners in the concentration camps were subjected to barbarous research: attempts to conjoin twins by sewing, hypothermia experiments in tanks of ice water, infecting wounds with gangrene and tetanus, and countless more cases.<sup>50</sup> At the subsequent Nuremberg war crimes tribunals, those indicted sought to defend themselves by arguing that genuinely voluntary consent was never obtained by ordinary physicians in their medical research. This defence was rejected by the tribunal's judges, who in 1947 drew up the influential (albeit not then legally binding) Nuremberg Code, outlining fundamental principles to govern research on humans. At its heart was a requirement for consent that was voluntary, competent, informed and comprehending.

The Nuremberg Code is often taken to mark a turning point in human subject research, although its immediate influence is questionable. In an age when science was both the repository of utopian social hopes and taken to be an engine of progress, such obstacles to research, often thought to unduly limit benign scientific inquiries, were prone to be frowned upon. The Declaration of Helsinki, made by physicians of the *World Medical Association* in 1964, relaxed the Nuremberg principles and simply required consent "if at all possible, consistent with patient psychology."<sup>51</sup> But as shown by cases like the Tuskegee syphilis study – which withheld information and life-saving treatment from participants – even these looser

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<sup>49</sup> *Partner v. Koch* 272 Mich. 273; 261 N.W. 762 (1935). For a translation and commentary on the *Richtlinien*, see H.M. Sass 'Reichsrundschreiben 1931: Pre-Nuremberg German Regulations Concerning New Therapy and Human Experimentation,' *The Journal of Medicine and Philosophy* (1983), 99-111. For more on human subject research in Germany before Nuremberg tribunals, see Jochen Vollman and Rolf Winau, 'Informed Consent in Human Experimentation Before the Nuremberg Code,' *British Medical Journal* 313 (1996), 1445-7.

<sup>50</sup> Michael Berenbaum, *The World Must Know: The History of the Holocaust as Told in the United States Holocaust Memorial Museum* (Boston: Little, Brown & Co, 1993), 194–5; David Bogod, 'The Nazi Hypothermia Experiments: Forbidden Data?' *Anaesthesia* 59: 12 (2004), 1155.

<sup>51</sup> 'Declaration of Helsinki,' adopted by the 18th World Medical Association General Assembly, Helsinki, Finland (1964), s. II.1.

standards were not always met.<sup>52</sup> Outrage about Tuskegee, combined with earlier influential work by Henry Beecher in the 1960s recounting dubious post-war human subject research, was instrumental in the requirement for consent to research becoming so heavily policed in recent decades, particularly in the United States.<sup>53</sup>

In understanding why consent arose to be a cardinal issue in all these different areas, we can also look to the specific conception of freedom foregrounded in many modern conceptions of the good life. Autonomy has become a principal value, with the ideal of individual self-determination appearing in much legal, political and professional rhetoric.<sup>54</sup> Often this is understood relatively narrowly: the individual should be free from the coercive power of others, and is to be supported when there are serious deficiencies in their decision-making capacity. In the words of the US Supreme Court:

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<sup>52</sup> The Tuskegee syphilis study, begun in 1932, sought to investigate untreated syphilis in nearly four hundred black men who were found to be infected. By the late forties, penicillin was recognised as effective in combating syphilis, but the study continued unabated, regardless of the Nuremberg Code and then the Declaration of Helsinki. Not only was there was no attempt to treat the men (who were led to believe that their involvement was beneficial for their health), active steps were taken to prevent any such treatment. Only when the study's existence was widely publicised in 1972 (and after over a hundred had died of syphilis-related complications) was it finally shut down and treatment given to the survivors. See Susan Reverby, *Examining Tuskegee: The Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina Press, 2009).

Reverby's recent research outlines another shocking syphilis study, when between 1946-8 the United States Public Health Service paid prostitutes with syphilis to actively infect Guatemalan prisoners, and conducted inoculation research on soldiers and psychiatric patients, before using penicillin to treat them. R.C. Arnold, the PHS physician supervising the head of the study, did have fears about consent: "I am a bit, in fact more than a bit, leery of the experiment with the insane people. They cannot give consent, do not know what is going on, and if some goody organization got wind of the work, they would raise a lot of smoke. I think the soldiers would be best or the prisoners for they can give consent." R.C. Arnold to John Cutler, April 19, 1948, Box 1, Folder 17, Cutler Papers quoted in Susan Reverby, "Normal Exposure" and Inoculation Syphilis: A PHS "Tuskegee" Doctor in Guatemala, 1946-48' (forthcoming). Political sensitivities arising from these controversial aspects of the study led to it being wound up in 1948.

<sup>53</sup> See his landmark article: Henry Beecher, 'Ethics and Clinical Research,' *New England Medical Journal* 274 (1966), 1354-1360.

<sup>54</sup> Immanuel Kant is often, rather misleadingly, said to provide much of the philosophical basis for this conception of freedom. In fact, J.S. Mill's liberalism more readily underpins it, particularly with its defence of 'character,' and thereby the person "whose desires and impulses are his own — are the expression of his own nature, as it has been developed and modified by his own culture." John Stuart Mill, 'On Liberty' in *On Liberty and Other Essays*, John Gray (ed.) (Oxford: Oxford University Press, 1991), 67. For more on how Kantian autonomy differs from most contemporary conceptions of autonomy, see Onora O'Neill, 'Autonomy: The Emperor's New Clothes,' *Aristotelian Society Supplementary Volume* 77:1 (2003), 1-21.

