INFORMED CONSENT IN MEDICAL ETHICS, REGULATION, AND THE LAW

A UNIFIED MODEL

Louise Austin

ROUTLEDGE

Informed Consent in Medical Ethics, Regulation, and the Law

This book constructs a model of informed consent to surgery utilising empirical ethics and socio-legal analysis to bring together medical ethics, medical professional regulation, and medical law. The work includes an original socio-legal analysis of the models of informed consent to surgery present in court judgments and fitness to practise decisions. It constructs such a model using the empirical ethics methodology of reflexive balancing to both develop and challenge its construction. This unified model enables patients to make autonomous choices about surgery by encouraging healthcare professionals to draw upon the patient's subjective perspective, as well as objective viewpoints, when determining what information needs to be given to patients about treatment. It incorporates a focus on the importance of patients understanding that information and having the opportunity to reflect upon it. The outcome is a model of informed consent to surgery that speaks to medical ethics, medical professional regulation, and medical law, giving equivalent weight to the insights offered by each. The book will be an invaluable resource for students, academics, and researchers working in the area of Medical Law and Ethics and Bioethics.

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2026
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Names: Austin, Louise (Lecturer in law) author
Title: Informed consent in medical ethics, regulation, and the law : a unified model / Louise Austin.
Description: Abingdon, Oxon [UK] ; New York, NY : Routledge, 2026.| Includes bibliographical references and index.
Identifiers: LCCN 2026007325 | ISBN 9781032268712 hardback | ISBN 9781032268750 paperback | ISBN 9781003290322 ebook
Subjects: LCSH: Informed consent (Medical law) | Medical laws and legislation--Moral and ethical aspects
Classification: LCC K3611.I5 A97 2026
LC record available at https://lccn.loc.gov/2026007325

ISBN: 978-1-032-26871-2 (hbk)
ISBN: 978-1-032-26875-0 (pbk)
ISBN: 978-1-003-29032-2 (ebk)

DOI: 10.4324/9781003290322

Typeset in Galliard
by Deanta Global Publishing Services, Chennai, India

To Paul, thank you for your endless love and support.

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Contents

Table of Cases

Table of Fitness To Practise Tribunal Decisions

Table of Legislation

Acknowledgements

This book arose out of my PhD research which was undertaken at the University of Bristol with the benefit of funding from the Economic and Social Research Council. I am grateful to all the friends and colleagues I met and worked alongside at Bristol but, in particular, to my PhD supervisors, Professor Oliver Quick and Professor Richard Huxtable without whom this book would never have been written. Thanks also to my PhD external examiners, Professor Jose Miola and Professor Jonathan Ives for their feedback and encouragement to develop my PhD thesis into a monograph. I am indebted to Alison Kirk at Routledge, Taylor & Francis for her infinite patience during the writing process and to the General Medical Council for their assistance in accessing the fitness to practise decisions analysed within this book. Thank you also to the University of Leicester and my friends and colleagues there for giving me time, space and support to complete this book. Finally, I would like to thank my husband, Paul Austin, whose unwavering support has been invaluable to me for so many years and my dog, Charlie, who has been my companion for much of the work on this book, whilst reminding me of the need to occasionally step away from my desk!

List of Acronyms and Abbreviations

FTPT:	Fitness to practise tribunal
GMC:	General Medical Council
GMP:	Good Medical Practice
MPTS:	Medical Practitioners' Tribunal Service
NSAIDs:	Non-steroidal anti-inflammatory drugs
RBL:	Reflexive balancing

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1 Finding a Unified Model of Informed Consent to Surgery

Introduction

Informed consent has been described as 'the most discussed, indeed the most hackneyed theme in bioethics'.[1] Yet this book demonstrates that despite this view, there remain unexplored approaches to informed consent that can offer fresh insights, such as the variety of ethical concepts seen to be the foundations of informed consent beyond autonomy, and the approach taken within the fitness to practise tribunals (FTPT).

