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NEGLIGENCE AND AUTONOMY

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The complex relationship between negligence and autonomy is of increasing practical and theoretical interest, as is shown by recent cases such as *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, *Shaw v Kovac* [2017] EWCA Civ 1028 and *ACB v Thomson Medical Pte Ltd* [2017] SGCA 20. My discussion of this relationship divides into three parts. In the first part, I make some general observations about the relationship between negligence law and autonomy. In the second part, I argue that interference with autonomy *per se* should not be recognised as a form of damage that grounds a negligence claim, although I acknowledge that it may be useful for the law to recognise specific forms of autonomy loss as damage in this sense. And in the third and final part, I consider the uneasy relationship between negligence doctrine and patient autonomy in the law of liability for medical non-disclosure, and argue that as a result of recent developments, this may no longer be properly described as liability for negligence.

I. Introduction

This article concerns the complex relationship between negligence and autonomy, which recent academic commentary and case law demonstrates is of increasing theoretical and practical interest. My discussion divides into three parts. In the first part, I make some general observations about the relationship between negligence law and autonomy. In the second part, I consider whether interference with autonomy should be recognised as a form of damage that grounds a negligence claim. And in the third and final part I consider the uneasy relationship between negligence doctrine and patient autonomy in the law relating to liability for medical non-disclosure.

I should make it clear at the outset that although philosophers tend to distinguish between autonomy on the one hand and freedom or "liberty" on the other,[1] lawyers

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1 See, *eg*, James Griffin, *On Human Rights* (Oxford: Oxford University Press 2008) chs 8 and 9, arguing that autonomy concerns the ability of a normative agent to make decisions about the life they wish to pursue, whereas liberty concerns the ability to act on those decisions free of constraints imposed by others.

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are not always so punctilious, and in the article I use the word "autonomy" in what I see as its broader, legal sense, as encompassing not only the ability to make meaningful choices about the direction of one's life (in Joseph Raz's words, an "ideal of self-creation"[2]), but also freedom of action more generally. I should also make it clear that my discussion pertains to negligence in Commonwealth legal systems generally, although my examples tend to come from the United Kingdom ("UK") (the differences between the three UK jurisdictions not being significant for present purposes).

II. General Observations

I want to begin my consideration of the relationship between negligence and autonomy with four general observations about that relationship.

The first observation is that since negligence law is, in Hanoch Dagan's terminology, a "duty-imposing" area of private law and not a "power-conferring" one,[3] in my view it is not plausible to construct an overall justification for negligence law in autonomy terms, as one can do (and as Dagan has done[4]) when it comes to facilitative legal institutions such as property and contract.

The second observation is that although the law of negligence cannot itself plausibly be explained in autonomy terms, negligence protects autonomy as a second-order value because the kinds of injuries that ground negligence claims almost inevitably have a negative impact on the plaintiff's ability to live the life she would choose to live.[5] Suppose, for example, that your negligence causes a car accident in which I lose a leg. The resulting disability significantly reduces the meaningful choices that are open to me in the remainder of my life, and hence (since my autonomy is in part a function of those choices) my self-determination. Many potentially significant options are now closed to me – possible careers, perhaps, as well as leisure pursuits, such as hiking up mountains – while others are made much more difficult, so that my ability to incorporate those options into my life plan is now more challenging, and the extra time spent and cost incurred themselves have autonomy implications. Furthermore, in the most serious of personal injury cases, the impact of the injuries on the plaintiff's ability to live the life she wishes can be nothing short of catastrophic, and is even capable of depriving the plaintiff of the capacity to make life choices at all, and hence of the very possibility of living an autonomous existence.

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2 Joseph Raz, *The Morality of Freedom* (Oxford: Oxford University Press 1986) at 369 [Raz].

3 See Hanoch Dagan, "Autonomy and Pluralism in Private Law" in Andrew S Gold *et al*, eds, *The Oxford Handbook of the New Private Law* (New York: Oxford University Press 2020).

4 See especially Hanoch Dagan & Michael Heller, *The Choice Theory of Contracts* (Cambridge: Cambridge University Press 2017); Hanoch Dagan, *A Liberal Theory of Property* (Cambridge: Cambridge University Press 2021).