No right is held more sacred, or is more carefully guarded [...] 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.<sup>55</sup>

If absence of interference from others is a fundamental right, and consent is the main vehicle for ensuring acts are not coercive in this fashion, then consent will be a crucial requirement for a whole range of interpersonal interventions. When articulated so starkly, some of the rationale becomes clear for hardline pronouncements about the need for permissive consent, such as that “the patient’s right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent.”<sup>56</sup> But this libertarian strand of liberalism has also been fiercely contested, and the proper bounds of consent are by no means clear, as we shall see shortly.

### *Theory and Practice of Consent*

Our historical survey has told some of the story of how consent became integral to many contemporary social relationships. We touched upon its role in medicine and psychiatry, politics, economics, research and marriage; but it is also important in social care, sexual relations, religious observance, and many other arenas. This section aims to provide a guide to the key issues and debates concerning permissive consent and to illustrate these with concrete examples. In particular, the discussion will focus on consent as solicited in professional practice, as typically sought by carers, solicitors, researchers, surgeons, psychiatrists and others in similar roles.<sup>57</sup>

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<sup>55</sup> *Cruzan v Director, Missouri Department of Health* (1990) 110 S. Ct 2841 quoted in *Ms B v An NHS Hospital Trust* (2002) EWHC 429 Fam. 2, para 21.

<sup>56</sup> *Re T (Adult: Refusal of Treatment)* (1993) Fam. 95, 113.

<sup>57</sup> Even with this limited scope, it is important to be sensitive to the different reasons why consent can be sought and the varied standards for obtaining a valid consent. For instance, the patient and doctor on the psychiatric ward need not have the same interests, rights and responsibilities as the scientist and their research subject in the

On a simple model of permissive consent, it has three main conditions: information, competence and voluntariness.<sup>58</sup> So understood, someone can provide genuine consent (or refusal) when they possess pertinent information, alongside the ability to use it in their decision-making, and when the resulting decision is their own rather than subject to interference. In practice, these conditions for consent are most often taken to impose on professionals responsibilities to inform (such as by disclosing specialist knowledge), to ensure people have at least the legally mandated degree of mental capacity, and to prevent forms of coercion. Each such condition shall be examined in turn.

### *Consent and Information*

The language of ‘informed consent’ is commonplace, yet the relation between consent and information is complex and bears a great deal of scrutiny.<sup>59</sup> Consent is conditional upon information in two main ways: it allows us to *specify* our consent and provides *grounds* for adequate decision-making. Ordinarily, for permissive consent to have legal and ethical force then both must be met, though the threshold for the second condition can vary greatly between different contexts.

In the first instance, if someone is to consent, then they must be aware what they mean to give consent for. Consenting has an *intentional* character: it is directed towards some activity (or description of activity); and so, people cannot simply consent in general but only in some

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lab or the solicitor and the client at her desk. Nevertheless, some commonalities between these situations make it possible to make some general remarks which speak to a number of such scenarios.

<sup>58</sup> Faden and Beauchamp point to five main elements of consent: “1. Disclosure / 2. Comprehension / 3. Voluntariness / 4. Competence / 5. Consent.” However, comprehension and consent (as a decision) are implicit within the three conditions outlined here. For their discussion, see *A History and Theory of Informed Consent*, 274.

<sup>59</sup> The expression itself has a North American provenance and appears less frequently in UK law and academic discussion. Nevertheless, it remains an influential term within all recent discussions of consent, even amongst those who are suspicious of overemphasising the informational or cognitive basis of consent. In *Re T* Lord Donaldson claimed at 35 that “English law does not accept the transatlantic concept of ‘informed consent,’” but this would be misleading if taken to imply that English law does not accept substantial informational obligations in relation to consent. For more on this, see Alasdair Maclean, ‘The Doctrine of Informed Consent: Does it Exist and Has it Crossed the Atlantic?’ *Legal Studies* 24:3 (2006), 386-413.

respect. For example, marital consent presupposes that I have some sense of what it is to get married and am aware of who I intend to marry. Similarly, my consent to enter a clinical trial for tuberculosis treatment cannot be given if I do not know that there is a trial or that I will be agreeing to undergo treatment. Thus, sufficient information is needed to specify and thereby direct consent.

Despite having sufficient information to specify their consent, people can still lack the information needed to make a competent or authoritative decision. For instance, imagine the researchers seeking your consent to participate in a clinical experiment explain the broad nature of the trial, but fail to tell you about a non-negligible risk of permanent liver damage, which learning about would have caused you to refuse. In some such circumstances, where important information is absent, like risks or probable consequences, then consent can be vitiated. Modern thought about permissive consent, since the mid-twentieth century, has tended to emphasise these stricter informational requirements and this is often what is signalled by the language of ‘informed’ consent.