There is no agreed definition of the term 'informed consent', but within this book, the term is used to refer to the provision of information about medical treatment to enable people to make decisions as to whether to undergo that treatment or not. In the context of healthcare, informed consent is interdisciplinary in nature, engaging with medical ethics, medical professional regulation, and medical law. This interdisciplinarity leads to cross-referencing between the three areas. For example, all three areas engage with the notion of autonomy as the primary justification of the need for informed consent[2] (albeit this underpinning has been questioned in both medical ethics and medical law),[3] and this has led to conceptions of autonomy within medical ethics being used to critique standards of informed consent in medical law.[4] Meanwhile, medical professional regulation (in the form of the General Medical Council's (GMC) consent guidance) and medical law cross-reference each other, with medical law using GMC guidance to justify legal standards of disclosure in

1 Neil C. Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press 2007) 183.

2 See: Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019) 118 and 119; General Medical Council, *Decision Making and Consent* (General Medical Council, 2020) Front Page; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [80].

3 See, for example: Manson and O'Neill (n1) 72; *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, (2018) 164 BMLR 1, [88] per Leggatt LJ.

4 See, for example: Sheila A. M. McLean, *Autonomy, Consent and the Law* (Routledge 2010); Louise Austin, 'Correia, Diamond, and the Chester Exception: Vindicating Patient Autonomy?' (2021) 29(3) Med Law Rev 547 https://doi.org/10.1093/medlaw/fwab016.

DOI: 10.4324/9781003290322-1

informed consent,[5] while the GMC's consent guidance defers to medical law.[6] Despite this, each discipline has constructed its own model(s) of informed consent which, although there are areas of commonality between them, remain distinct and separate. This chapter addresses the absence of a unified model of informed consent across the three disciplines before explaining the methodology and method of reflexive balancing which is used within this book to construct a model of informed consent which unifies insights from medical ethics, professional regulation, and the law.

The Absence of a Unified Model of Informed Consent

Miola has previously written in support of a distinction between the models of informed consent in medical ethics and medical law. Writing about the differences in their approaches to the standard of disclosure, Miola has argued that it makes sense for ethics to be 'more stringent than law'.[7] Miola was referring to the different approaches taken to the standard of disclosure by the GMC's consent guidance and the courts. Miola classifies GMC guidance as a formal source of medical ethics discourse,[8] but this book classifies it as medical professional regulation distinct from medical ethics because the GMC's guidance is underpinned by legal statutory powers governing doctors' ability to practice.[9] The GMC consent guidance adopts a patient-centred standard of disclosure, whereas the courts (at the time Miola was writing) adopted a reasonable doctor standard of disclosure subject to consideration of a reasonable patient standard.[10] However, such an approach risks healthcare professionals following the less demanding standard, rather than the more stringent 'ethical' (or, in this book, regulatory) standard. This is illustrated in the Supreme Court judgment of *Montgomery v Lanarkshire Health Board*.[11]

Montgomery concerned a pregnant diabetic woman who was not advised of the increased risk of shoulder dystocia associated with vaginal delivery. Shoulder dystocia occurs when the baby's shoulders get stuck behind the pelvis during delivery and the risk in Mrs Montgomery's case was estimated at 9–10%.[12] Despite Mrs Montgomery expressing concerns about the size of her baby,[13] the risk was not disclosed to her although the GMC consent guidance in place

5 *Montgomery* (n2) [93].
6 GMC (n2). This deference is illustrated by the guidance stating it is 'consistent with the law' in the United Kingdom, at page 4.
7 José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart Publishing 2007) 85.
8 ibid 6 and 7.
9 s.1B Medical Act 1983 (as amended).
10 The differing standards of disclosure and their development are discussed in Chapters 3 and 4 of this book respectively.
11 n2.
12 ibid [7].
13 ibid [14].

at the relevant time stated that the patient's own wishes should be taken into account when deciding how much information to give.[14] The guidance also stated that patients should be given information about serious risks.[15] The judgment records that whilst some women are unaware that shoulder dystocia has occurred, for those who are aware it is 'an unpleasant and frightening experience [which] also gives rise to a variety of risks to her health'.[16] Thus, applying the GMC's guidance it seems the risk of shoulder dystocia should have been discussed. Yet the GMC guidance was not referred to in the lower courts,[17] with both parties instead relying on expert evidence from obstetricians as to whether the risk should have been disclosed. This reliance on medical experts arose because the applicable legal standard of disclosure at the time was the *Bolam* test based upon what a responsible body of medical opinion would have discussed.[18] As there was a body of opinion who would not have disclosed the risk of shoulder dystocia, the lower court concluded there was no breach of the duty to disclose.[19] That expert evidence, however, did not refer to the GMC guidance and thus, healthcare professionals were following the less demanding standard of disclosure.