5 See also Craig Purshouse, "Liability for Lost Autonomy in Negligence: Undermining the Coherence of Tort Law?" (2015) 22 Torts LJ 226 at 232 [Purshouse, "Liability for Lost Autonomy in Negligence"] (by protecting an interest in not being physically injured, negligence indirectly protects people's autonomy).

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This connection between negligence and autonomy may be obvious, but it is certainly not trivial. Many of the injuries that ground negligence actions are genuinely "life-changing", and a large part of what makes them so is the impact of the resultant disability on the plaintiff's life choices. Although a poor substitute for the loss, the award of monetary compensation in such cases can finance practical measures that will help to restore some of the plaintiff's independence and (through awards for so-called "loss of amenity") serve to acknowledge the effect of the injury on the plaintiff's ability to do those things she would otherwise have chosen to do. Furthermore, since loss of amenity damages are both tailored to the plaintiff's own particular interests and pastimes and assessed objectively – in the sense that they compensate for the actual deprivation, rather than the plaintiff's subjective perception of it[6] – we can see that negligence law recognises and responds to the autonomy impact of personal injury on its (that is to say autonomy's) own terms.

My third general observation about the relationship between negligence and autonomy switches the focus from plaintiffs to (potential) defendants. It is a truism that in setting the boundaries of negligence liability the law must strike a balance between the security interests of potential plaintiffs and the freedom of action of potential defendants. And yet it seems to me that negligence lawyers, having been distracted by instrumentalist concerns – such as the largely spurious "floodgates argument" – have given insufficient recognition to the threat that negligence liability poses to freedom of action.

Two contexts in which that threat is particularly acute are omissions cases and pure economic loss cases. If we begin with omissions liability – by which I mean liability for failing to confer a benefit on the plaintiff – it is generally accepted that duties of positive action pose greater threats to our autonomy than duties to act carefully, because instead of the law saying "If you choose to do *x* (drive a car, perform brain surgery, *etc*) you must do it with reasonable care", the law is saying "You *must do x*" (rescue the drowning child, warn the blind person near the cliff edge, etc), as opposed to *y* or *z* or whatever else it is that you might like to do at that moment.[7] I hope it can readily be accepted, therefore, that a *general* legal obligation to exercise reasonable care to confer benefits on others would represent a grave threat to our autonomy, and that wide-ranging obligations of beneficence are better left to the moral and political realms. At the same time, however, we should be clear that this legitimate autonomy concern in respect of positive obligations has its limits. An obligation to pull the endangered child to safety or to shout a warning to the blind person is likely to have only a very trivial impact on one's self-determination, so that opposition to a duty of easy rescue is difficult to sustain on autonomy grounds alone (though of course it may be that it can be justified in other ways, including perhaps the difficulty of drawing a sufficiently clear line between cases where the autonomy impact of the duty is trivial and those where it is not).

The second context in which freedom of action concerns are central to negligence law's abstentionist stance is recovery for "pure economic loss", by which I mean financial loss that does not result from damage to the plaintiff's person or property.

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6 *H West & Son Ltd v Shephard* [1964] AC 326 (HL, Eng).

7 See Sandy Steel, "Rationalising Omissions Liability in Negligence" (2019) 135 Law Q Rev 484 at 493–494 [Steel].

A general right not to suffer negligently inflicted economic loss would again represent a very significant threat to the autonomy of potential defendants, since the range of actions which may foreseeably cause economic loss to others is so much greater than the range of actions which may foreseeably cause them personal injury or property damage. Examples of such actions include opening a supermarket down the road from a grocery store, thereby reducing its custom; a financial commentator criticising a company, with the result that its share price falls and its shareholders lose money; a footballer scoring a goal, so that a gambler loses a bet; and so on and so forth. Subjecting all such actions to a standard of reasonableness is pretty much inconceivable, though again, as with omissions, the force of the autonomy concern can be substantially lessened provided a duty of care in respect of the economic interests of others is sufficiently narrowly tailored.