In a professional setting, making sure that consent is sufficiently informed is most often a matter of *disclosure*. Ordinarily, one of the characteristics of the relationship between professionals and those from whom they seek consent is the asymmetry of information available to them; and it is often the expertise and skills that professionals possess which support their claim to authority. Since their expert knowledge so frequently bears upon decision-making with respect to consent or refusal, then the responsibility to educate typically falls to the professional at hand. For example, this could be the solicitor with knowledge of the law pertaining to estates and wills, the psychiatrist with knowledge of mental disorder and the likely success of a suggested treatment, or the scientist with knowledge of the nature of their research and any risk it poses to human subjects.

When by way of contrast we look to political, religious or sexual consent, say, then it is not usually disclosure that is the main vehicle for securing sufficiently informed consent. Genuine political consent relies upon an informed populace, buttressed through institutions such as a vigorous media, but there is no clear role for authoritative experts possessed of special information that they can disseminate in any relatively uncontroversial fashion. The informational disparities faced by civic professionals give them great power in the consent process, and there is understandable pressure for them to share this power with those from whom they are soliciting consent (not least due to contemporary distaste for paternalism). But whether and how this should be done is another matter.

We could demand that consent be fully informed; but this soon raises problems. If consent required all decision-relevant information to make it genuine, then any gaps in what we knew about the nature or consequences of consented to actions would invalidate such consent. We rarely, if ever, possess all the information that relates to our decision-making though, and so requiring full information would mean that people's reasonably well-informed choices were ignored or treated with diminished authority. Indeed, some philosophers have plausibly argued that full information is "neither definable nor achievable."<sup>60</sup> In short, the full information standard sets the bar too high.

If full information is an implausible standard, we might seek to replace it with the information available to the researcher, clinical team, care worker or lawyer who someone is dealing with. Yet, practical difficulties loom large here, especially when understanding may depend upon technical proficiencies and the ability to master complex data that are beyond most non-specialists. Consider the cognitive capacities and training that are needed to properly grasp the fine detail of a serious medical diagnosis or some baroque point of law. In

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<sup>60</sup> Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 44. See also Neil Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge: Cambridge University Press, 2007), 13.

most situations, reduction rather than elimination of disparities of information is the best we should hope for. Indeed, this will often be perfectly sufficient; without qualms, we make such agreements all the time that are premised on asymmetries of information – whether that is calling a plumber to fix our central heating or a solicitor to handle our legal affairs, without this meaning that we completely understand the technicalities of all they do.

Common law in England and Wales has set looser standards for how much information disclosure is appropriate in soliciting of consent in professional contexts.<sup>61</sup> Neither full information nor exhaustive disclosure is expected. Instead, the minimum level of disclosure is set by the Bolam test, which requires meeting responsible professional standards. Originally, the Bolam test arose in a case of non-consensual psychiatric treatment, where it was found that

a doctor is not guilty of negligence if he has acted in accord with a practice accepted as proper by a responsible body of medical men skilled in that particular art.<sup>62</sup>

Subsequently, the standard of agreement with a responsible body of opinion was extended to professional conduct in general, and the *Sidaway* case reconfirmed its application to standards of consent, with Lord Diplock ruling that the appropriate degree of disclosure was fundamentally “an exercise of professional skill and judgement” to which Bolam applied.<sup>63</sup> In these situations, if a competent person understands the general nature of the action for which consent is required then the law takes the consent itself to be valid, but failure to adequately

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<sup>61</sup> Common law is the main locus of consent law, although some statutory law does exist, such as in The Mental Health Act 1983, The Human Tissue Act 2004 and The Mental Capacity Act 2005.

<sup>62</sup> *Bolam v Friern Hospital Management Committee* (1957) 1 BMLR 5.

<sup>63</sup> *F v R* (1983) 33 SASR 189 and *Sidaway v Bethlam Royal Hospital Governors and others* (1985) 1 BMLR 151.

disclose information, such as risks, can breach the duty of care in relation to that consent and so make someone liable to negligence actions.<sup>64</sup>

The Bolam test fails to outline a standard for adequate disclosure, and instead it passes the buck to responsible bodies of professionals. Critics have worried the test is thus too easy to pass, since it only requires a “vanishingly small” body of responsible professionals who endorse some standard, “even if there are many more who would not agree.”<sup>65</sup> However, this problem has begun to be mitigated by a move towards a requirement that not only should the relevant bodies be *responsible* but that their judgements should be *reasonable*.<sup>66</sup> For medical consent, reasonableness has been interpreted to mean disclosing what a reasonable or prudent patient would want to know, which echoes similar patient centred standards in much U.S. and Australian law.<sup>67</sup> In a sense, this only defers the issue, since professionals and ultimately courts must decide what a reasonable person wants; but it does ensure that some consideration is given to the perspective of those from whom consent is sought.<sup>68</sup>

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<sup>64</sup> Technically, charges of battery can be made when disclosure has been insufficient and the relevant action involves touching of the body, but in practice this legal route is now seldom taken. On the relation between battery and negligence in UK consent law, see Sheila McLean, *Autonomy, Consent and the Law* (London: Routledge, 2010), 70f and Alasdair Maclean, ‘The Doctrine of Informed Consent,’ 399. See also *Chatterton v Gerson* (1980) 1 BMLR 89, where the judge makes clear that, in the medical context, battery or assault would imply “a greater failure of communication between doctor and patient than involved in a breach of duty if the claim is based on negligence.”