As discussed in Chapter 5 of this book and elsewhere,[20] this approach has been echoed by the FTPT who also apply the less demanding reasonable doctor standard when considering allegations of inadequate informed consent. This has led Miola to shift his view writing together with this author that if, as the GMC and medical law claim, the purpose of informed consent is to respect patient autonomy, then both the GMC guidance and medical law should adopt a patient-focused standard of disclosure.[21] This reflects the view expressed by the Supreme Court in *Montgomery* who rejected the reasonable doctor standard of disclosure in favour of applying a combined reasonable/particular patient standard of disclosure to the question of what risks should be disclosed.[22] The Supreme Court had no difficulty with the standards being the same and saw some benefit, recognising that otherwise, some doctors

14 General Medical Council, *Seeking Patients' Consent: The Ethical Considerations* (General Medical Council, 1998) [4].

15 ibid [5].

16 *Montgomery* (n2) [11].

17 ibid [79].

18 ibid [26]. The *Bolam* test is derived from the case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QBD). In Scotland (where the *Montgomery* case originated) it is referred to as the *Hunter v Hanley* test, *Hunter* being the Scottish case which contains the responsible body of opinion test, and which predates *Bolam* (*Hunter v Hanley* [1955] SC 200).

19 *Montgomery* (n2) [26].

20 Chapter 5, pages 116–123; Louise Austin and José Miola, 'Mind the (Ethico-Legal) Gap: The Relationship Between Medical Law and Ethics in Informed Consent' in José Miola and Louise Austin (eds), *Research Handbook on Medical Consent* (Edward Elgar 2026).

21 ibid.

22 *Montgomery* (n2) [87].

would adopt the least demanding standard: 'those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion'.[23]

Despite this clear statement in *Montgomery*, the Supreme Court appeared to take a step back in *McCulloch v Forth Valley Health Board*, reverting to the application of a reasonable doctor standard when determining if alternative treatments should be disclosed.[24] This, together with the approach of the FTPT in respect of disclosure, creates uncertainty for healthcare professionals as to the standards they will be held to. Using the facts in *Montgomery*, the application of the reasonable doctor standard justified the doctor's decision not to disclose the risk of shoulder dystocia in the lower courts, yet the application of the hybrid reasonable/particular patient standard in the Supreme Court mandated disclosure. Thus, in an FTPT decision, a doctor may be found to have met the relevant standards concerning risk disclosure, yet in a court judgment, where the reasonable/particular patient standard is applied, they would not. A doctor in such circumstances would be justified in feeling aggrieved to find themselves liable in a court, despite their behaviour being compliant with their professional regulatory standards. Unifying the standards across medical ethics, medical professional regulation, and medical law not only acts to close the gap between the three disciplines in terms of the standards being applied, but also provides consistency and certainty for healthcare professionals who must give effect to these standards in clinical practice.

One objection to a unified model of informed consent may lie in the view that medical ethics, medical professional regulation, and medical law have different aims. As an academic discipline, ethics studies morality in the sense of codes of conduct intended to apply to particular groups or individuals.[25] Medical ethics is concerned with ethical issues arising in and out of the doctor-patient relationship,[26] and it aims to guide human behaviour within the context of that relationship.[27] Medical professional regulation in the form of the GMC's guidance also aims to shape doctors' behaviour through standard-setting aimed at protecting, promoting, and maintaining the health, safety, and wellbeing of the public, and public confidence in the medical profession.[28] Law is concerned

23 ibid [93].

24 [2023] UKSC 26, [2024] AC 925. I have argued elsewhere that this case was wrongly decided: Louise Austin, 'McCulloch v Forth Valley Health Board [2023] UKSC 26: Hello Bolam, The Court's Old Friend' [2024] 32(2) Med Law Rev 264, https://doi.org/10.1093/medlaw/fwae013.

25 Wibren van der Burg, 'Law and Ethics: The Twin Disciplines' (2010) 10–02 Erasmus Working Paper Series on Jurisprudence and Socio-Legal Studies 1, 5; Bernard Gert and Joshua Gert, 'The Definition of Morality' in Edward N. Zalta (ed.), *The Stanford Encyclopaedia of Philosophy* (Fall 2017 edn) <https://plato.stanford.edu/entries/morality-definition/> accessed 7 October 2025.