If autonomy considerations serve as a partial justification for the general no-recovery rules in respect of omissions and pure economic loss observable in many common law systems, they may also help to explain the most important exception to those no-recovery rules in English law, which is the doctrine of "assumption of responsibility". In a recent article on that doctrine,[8] I defined an assumption of responsibility as the taking on of a task for another person, in circumstances in which it is plausible to imply an undertaking to exercise due care in the performance of the task. I also argued that one of the reasons it may be justifiable to tie obligations of due care to prior assumptions of responsibility is that in such cases any autonomy concern is alleviated by the fact that (a) the defendant has chosen to take on a relevant responsibility in respect of an aspect of the plaintiff's well-being; and (b) the law allows the defendant to make clear that no liability is to attach to such an assumption of responsibility, and also to limit its scope in a number of important respects.[9]

My fourth and final general observation about the relationship between autonomy and negligence is that we should be careful not to overplay the significance of autonomy considerations in negligence law, but should instead recognise the limits of autonomy's justificatory power. Two examples spring to mind.

The first of those examples is *Greatorex v Greatorex*,[10] a first-instance decision in the English case law on liability for psychiatric injury suffered by so-called "secondary victims", which is to say, persons who have suffered mental trauma as a result of witnessing the death, injury or imperilment of another (whom we can refer to as the "immediate victim"). The defendant in the *Greatorex* case had been badly injured in a road accident caused by his own careless driving, and it just so happened that his father was one of the fire officers who attended the scene, and who helped to extricate his son from the car in which he was trapped. As a result, the father developed post-traumatic stress disorder, and he brought a negligence action against his own son seeking damages for this psychiatric illness. Although the father satisfied the requirements for secondary victim recovery laid down in the English authorities,[11] Cazalet J held that as a matter of law an immediate victim owed no

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8 Donal Nolan, "Assumption of Responsibility: Four Questions" (2019) 72 Current Leg Probs 123.

9 See also Steel, *supra* note 7 at 499–500.

10 [2000] 1 WLR 1970 (HC, Eng) [*Greatorex*].

11 In particular, *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310 (HL, Eng).

duty of care to a secondary victim traumatised by an injury that the immediate victim had negligently or deliberately inflicted on herself. One reason that the judge gave for this rule was that the imposition of a duty of care in these circumstances would be a significant limitation upon an individual's freedom of action (if, for example, she could be liable for the trauma which her suicide would cause others). With respect, this seems to me to be a completely unconvincing invocation of autonomy considerations. Surely the last thing on the mind of a person bent on self-harm or suicide is the possible liability of themselves or their estate to someone traumatised by their actions? Furthermore, in the highly unlikely event that such a person is both aware of, and concerned about, such a possibility, the impact on her autonomy is in any case generally going to be negligible, since she need only take reasonable steps to ensure that no-one in a close relationship to her witnesses her potentially trauma-inducing actions.

Like the judge in *Greatorex,* some academic commentators are also prone to exaggerate the force of autonomy considerations in the negligence context. A good example here is the argument that in a medical malpractice case where the defendant's negligence has deprived the plaintiff of a less than 50 per cent chance of avoiding physical harm (with the result that on the balance of probabilities the plaintiff is unable to establish causation of that physical harm) an award of damages can nevertheless be justified on autonomy grounds, since a result of the negligent treatment was that the plaintiff lost the option of receiving non-negligent treatment. The original proponent of this view was Stephen Perry, who claimed that in such a case the gist of the claim is not the lost chance, but "the deprivation of an opportunity to follow a preferable course of action",[12] so that the protected interest at stake is the plaintiff's autonomy as opposed to her bodily integrity.[13]

To see why this argument fails, it is important to remember that the ideal of autonomy is the notion that an individual is able "to make the basic choices that affect her life prospects".[14] And the problem with the argument is that it is difficult to see how the negligence of the doctor in the loss of a chance case has interfered with this ability. Note first that the argument obviously does not work unless the

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[12] Stephen R Perry, "Protected Interests and Undertakings in the Law of Negligence" (1992) 42 UTLJ 247 at 291.