<sup>65</sup> Sheila McLean, *Autonomy, Consent and the Law*, 74.

<sup>66</sup> See *Pearce v United Bristol NHS Trust* (1999) PIQR P53 (CA) and *Chester v Afshar* (2004), UKH 41. Particularly striking in this respect is Chief Justice King in *F v R* at 189: “In many cases an approved professional practice as to disclosure will be decisive. But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession. [...] The ultimate question, however, is not whether the defendant’s conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.”

<sup>67</sup> For discussion of this shift, see John Reynard and Howard Marsh, ‘The Development of Consent from Bolam to Chester: What You Need to Know and What Your Patients are Entitled to Know,’ *Journal of the British Association of Urological Surgeons* 103 (2009), 1458-60 and Scott Y. H. Kim, *Evaluation of Capacity to Consent to Treatment and Research* (Oxford: Oxford University Press, 2010), 8-9.

<sup>68</sup> Some jurisdictions have gone further still, such that “the standard of disclosure is not determined by what would be important to a reasonable patient but to the particular patient in question.” Kim, *Evaluation of Capacity*, 9.

Unsurprisingly, many professionals go much further than the minimum legal standards in informing consent and refusal decisions.<sup>69</sup> Should maximal disclosure then serve as a regulative ideal – for which to aim – even if it is never completely achieved? Empirical evidence regarding informed consent in healthcare suggests this effort could be misdirected. Firstly, one study found that whilst 93% of patients claimed to find disclosed information beneficial, the same percentage reported making their treatment decision before any formal disclosure.<sup>70</sup> Furthermore, increased verbal and written information has been found to have no significant effects upon patients’ understanding of treatment options or their anxiety levels (though provision of written information is correlated with increased patient satisfaction).<sup>71</sup>

Secondly, comprehensive disclosure may not be merely redundant in many cases but positively harmful and traumatic. Tobias and Souhami warn of the “needless cruelty” of some attempts at fully informing consent, such that:

An increasing degree of frankness on the part of the doctor, for the most part laudable and constructive, may cause considerable anxiety in those patients who would prefer to be directed rather than to participate as an equal partner.<sup>72</sup>

This problem has long been recognised in medicine, where disclosures are regularly traumatic, and discretion with information likely to cause serious psychological harm has often been encouraged under the notion of ‘therapeutic privilege.’<sup>73</sup> But the issue raised is both general and thorny: assuming people meet the minimum legal standards for permissive

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<sup>69</sup> For example, see the GMC’s guidance on consent: *Consent: Patients and Doctors Making Decisions Together* (London: General Medical Council, 2008).

<sup>70</sup> Ruth Faden and Thomas Beauchamp, ‘Decision-Making and Informed Consent: A Study of the Impact of Disclosed Information,’ *Social Indicators Research* 7 (1980), 327.

<sup>71</sup> B.M. Stanley, D.J. Walters and G.J. Maddern, ‘Informed Consent: How Much Information is Enough?’ *ANZ Journal of Surgery* 68 (1998), 788-91.

<sup>72</sup> Jeffrey Tobias and Robert Souhami, ‘Fully Informed Consent Can Be Needlessly Cruel,’ *British Medical Journal* 307 (1993), 1199.

<sup>73</sup> On therapeutic privilege, see Carolyn Johnston and Genevieve Holt, ‘The Legal and Ethical Implications of Therapeutic Privilege – Is It Ever Justified to Withhold Treatment Information From a Competent Patient?’ *Clinical Ethics* 1:3 (2006), 146-151 and Claude Richard, Yvette Lajeunesse and Marie- Thérèse Lussier, ‘Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth’ *Journal of Medical Ethics* 36:6 (2010), 353-357.

consent, does there remain a responsibility to educate or be educated when, for whatever reasons, people prefer to remain ignorant? Liberal assumptions concerning personal autonomy might struggle to accommodate such a duty, rather than the mere right to know; but perhaps so much the worse for liberalism.

### *Competence*

In addition to information, consenting also requires decision-making capacity or competence. Competence and capacity are sometimes distinguished as legal and medical concepts respectively, but following common usage we shall use the terms interchangeably.<sup>74</sup> Capacity is often treated as primarily a cognitive matter, inclusive of the abilities to understand and draw inferences from information, so that a person is able to grasp the likely consequences of decisions to consent or refuse. But emotional skills and the ability to appraise are also integral, and can be thought to constitute an evaluative dimension to decision-making capacity. Furthermore, circumstantial factors, such as pain, stress, unconsciousness, communication problems and drunkenness, can all undermine our capacity to provide meaningful consent.