26 B. Steinbock (ed.), *The Oxford Handbook of Bioethics* (Oxford University Press 2009), 2.

27 Van der Burg (n25) 18.

28 n9.

with subjecting human conduct to the governance of rules,[29] and medical law is specifically concerned with the relationship between healthcare professionals (particularly doctors) and patients.[30] Therefore, whilst different sanctions may attach to non-compliance with the standards of medical ethics, medical professional regulation, and medical law,[31] each has the same aim: to guide the conduct of those within the doctor-patient relationship with a particular focus on the conduct of doctors. A unified model of informed consent across all three disciplines would be consistent with these aims. This book, therefore, offers a new approach to informed consent by utilising empirical ethics and socio-legal analysis to construct a unified model that draws upon insights from the three areas of medical ethics, medical professional regulation, and medical law.

Finding a Unified Model

Both the structure of this book and the structure for constructing the unified model of informed consent are underpinned by the empirical ethics methodology and method of reflexive balancing. Reflexive balancing involves a three-stage approach:

1. identification of a problem;
2. inquiry into the problem (for example, through consulting literature, looking at legal cases and/or policy, and gathering empirical data); and
3. reflexive balancing.[32]

Identifying the Problem

The problem under consideration in this book has been outlined above; the absence of a unified set of standards for informed consent across medical ethics, medical professional regulation, and medical law. To address this absence, I aim to construct a unified model of informed consent to surgery, drawing upon insights from each discipline. This book focuses on informed consent to surgery because the appellate judgments discussed in Chapter 4 which develop the legal standards of informed consent, all involve surgery. Although the ethical literature and GMC guidance discussed in Chapters 2 and 3 are focused on medical treatment, rather than just surgery, they are applicable to

29 Lon L. Fuller, *The Morality of Law* (rev. edn, Yale University Press 1969) 106.

30 Ian Kennedy and Andrew Grubb, *Medical Law* (3rd edn, Oxford University Press 2000) 3.

31 Breaches of medical ethics have no explicit sanction beyond professional disapprobation, whereas breaches of medical professional regulation may result in fitness to practise proceedings with sanctions ranging from a warning to removal of the right to practise as a doctor. Medical law sanctions in the context of informed consent focus on financial compensation.

32 Jonathan Ives, 'A Method of Reflexive Balancing in a Pragmatic, Interdisciplinary and Reflexive Bioethics' (2014) 28(6) Bioethics 302, 311, https://doi.org/10.1111/bioe.12018.

surgery. I adopt the broad definition of surgery offered by McCulloch et al. as 'an operation, invasive procedure, or use of a medical device'.[33]

Inquiry

To conduct the inquiry into the construction of a unified model, I draw upon the following:

a. ethical literature to identify existing models of informed consent within medical ethics;
b. the model of informed consent reflected in medical professional regulation in the form of GMC consent guidance; and
c. the model of informed consent reflected in court judgments setting out the legal standards that informed consent to surgery should meet.

Consideration of (a) to (c) of the inquiry takes place in Chapters 2 to 4. Chapter 2 explores three models of informed consent present within the medical ethics literature and developed by Beauchamp and Childress, Manson and O'Neill, and Maclean.[34] These different models illustrate the lack of a unified model of informed consent within medical ethics itself. In Chapter 3, I explore the model of informed consent present across the three iterations of the GMC's consent guidance.[35] This shares some similarities with elements of medical ethics' models of informed consent, but also some differences. From there, Chapter 4 moves on to consideration of medical law's model of informed consent. This illustrates that through the development of the legal standards of informed consent, different approaches have been taken to the content and extent of disclosure. Medical law's model of informed consent also shares similarities and differences with both the medical ethics' and medical professional regulation's models, leading me to conclude that whilst there is not currently a unified model of informed consent to surgery across the three areas, such a model can be constructed using reflexive balancing.

Reflexive Balancing

Reflexive balancing requires identification of boundary principles which are then systematically challenged using disconfirming data and/or alternative

33 Peter McCulloch, Jonathan A. Cook, Douglas G. Altman, Carl Heneghan and Markus K. Diener, 'IDEAL Framework for Surgical Innovation 1: The Idea and Development Stages' (2013) BMJ 346, https://doi.org/10.1136/bmj.f3012.

34 Beauchamp and Childress (n2); Manson and O'Neill (n1); Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press 2009).