[13] A variation on this argument is put forward by Gemma Turton, *Evidential Uncertainty in Causation in Negligence* (Oxford: Hart Publishing 2016) at 146–163. According to Turton (at 148), in a loss of a chance case the patient "suffers an interference with her autonomy interest since the diagnosis is a prerequisite of making informed decisions about treatment". Although there is not space to respond to this version of the argument in full here, it also seems to me to be flawed. Even if we accept (which some do not: see *infra* text to note 41) that a doctor interferes with a patient's autonomy by carelessly failing to warn the patient of a risk associated with a particular procedure which the same doctor is going to perform on the patient, that is a far cry from the notion that, by negligently failing to identify a health condition, a doctor is interfering with the autonomy of a patient who cannot then make a fully informed decision about future treatment, probably at the hands of other doctors. And if the latter were true then presumably all mistaken advice—including omitting to identify a relevant consideration—would amount to an autonomy interference and hence (on Turton's view) potentially ground a standalone claim for damages, regardless of whether it otherwise caused the advisee any loss. (Indeed, since the autonomy damage is independent of any other loss caused, on Turton's analysis it should be recoverable in the "loss of a chance" scenario where the claimant *can* establish causation of the physical harm on the balance of probabilities, in addition to the personal injury claim that would then lie.)

[14] Peter H Schuck, "Rethinking Informed Consent" (1994) 103 Yale LJ 899 at 924.

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patient had a choice of doctor in the first place and was both competent and conscious at the relevant time. But even if those conditions are satisfied, it is unclear how the doctor who *was* chosen has interfered with the patient's ability to make an important life choice by subsequently providing sub-standard care. In the very different case of medical non-disclosure of risk, the link with autonomy is that, by withholding important information, the doctor has deprived the patient of the ability to make a fully informed choice.[15] But clearly that is not what has happened here, unless the doctor is so serially incompetent that she should have warned the patient of this fact! All that *has* happened is that, as a result of the doctor's negligence, the free and informed choice that the patient made has turned out to be a bad one. It is surely self-evident, however, that I do not interfere with your autonomy just because I do something that in retrospect turns your earlier free and informed decision into a bad choice to have made. The truth is that in the loss of a chance case the patient's complaint relates to the negligent treatment and its possible consequences for her health, and not in any way whatsoever to her inability to make an informed choice. Analysis of the patient's complaint in autonomy terms is therefore quite simply misguided.

III. Autonomy Interference as Damage

The first of the two more specific aspects of the relationship between negligence and autonomy that I wish to explore is the question of whether interference with autonomy (or "loss of autonomy", as it is often styled) should be recognised as a form of damage that grounds a negligence claim. My exploration of this issue divides into three parts. I start with a discussion of some (mostly very recent) case law on the question. I then explain why it is that in my view interference with autonomy *per se* should not be recognised as damage for the purposes of a negligence claim. And I conclude by flagging the possibility that it may nevertheless be useful for the law to recognise some specific forms of autonomy loss as damage in this sense.

I should however first make two preliminary points. The first is that my concern in this section of the article is with loss of autonomy as *damage* (meaning the kind of interference with a person's interests that grounds a cause of action in negligence), rather than with the distinct question of whether a plaintiff who has established such a cause of action should be entitled to recover for loss of autonomy as a head of *damages*. Having said that, some of the considerations that are in my view relevant to the damage issue may also be relevant to the damages question.

The second preliminary point is that it is important not to confuse the question of autonomy interference as damage with the very different question of whether in medical non-disclosure cases the courts should respond to autonomy considerations by adapting the negligence rules governing matters such as breach of duty and causation (the subject-matter of cases such as *Montgomery v Lanarkshire*

[15] See *Daaka v Cartmel Hospital* [1999] CA 2781/93 at [34] *per* (Strasberg-Cohen J) (Supreme Court Sitting as the Court for Civil Appeals, Israel) [*Daaka*].

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Health Board[16] and *Chester v Afshar*[17]). Again, however, a caveat is needed, as Lord Hoffmann in *Chester* suggested that perhaps the solution to the issue in that case lay in what he called a small "solatium" to mark the infringement of the patient's autonomy.[18] This shows us that there is a link between cases like *Chester* and the question of autonomy interference as damage, as it can be argued that instead of altering the causation rules in such cases in order indirectly to vindicate a patient's autonomy interest by allowing recovery for physical injury arising out of the medical procedure, it would be better to vindicate that interest directly by awarding compensation for the autonomy interference itself.[19]