When ascribing competence to consent, we can make a distinction between those with competencies as persons and those competent in relation to some specific decision. For instance, in the UK, those under 16 are not legally able to consent to sexual activity, regardless of considerations of intellectual or emotional maturity. In this example, competence to consent is treated as a *status* attaching to a person, rather than in terms of a *function* measured by an ability to perform a specific task.<sup>75</sup> But competency can instead be

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<sup>74</sup> For a more detailed discussion of this issue, which also recommends interchangeable use, see Kim, *Evaluation of Capacity*, 17-8.

<sup>75</sup> We might also talk in terms of global and local competences or absolute and decision-relative competencies. For a discussion of the rise of decision-relative conceptions of capacity, see Alan Buchanan and Dan Brock,

tied to specific decisions, no longer assessing a person's qualities or abilities in the round, and instead considering the demands and seriousness of some particular decision.<sup>76</sup> For example, a person with dementia may be found to lack capacity to consent to the sale of their house but to have capacity to consent to more minor economic transactions; or they may be found able to consent to research, though only because they have given support to ensure that they appreciate what this involves.<sup>77</sup>

In the law, some core constituents of capacity are agreed across a number of jurisdictions. The 'four abilities approach,' based upon a major study of case law by Grisso and Appelbaum, has become the dominant standard in the US; and in England and Wales, the Mental Capacity Act (MCA) is the primary piece of legislation.<sup>78</sup> Understanding and communicating a decision are abilities required by both approaches, and these conditions are relatively uncontroversial.<sup>79</sup> But others are more disputed, and it is not clear how we should spell out what the MCA describes as a capacity to 'use and weigh' relevant information and Grisso and Appelbaum call the 'ability to manipulate information rationally' and 'the ability to appreciate the nature of the situation and its likely consequences.'

Capacity can be interpreted cognitively, such that incapacity arises from "intelligence or neuropsychological performance too poor to understand a given decision."<sup>80</sup> But competency

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*Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989), 18-23.

<sup>76</sup> The Mental Capacity Act draws upon this understanding of competence and consistently talks about "capacity in relation to a matter" rather than mental capacity in general. The Mental Capacity Act 2005, s. 2(1).

<sup>77</sup> This has an analogue in common law, where we find Lord Donaldson claim: "the more serious the decision, the greater the capacity required." *Re T* (1992) EWCA Civ. 18. This is sometimes called 'proportionality' in decision-making capacity.

<sup>78</sup> See Binyamin C. Appelbaum, Paul Appelbaum and Thomas Grisso, 'Competence to Consent to Voluntary Psychiatric Hospitalization: A Test of a Standard Proposed by APA,' *Psychiatric Services* 49 (1998), 1193-96.

<sup>79</sup> The MCA also makes explicit the need to retain this information long enough to make a decision. In outline, the MCA states that "a person is unable to make a decision for himself if he is unable—(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)." The Mental Capacity Act 2005, s. 3(1).

<sup>80</sup> Gareth Owen, Fabian Freyenhagen, Genevra Richardson and Matthew Hotopf, 'Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge,' *Inquiry* 52: 1 (2009), 81.

can also be understood more widely, so that it encompasses an ability to undertake adequate appraisal or grasp the significance of the decision, which would draw upon evaluative judgements and emotions.<sup>81</sup> Modern liberal societies are often taken to defend a reasonable pluralism regarding the values their citizens hold, and so linking evaluative skills to assessments of competence to consent can be controversial insofar as this appears to forsake value-neutrality.<sup>82</sup>

One striking illustration of these issues is anorexia nervosa, with studies showing that, cognitively, patients have “excellent understanding, reasoning, and ability to express a choice.”<sup>83</sup> Yet, anorexics consistently make decisions influenced by values that most people find highly problematic (e.g. in some cases preferring thinness to life). Can we say that decisions made on this basis, such as to refuse treatment, show a failure in appreciation, reasoning or an ability to use and weigh information?<sup>84</sup> If not, we may lack grounds to intervene with harrowing but potentially life-saving medical interventions. If so, there may be a legal basis for intervention, but we are committed to stronger paternalistic limits on individual self-determination than many would be happy with.

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<sup>81</sup> In psychiatric settings, Owen et al suggest that cognitive and non-cognitive capacity issues are typically, respectively, correlated with “organic psychiatric disorders (learning disability, dementia and other organic brain syndromes) and non-organic psychiatric disorders (psychotic illness, depression, anorexia nervosa, etc.)” *ibid.*

<sup>82</sup> Demian Whiting expresses these concerns over neutrality in assessments of competency, claiming that “the requirement to respect patients' autonomy or decision making seems in large part designed to protect patients from those who might wish to impose on patients values (including judgments of what is wise or prudent) that are not necessarily possessed by the patient; it can hardly be a presupposition of that requirement then that patients have the capacity to make decisions that accord with the values held by others.” Demian Whiting, ‘Does Decision-Making Capacity Require the Absence of Pathological Values?’ *Philosophy, Psychiatry and Psychology* 16: 4 (2009), 343. For more on the possible justifications for such neutrality, see Andrew Mason, ‘Autonomy, Liberalism and State Neutrality,’ *The Philosophical Quarterly* 40:160 (1990), 433-52.