35 GMC (n14); General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (General Medical Council, 2008); GMC (n2).

theoretical perspectives. The aim is to find coherence within the boundary principles and so the reason for accepting or rejecting the new addition must be explicated and justified in terms of the overall coherence.[36]

I develop the boundary principles in Chapters 5 and 6 through an empirical analysis of fitness to practise decisions of the Medical Practitioners' Tribunal Service (FTPT decisions) and court judgments, which respectively apply the medical professional regulatory and legal standards identified in Chapters 3 and 4. Chapter 7 then challenges these principles using ethical literature, the medical regulatory and legal standards of informed consent, and disconfirming data within the FTPT decisions and court judgments. This leads me to the construction of a model of informed consent which unifies insights from medical ethics, medical professional regulation, and medical law. This model enables autonomous choices about surgery, utilising objective and subjective perspectives in determining what information should be given to patients and requiring understanding and reflection. I then conclude in Chapter 8 with suggestions for future implementation of the model.

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36 Ives (n32) 311.

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2 Medical Ethics
Contested Models of Informed Consent

Introduction

There is an extensive body of literature dealing with informed consent in the context of medical ethics.[1] Yet amongst this, there is no agreed model of informed consent within medical ethics. The vastness of the literature on this topic makes it impractical to review all accounts of informed consent and so this chapter focuses upon three accounts of informed consent within the medical ethics literature: Beauchamp and Childress' dominant medical model;[2] Manson and O'Neill's account of how we can rethink informed consent;[3] and Maclean's relational challenge.[4] Whilst each of these examines informed consent to medical treatment rather than informed consent to surgery, which is the focus of this book, the models explore some key approaches to informed consent in medical ethics and are applicable to a surgical context. I selected the three models as Beauchamp and Childress' account has been a dominant approach in medical ethics but as noted by Beauchamp and Childress, Manson and O'Neill provide a challenge to their focus on autonomy as the primary justification of informed consent.[5] Maclean provides a different form of challenge, reflecting a focus upon relational, rather than individual, autonomy.[6]

1 For example, a Google Scholar search for: 'informed consent' and 'medical ethics' produces approximately 477,000 results whilst a search for: 'informed consent' and 'surgery' produces 2,420,000 results. The same search on PubMed produces 66,010 and 54,023 results respectively. These searches were last carried out on 7 October 2025.

2 Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019).

3 Neil C. Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press 2007).

4 Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press 2009).

5 Beauchamp and Childress (n2) 119. Other scholars have also rejected Beauchamp and Childress' positioning of autonomy as the ethical underpinning for informed consent: see, for example, James Stacey Taylor, 'Autonomy and Informed Consent: A Much Misunderstood Relationship' (2004) 38 J Value Inq 383, https://doi.org/10.1007/s10790-005-5868-8.

6 Other scholars have also engaged with relational autonomy in the context of informed consent: see, for example, Peter I. Osuji, 'Relational Autonomy in Informed Consent as an Ethics of Care

DOI: 10.4324/9781003290322-2

In setting out the three accounts, and their areas of similarity and difference, I seek to illustrate the range of understandings of informed consent within medical ethics and the absence of an agreed model. I do not argue that one account should be preferred over another but instead identify the elements underpinning the different accounts which inform the construction of a unified model of informed consent in Chapter 7. Analysing alternative accounts of informed consent may have led to different findings within this chapter but when constructing the model of informed consent in Chapter 7, the wider ethical literature is engaged with which, together with the analysis in this chapter and Chapters 3 to 6, accounts for different approaches to informed consent.

Whilst the focus of this chapter is on models of informed consent within medical ethics, the accounts themselves are drawn from scholars beyond medicine and ethics. However, as Kennedy notes, medical ethics 'is not a field in which it is necessary to be trained in medicine'.[7] Thus, whilst these accounts are drawn from scholars outside of the medical profession (Maclean, for example, is a legal scholar), they are all scholars whose focus is upon a medical ethical account of informed consent.[8] Whilst Maclean's legal background risks his analysis reflecting a model of informed consent consistent with the medical law model, we will see in Chapter 4 of this book that there are key differences between Maclean's model and that present in medical law. In addition, Maclean's analysis is underpinned by ethical concepts of autonomy, justice, virtue, and beneficence.

This chapter begins with an exposition of the typologies of autonomy within ethics. Beauchamp and Childress note that since the mid-1970s, the primary justification of informed consent has been the protection of autonomous choices.[9] Autonomy is an ethical concept used in ethical literature beyond medical ethics, yet autonomy remains a contested concept with no agreed philosophical definition. As such, some of the key differences between the models of informed consent considered in this chapter are between: (a) how autonomy should be conceptualised; and (b) whether autonomy should be the justification for informed consent. Given the relevance of autonomy to the models of informed consent considered throughout this book, this chapter outlines some typologies of autonomy drawn from the broader ethical literature and which encapsulate the understandings of autonomy seen within medical ethics, medical professional regulation, and medical law.