A. *The Case Law*

It will be helpful to put the discussion of loss of autonomy as damage in context by considering three cases in which plaintiffs sought compensation for such loss. The first of those cases is the landmark Israeli decision in *Daaka v Cartmel Hospital*.[20] The plaintiff in that case was admitted to the defendant hospital for an operation on her left leg. When she was on the operating table and had received sedatives in advance of undergoing anaesthesia, she was asked to sign a consent form in respect of a biopsy operation on her right shoulder, which she did. The biopsy was then carried out, but the shoulder on which it had been performed suffered damage and the plaintiff sought compensation from the defendant in respect of this injury. The Israeli Supreme Court held that the defendant had been negligent in not obtaining the plaintiff's informed consent for the biopsy, but that she could not recover for the physical injury that had resulted from that procedure, because she would almost certainly have agreed to it even if she had been fully informed of the risks. However, a majority of the court held that she was entitled to recover compensation for the violation of her autonomy in not obtaining her informed consent, albeit that the compensation awarded under this head of damage was quite a modest sum.[21] According to Or J, "the violation of human dignity and right to autonomy caused by the performance of a medical procedure on a person without his or her informed consent entitles him or her to compensatory damages under tort law".[22] The harm to a person's sensibilities attendant on "the failure to respect the basic right to shape

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16 [2015] AC 1430 (SC, Eng) [*Montgomery*].

17 [2005] 1 AC 134 (HL, Eng) [*Chester*]. For an example of this kind of confusion, see Tsachi Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law: Inconsistent Recognition" (2018) 26 Med L Rev 585 at 592–593 [Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law"], where the author fails to distinguish between *what the claim is for* (in *Chester*, physical injury) and *the purpose of the damages award* (in *Chester*, to vindicate patient autonomy). Only the former is a question of "damage". By contrast, the two issues are carefully separated out in *Shaw v Kovac* [2017] 1 WLR 4773 at [59]–[66] (CA) [*Shaw*] and in *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [122] (CA) [*ACB*].

18 *Chester*, *supra* note 17 at [34].

19 See, *eg*, Tamsyn Clark & Donal Nolan, "A Critique of *Chester v Afshar*" (2014) 34 Oxford J Leg Stud 659 at 684 [Clark & Nolan].

20 *Daaka*, *supra* note 15.

21 NIS 15,000 (about UKP 3,000 or SGD 5,000 at current exchange rates).

22 *Daaka*, *supra* note 15 at [21].

his or her life according to his or her own will" constituted a detriment to that person's welfare and hence fell under the broad definition of "damage" in section 2 of the Israeli Tort Ordinance.[23]

The majority in *Daaka* made it clear that the action for violation of autonomy was quite independent of any possible claim in respect of bodily injury and was neither conditional on, nor a substitute for, such an action.[24] According to Strasberg-Cohen J:

> Recognition of the right to compensation due to violation of the right to autonomy provides protection for the patent's autonomous status in the decision-making process and his or her right to receive information for the purpose of formulating a position about the performance of a medical procedure. … As a matter of principle, protecting these rights and interests should not be conditional upon providing compensation for the real harm caused by the medical treatment, which protects the interest of preservation of a person's bodily integrity.[25]

The Singapore Court of Appeal took a very different approach to the issue of autonomy loss as damage in *ACB v Thomson Medical Pte Ltd*,[26] a reproductive negligence case where the defendant provider of in vitro fertilisation ("IVF") treatment mishandled sperm samples and mistakenly fertilised the plaintiff's ovum with the sperm of a stranger instead of her husband. According to the court, while loss of autonomy might underlie a more specific award of damages in a reproductive negligence context, it should not be recognised as an actionable injury in its own right. Such a development, it was said, "would pose significant problems of legal coherence and would be contrary to well-established principles on the recovery of damages".[27] Scepticism as to the desirability of recognising autonomy loss as damage was also evident in the English case of *Shaw v Kovac*,[28] where the claimant was the personal representative of a man who had died following a medical procedure conducted by the first defendant cardiologist at the second defendant's hospital. It was conceded by the defendants that the deceased had not been properly informed of the risks of the procedure and that if he had been he would not have undergone the operation. Although an award of just over £15,000 was made for pain, suffering and loss of amenity, the English Court of Appeal rejected a separate claim for substantial compensatory damages for the invasion of personal autonomy by reason of the performance of a surgical procedure without proper informed consent, and also refused to recognise a new cause of action for the wrongful invasion of personal autonomy. While it was accepted that the duty of care doctors owed in respect of information provision was founded on the autonomy interests of patients, the remedy for breach of that duty consisted of the conventional compensation awarded for

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23 *Ibid*.