<sup>83</sup> Jacinta Tan, Tony Hope, Anne Stewart and Raymond Fitzpatrick, ‘Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values,’ *Philosophy, Psychiatry and Psychology* 13 (2006), 270. For scepticism about the appeal in Tan et al to ‘pathological values,’ see the reply to the above article: Thomas Grisso and Paul Appelbaum, ‘Appreciating Anorexia: Decisional Capacity and the Role of Values,’ *Philosophy, Psychiatry and Psychology* 13 (2006), 293-7. See also, Jacinta Tan, Anne Stewart and Tony Hope, ‘Decision-Making as a Broader Concept,’ *Philosophy, Psychiatry, and Psychology* 16:4 (2009).

<sup>84</sup> In their ‘Appreciating Anorexia,’ Grisso and Appelbaum take it that anorexics will often fail on the appreciation standard, namely in their ability to “apply the information abstractly understood to their own situation,” even if their ability to process information means that they meet standards for the ability to reason. Thomas Grisso and Paul Appelbaum, ‘The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment,’ *Law and Human Behaviour* 19:2 (1995), 110.

In the context of mental illness, the possibility of values distorting decision-making, and so undermining capacity to consent, has sometimes been implicitly recognised in common law judgements (and the Code of Practice to the Mental Capacity Act).<sup>85</sup> Commonly, the argument runs that it is not these values *per se* that diminish capacity, but rather their origin in (or relationship to) psychopathology that is the problem. This gives competence a *procedural* rather than *substantive* interpretation, where it is not primarily what we value that is important but how we came to value it.<sup>86</sup> But it is debatable how much neutrality, if any, professional practice can retain even on this position.

### *Social Dimensions of Consent*

Deciding *for oneself* does not always take place *by oneself*. Consenting is no exception, and other people can undermine or support the exercise of someone's capacity to consent. For instance, threats, deception, manipulation and abusing relationships of trust may disrupt this capacity; whereas physical, emotional and intellectual assistance, such as through advice, talking over matters or providing necessary care when appropriate, can help build capacity. Social relations thus significantly shape the environment in which consent is sought and given.

In the first instance, where capacity to consent is disrupted by others, when do consent or refusal decisions become compromised by the pressure exerted by others? Outright violence or its threatened use would be a clear case—for example, putative consent to marriage given by someone cowed by the physical abuse of their partner. In addition, there are other kinds of threat and unfair inducement, such as consent to changes in their legal will by an elderly

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<sup>85</sup> For example, see The Mental Capacity Act 2005 Code of Practice, s. 4.22. For more on the law's 'pragmatic' approach to this question, see Geneva Richardson, 'Mental Capacity at the Margin: the Interface Between Two Acts,' *Medical Law Review* 18 (2010), 70f.

<sup>86</sup> For more on this distinction, see Owen et al, 'Mental Capacity and Decisional Autonomy,' 87f.

person whose children have threatened to put them in a nursing home unless they comply. Even without overt pressure, we may we may think that the influence of another person has prevented someone from making their own decision. Consider the case of *Re T* in which the Court of Appeal found an injured pregnant woman's refusal to consent to blood transfusion was invalid as a consequence of her mother visiting, finding that the latter's religious objections had a disproportionate effect on her daughter, who was readily susceptible. In situations like these, it becomes increasingly difficult to distinguish legitimate persuasion (which may be vigorous and impassioned) from coercion or inordinate influence.

Jurisdictions influenced by English law have drawn a distinction between duress and undue influence. An agreement, such as a permissive consent, can be found to be legally void because of duress, which occurs when illegal violence or imprisonment is used or threatened.<sup>87</sup> Contract law has more recently recognised duress through illegally withholding another's goods, and (more recently still) economic duress arising from an improper pecuniary threat.<sup>88</sup> However, the more familiar scenario in professional practice is likely to be undue influence.

For there to be undue influence in law, it must be shown that the person affected was vulnerable or susceptible, which is most often through some existing relationship to the influencer of trust, dependency or domination. In *Re T*, undue influence was found because of the parental relationship, in the context of illness and an unusual change of mind, but this could also apply to amorous relationships, those between solicitor and client, religious masters and disciples, and so on. When it is that influence becomes undue has not been rigorously specified, and Lady Hale notes that "it has frequently been said that undue

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<sup>87</sup> *Barton v Armstrong* (1976) 1 AC 104 and *Williams v Bayley* (1886) LR 1 HL 200.

<sup>88</sup> *Skeate v Beale* (1840) 11 Ad. & El. 983 found that illegal withholding of goods did *not* constitute duress, but this principle was overturned in *Occidental Worldwide Investment Corp v Skibs A/S Avanti (The Sibeon and The Sibotre)* (1976) 1 Lloyd's Rep 293.

influence is more easily recognised than defined,” and that such decisions require the exercise of judgement.<sup>89</sup> The most common formulation is that undue influence involves “overbearing of the will.”<sup>90</sup> How, then, should we think about this notion?

To illuminate overbearance of the will, and thereby undue influence upon consent, we could contrast it with authentic decision-making. An oft-noted President’s Commission report concludes that consent must proceed from the “possession of a set of values and goals.”<sup>91</sup> In this fashion, could we conclude that consent succumbs to undue influence when the affect of another leads a person to act against their values and goals? If we do say this, we must not forget that others can inform, assist and persuade in ways that change our minds benignly, and without thereby merely foisting their point of view on us. Thus, it must be more than the mere causal influence of others alone on our decisions or former values that would vitiate consent, but rather something more specific.