Approach to the Concept of Informed Consent' (2017) 21 Med Health Care Philos 101, https://doi.org/10.1007/s11019-017-9789-7.

7 Ian Kennedy, *The Unmasking of Medicine* (George Allen and Unwin 1981) vii.

8 Beauchamp and Childress' and Manson and O'Neill's accounts apply to biomedical ethics and bioethics respectively, which are broader fields than medical ethics. However, their models of informed consent have direct application to the field of medical ethics, which is the focus of this chapter.

9 Beauchamp and Childress (n2) 118.

The chapter then goes on to set out three different models of informed consent, beginning with Beauchamp and Childress's dominant medical model. This draws upon their account of the four principles of biomedical ethics of autonomy, beneficence, non-maleficence, and justice, with autonomy being given primacy in their model of informed consent. I then go on to consider Manson and O'Neill's rejection of autonomy as the justification of informed consent. Instead, Manson and O'Neill seek to rethink informed consent by conceptualising it as a waiver of ethical, legal, or other rights, and positioning informed consent as a communicative transaction by which those rights are waived. Finally, I look at Maclean's model of informed consent which accepts autonomy as the justification for informed consent but focuses upon the relational nature of the doctor-patient relationship. The chapter concludes with a discussion of the key areas of similarity and difference between the three models, highlighting the lack of a unified model of informed consent to surgery within medical ethics.

Typologies of Autonomy

Autonomy is a contested ethical concept, yet as we will see throughout this book, it is often cited as the justification for informed consent within medical ethics, medical professional regulation, and medical law. Some scholars have sought to capture these differences by explicating different typologies of autonomy. Throughout this book, the types of autonomy that the different models of informed consent engage with are identified, drawing upon Coggon and Christman's typologies. Before setting out these typologies, this section sets out a basic definition of autonomy and the distinction made within medical ethics between autonomous choices and autonomous persons. It then outlines Coggon and Christman's typologies of autonomy and the reasons for utilising these.

A Basic Definition

Translated literally from its Greek origins, 'autonomy' means 'self-rule'[10] and is equated with terms such as: 'liberty […] self-rule or sovereignty […] freedom of the will […] dignity, integrity, individuality, independence, responsibility, and self-knowledge'.[11] Whilst there is agreement within the literature that 'autonomy is a feature of persons and that it is a desirable quality to have',[12] what generates debate is the specification of the precise conditions

10 Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1988) 108.
11 ibid 6.
12 ibid.

of autonomy and, therefore, how it should be conceptualized.[13] The first difference I consider is that between autonomous choices and autonomous persons.

Autonomous Choices and Autonomous Persons

Beauchamp and Childress distinguish between autonomous choices and autonomous persons.[14] Autonomous persons can make non-autonomous choices, whilst non-autonomous persons can make autonomous choices.[15] This book is concerned with autonomous choices, rather than autonomous persons, as it focuses upon decisions about whether to proceed with surgery in the context of informed consent. I therefore concentrate upon competent adults with the ability to understand and decide (the ethical and legal threshold for autonomous persons in this context),[16] rather than adults who lack competence, or children. The following sections set out the broad understandings of autonomy present within medical ethics and captured in Coggon and Christman's typologies of autonomy.

Coggon's Typology of Autonomy

Coggon's typology of autonomy is employed throughout this book to aid understanding of the types of autonomy underpinning the different models of informed consent considered.[17] I utilise Coggon's typology because not only does it capture the different understandings of autonomy present within the ethical literature, but the framing also suggests a focus on autonomous choices, rather than autonomous persons, as the typology refers to 'desires' and 'actions'. As set out in the preceding section, this book is concerned with autonomous choices, rather than autonomous persons.

Coggon identifies three broad philosophical understandings of autonomy:

(1) ideal desire autonomy which encompasses an 'action decided upon because it reflects what a person *should* want, measured by reference to some purportedly universal or objective standard of values';[18]

13 Beauchamp and Childress (n2) 100.
14 ibid.
15 ibid.
16 See, for example: Beauchamp and Childress (n2) 122; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 [87].
17 John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235, https://doi.org/10.1007/s10728-007-0062-8.
18 ibid 240.