24 See *ibid* at [27] *per* (Or J) and [44] *per* (Strasberg-Cohen J). For a different view see the discussion in the dissenting judgment of Beinisch J at [13].

25 *Ibid* at [44].

26 *ACB*, *supra* note 17.

27 *Ibid* at [115] *per* (Andrew Phang JA).

28 *Shaw*, *supra* note 17.

any physical injury which resulted from it, and so the claimed additional award was "unnecessary and unjustified".[29]

B. *Arguments Against Recognition of Autonomy Interference Per Se as Damage*

I now turn to consider whether the Singaporean and English courts were right to reject autonomy interference *per se* as damage in the negligence context, or whether they should have echoed the more positive response of the Israeli court in *Daaka.* The most comprehensive critiques of the idea of loss of autonomy as damage in negligence have been put forward by Craig Purshouse[30] and by Andrew Phang JA in the *ACB* case. In my view, most of their objections to this notion are convincing, but one is not.

The objection that Purshouse and Andrew Phang JA put forward which I find unpersuasive is that damage entails the plaintiff being left worse off by the defendant's conduct, and that sometimes depriving a person of an aspect of their personal autonomy can leave them better off, as where a gambling addict is barred from using gambling websites, or a patient would have refused beneficial medical treatment if she had been warned of the risks.[31] There are two reasons why I am not convinced by this argument. The first is that in my view, it is a mistake to equate damage with being left worse off, and doing so confuses the concept of damage with the very different concept of loss.[32] And the second reason is that the objection fails to respond to the case for autonomy loss as damage on its own terms. If the loss of autonomy is *itself* the damage, then the fact that it happens to have resulted in the plaintiff obtaining a *different kind of* benefit (such as the gambler's financial gain, or the patient's positive physical outcome) is no more relevant to the question of negligence liability than the fact that after you carelessly broke my leg, I used the time I was at home recuperating to make some profitable investments.

There are however several much more convincing arguments against recognition of autonomy loss as damage. The first of these is the difficulty of pinning down the autonomy concept itself. This was dubbed the "conceptual" objection in *ACB*, where Andrew Phang JA described autonomy as a "slippery concept",[33] and said that:

> [T]he very concept of "autonomy" itself is the subject of rigorous theoretical and conceptual disagreement as well as controversy. The differences amongst [the] competing conceptions … of the concept of "autonomy" turn on more fundamental questions of political (the proper relationship between the State and its citizens) as well as moral (different conceptions of "the Good") philosophy. At the end of the day, it is neither possible nor is it the place of this court to decide

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29 *Ibid* at [69] *per* (Davis LJ).

30 See Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5.

31 *Ibid* at 237; *ACB, supra* note 17 at [120] (where this is termed the "coherence objection" to recognition of loss of autonomy as damage).

32 See Donal Nolan, "Rights, Damage and Loss" (2017) 37 Oxford J Leg Stud 255.

33 *ACB*, *supra* note 17 at [116].

> such questions. But without a workable concept of autonomy, it is impossible to say that autonomy can, in and of itself, be the subject matter of legal protection.[34]

Let us consider just a few of the disagreements about the nature of autonomy.[35] One is that while some philosophers conceive of autonomy as "a constituent of a person's well-being"[36] – a claim consistent with the idea of autonomy violations as damage – some influential conceptions of autonomy deny that it is a feature of persons, either because it is seen as a feature of some but not all persons, or because "it pertains not to persons but (for example) to the will, or to certain actions, or to certain principles".[37] A second source of disagreement is whether our autonomy interests are limited to the making of valuable choices (the "thick" view of autonomy) or whether the concept is value-neutral, and so unconcerned "with the desirability of the choices which are made, so long as they are freely chosen"[38] (the "thin" view).[39] This disagreement overlaps with a third, which concerns whether a person's autonomy relates to her immediate inclinations (the "current desire" view), her long-term goals in the light of her own values (the "best desire" view) or what she *should* want, according to some supposedly objective set of values (the "ideal desire" view).[40] Finally, what does respect for the autonomy of another actually entail? To give an example, in the case law and literature on medical non-disclosure there is a widespread assumption that autonomy considerations generate an obligation on doctors to disclose the risks and benefits of a proposed medical procedure, but at least one philosopher disagrees, arguing that respect for patient autonomy requires only that the patient understand in general terms what the procedure involves and not be manipulated into consenting to it.[41] All these doubts and uncertainties can be contrasted with the position regarding established forms of damage, such as physical damage to person or property, where there is broad agreement as to what these things mean (even if there are difficult cases at the margins).[42] In my

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34 *Ibid* at [119].