Some philosophers have attempted to understand authenticity in terms of a psychological relation to one’s own motivations.<sup>92</sup> On these views, decisions are authentic if they spring from authentic motivations, which are motivations properly integrated into our psyche in a way in which we are not alienated from them. This is understood to mean that authentic decisions are those which are motivated by desires which we desire to have; in other words, those for which we have a second-order desire. For example, if I am motivated to assent

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<sup>89</sup> *Centre for Reproductive Medicine v Mrs U* (unreported, High Court of Justice, Family Division, The President, 25 January 2002) at 27. Lord Lindley provides an earlier statement of this reluctance: “As no Court has ever attempted to define fraud so no Court has ever attempted to define undue influence, which includes one of its many varieties.” *Allcard v Skinner* (1887) 36 Ch.D. 183.

<sup>90</sup> *Hirani v Hirani* (1983) 4 FLR 232. See also *Hall v Hall* (1868) Vol. 1 P. & D. 482: “Importunities or threats, such as the testator has not the courage to resist, moral command asserted and yielded to for the sake of peace and quiet, or of escaping from distress of mind or social discomfort, these if carried to a degree in which the free play of the testator’s judgment, discretion or wishes, is overborne, will constitute undue influence.” Cognates of ‘overbearance’ are also used in *Re T* at 31-2 and 41.

<sup>91</sup> ‘Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship,’ (Washington: President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982).

<sup>92</sup> For the inspiration for such approaches to authenticity, see Harry Frankfurt, ‘Freedom of the Will and the Concept of a Person,’ *Journal of Philosophy* 68 (1971), 5-20.

(because I am intimidated by my solicitor, say) but I do not want to want to be so motivated (because I do not desire to be so intimidated), then this assent could be said to be inauthentic and so not amount to genuine consent. Introducing authenticity as a necessary condition of capacity to consent might thereby provide a tool for distinguishing benign persuasion from undue influence.

Authenticity conditions bring with them the danger of false negatives though: people whose decisions we intuitively think should be respected, but who this test would judge to lack capacity to consent. For example, consider the uncertain bridegroom who, after talking things over with his best man, wants to say, ‘I do,’ in the registry office, but is still torn over whether he should really want to do so. He thus lacks second-order endorsement of his first-order motivations. On the above view, his decision to consent to marriage would not be authentic; it would not fully be his own. If capacity to consent requires authenticity, this would mean that his assent would fall short of genuine consent. Few people would want to conclude that those like him should be legally barred from getting married because of their uncertainties though. Thus, this approach may be badly placed to illuminate consent, and we remain without an adequate account of undue influence.

Common law concerning consent has recognised what Lord Donaldson has called, “the vitiating effect of outside influence,” whilst remaining sensitive to the important role that friends and families can play in the consent process.<sup>93</sup> When it comes to the influence of others, Donaldson claims that it is not the strength of influence that matters so much as the nature of the decision it leads to. In this way, the legitimacy of rigorous persuasion and argument is maintained, alongside the possibility that the influence can become overbearing. However, what it means for someone’s decision to be independent is left relatively sketchy, with Donaldson having this to say:

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<sup>93</sup> *Re T*, s.30.

The real question in each such case is “Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?” In other words “Is it a decision expressed in form only, not in reality?”<sup>94</sup>

To help answers these questions, we are encouraged to look to the ‘strength of will’ of the person persuaded and their ‘relationship’ to the persuader, but relevant criteria are left implicit. Perhaps it is the wisdom of the common law that it has not sought a deeper answer than this. However, others will want a more regimented account of what an independent consent or refusal decision consist in, which arguably is still to be found.

We have seen how the influence of other people can undermine consent and refusal (as well as be compatible with them), but it is also important to recognise that this influence can actively support competent decision-making. As noted earlier, professionals can play a role in the provision of information, and beyond this more formal function as sources of information, when appropriate they can act as sounding boards, conversational partners and advisors. Similar roles can be played by a person’s friends and family, who in many situations will be the most appropriate people to discuss such matters with, or otherwise support, the decision-maker.<sup>95</sup> In many cases, such as drawing up a will, consent to marriage, and refusal of treatment, the decision is likely to affect them, so it is understandable should they want some input.

Clearly, there can be a social dimension to consenting, insofar as other people can provide instrumental support that helps someone make the decision to consent or refuse. But some have suggested that sociality has a more fundamental role, such that decision-making

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<sup>94</sup> *ibid.* s. 32.

<sup>95</sup> We find dedicated provision for this sort of activity in the work of Independent Mental Capacity Advocates, who are meant to provide support for vulnerable people without a network of friends and family to support their decision-making in serious matters.

regarding consent is an essentially “inter-personal transaction.”<sup>96</sup> We can develop this thought by thinking more about the nature of consent. Consenting seems to involve taking up a propositional attitude towards certain actions, such that we consent that a transaction takes place or consent that we undergo a course of treatment, for example. This seems to place consent squarely in the realm of individual psychology. But there are grounds for expanding this conception of consent and highlighting a social dimension to consenting.

Instead of approaching consent as an individual’s psychological attitude, we can understand it as closer to what philosophers have called an ‘illocutionary act,’ by which they mean a communicative action that *does* something.<sup>97</sup> For example, when you say, “I promise that I’ll be there to meet you,” this is not (or not merely) stating a prediction but is a form of communication in which you undertake a commitment that others can hold you to. Similarly, consenting can be thought of as a communicative act through which we bring about changes in the normative commitments and entitlements of our audience. For instance, signing the researcher’s form might thereby entitle him to attach the experimental apparatus to your forehead (where previously he was not so entitled), or rolling up your sleeve and holding out your arm might rescind what would otherwise be the nurse’s standing commitment not to give you an injection. This focuses our attention on the dialogical relationship between the person consenting or refusing and the audience who must interpret and respond to their communicative activity. So understood, consenting would be a socially distributed activity, even if its locus is one person who consents.

### *The Purpose of Consent*

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<sup>96</sup> E.D. Pellegrino and D.C. Thomsana, ‘The Conflict Between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution,’ *Journal of Contemporary Health Law and Policy* 23:3 (1987), 27.

<sup>97</sup> See John Searle, ‘A Taxonomy of Illocutionary Acts’ in *Language, Mind, and Knowledge*, Keith Gunderson (ed.) (Minneapolis: University of Minnesota Press, 1975).

Consent is often thought to be important because of its role in safeguarding personal autonomy. In McLean's words: "the law of consent is generally said to be the vehicle by which respect for autonomy is translated into law."<sup>98</sup> However, the relation between consent and autonomy is not often developed. This presents problems since accounts of autonomy are legion. 'Autonomy' is a notoriously thorny term, and both advocates and opponents often bemoan it having acquired so many different (even incompatible) meanings. These include liberty, self-control, dignity, authenticity, responsiveness to reasons, and many more besides.<sup>99</sup> When we look more closely, the fundamental thought of most of those who invoke autonomy in connection with consent is typically a libertarian one. Consent is valorised insofar as it provides a mechanism for protecting and respecting a person's choices, so long as this person is minimally competent and informed. But if this is the basis for seeking and respecting consent, then it stands in need of justification, which has not been forthcoming.<sup>100</sup>

Consent can, however, serve many other functions than promoting autonomy. O'Neill and Manson provide the most developed recent alternative. For them, consent is understood as a waiver by which people can legitimate actions that would otherwise be breaches of rights and obligations towards them. In this way, consent is put in the service of ordinary ethical norms, such as non-deception and non-coercion, rather than thought of as protecting decision-making for its own sake. The advantage of this approach is that it does not incur the commitment to

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<sup>98</sup> McLean, *Autonomy Consent and the Law*, 38.

<sup>99</sup> Nomy Arpaly has identified at least eight interpretations of autonomy in philosophical usage: agent-autonomy (i.e. self-control), personal efficacy, independence of mind, normative moral autonomy (i.e. anti-paternalism), authenticity, self-identification, heroic autonomy (i.e. Stoic *apathia*), and responsiveness to reasons. See her *Unprincipled Virtue: An Inquiry Into Moral Agency* (Oxford: Oxford University Press, 2003), 118f. Gerald Dworkin's survey (though by no means exhaustive) adds several more glosses upon autonomy: it is used "sometimes as an equivalent of liberty (positive or negative in Berlin's terminology), sometimes as equivalent to self-rule or sovereignty, sometimes as identical with freedom of the will. It is equated with dignity, integrity, individuality, independence, responsibility and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one's own interests. It is even equated by some economists with the impossibility of interpersonal comparisons." See his *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 6.

<sup>100</sup> On this point, see Onora O'Neill and Neil Manson, *Rethinking Informed Consent in Bioethics* (Cambridge: Cambridge University Press, 2007), 20.

justify respect for minimally rational decision-making whilst satisfying our intuitions that consent should have an integral place within much of modern life. Furthermore, O'Neill has argued that requiring informed consent is one mechanism in building trust, both between professionals and their clients, and public trust in institutions themselves.<sup>101</sup> Thus, this non-autonomist rationale for consent-seeking has two prongs: it is an instrument both for serving uncontroversial ethical norms and for building trust.

Once again, it may be salutary here to emphasise the variety of contexts in which consent is sought, such that we remain mindful of the many different purposes it can serve. Indeed, some have warned of the problems that arise from taking specific types of consent, such as consent to medical treatment, to be models for other consent practices, such as consent to social research.<sup>102</sup> Inquiring after the purpose of consent is likely to be most fruitful only when indexed to a specific kind of consent, rather than searching for a general answer that would cover all kinds. Nevertheless, it may not be too hard to see a general appeal of practices that respect competent and informed decision-making, defend liberty and seek to minimise coercion.

**[END]**

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<sup>101</sup> Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), ch. 7.

<sup>102</sup> Michael M. Burgess, 'Proposing Modesty for Informed Consent,' *Social Science and Medicine* 65:11 (2007), 2284-2295.