35 The list that follows is not intended to be exhaustive. I leave aside, for example, the challenge posed to the liberal ideal of individual autonomy by theories of "relational autonomy": see further, Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (New York: Oxford University Press 2000).

36 Roger Crisp, "Medical Negligence, Assault, Informed Consent, and Autonomy" (1990) 17 JL & Soc'y 77 at 81 [Crisp].

37 Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press 2002) at 22.

38 *ACB, supra* note 17 at [116].

39 For a recent discussion of the "thick" and "thin" views in the bioethics context, see Samuel Reis-Dennis, "Understanding Autonomy: An Urgent Intervention" (2020) 7 JL & Biosciences 1.

40 For this typology, see John Coggon, "Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?" (2007) 15 Health Care Analysis 234 [Coggon]. See further on the meaning of autonomy in this context, Craig Purshouse, "How Should Autonomy be Defined in Medical Negligence Cases?" (2015) 10 Clinical Ethics 107.

41 Tom Walker, "Respecting Autonomy without Disclosing Information" (2013) 27 Bioethics 388 at 395.

42 According to Craig Purshouse, "Autonomy, Affinity, and the Assessment of Damages: *ACB v Thomson Medical Pte Ltd* [2017] SGCA 20 and *Shaw v Kovak* [2017] EWCA Civ 1028" (2018) 26 Med L Rev 675 at 686, the disagreements as to the meaning of autonomy are not "an insurmountable obstacle" to the recognition of autonomy loss as damage. However, the two grounds he gives for this conclusion are unconvincing. One is that the courts have in fact adopted the "current desire" view of autonomy in other contexts, but his claim to this effect is disputed by other scholars: see, *eg*, Louise Austin, "*Correia*,

view, the lack of even a working consensus as to the meaning and significance of autonomy is a decisive argument against treating it as an interest directly protected by the law of tort.

A second objection to recognising loss of autonomy as damage is that this may be unduly burdensome for potential defendants, since there are such a wide range of actions which may affect another person's autonomy in potentially significant ways (for example, not giving a job to that person).[43] This problem is exacerbated by the difficulty of pinning the concept down, as it may be hard to know in advance what the law will consider to be an actionable interference with autonomy, which makes it more difficult for potential defendants to know what it is that they are required to do to avoid incurring negligence liability. It is possible that this final concern could be allayed to some extent by imposing limits on liability for loss of autonomy at the duty of care stage,[44] but it is nevertheless another reason not to recognise loss of autonomy *per se* as damage.

Another objection to recognising autonomy interference as damage is the difficulty of disentangling loss of autonomy from existing forms of damage, such as personal injury and property damage. As we have seen, the suffering of these paradigmatic forms of damage generally entails a loss of autonomy, and the damages awarded for personal injury are designed in part to compensate for that loss, while the damages awarded in property damage cases enable the plaintiff to repair or replace the property and hence to limit any autonomy loss the damage brings about. It is not entirely clear how a free-standing claim for loss of autonomy could comfortably co-exist with orthodox negligence actions such as these, since either the defendant would be exposed to double recovery, or a difficult separation out of the autonomy interference from the remainder of the patrimonial loss would be required.[45] By contrast, no such complications arise in connection with the existing heads of damage recognised in negligence law – such as personal injury and property damage themselves – since these are mutually exclusive concepts.

A possible response to this last objection is that loss of autonomy should be recognised as damage only in circumstances where there is no claim for personal injury, etc, as in the *Daaka* case.[46] However, that still leaves another problem, which

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Diamond and the *Chester* Exception: Vindicating Patient Autonomy?" (2021) 29 Med L Rev 547. The other ground is that judges frequently employ contested concepts, such as "property". But the difference in the case of autonomy seems to me to be the lack of agreement as to the core idea of what autonomy is and means. In the case of, say, property, there is clearly an agreed core legal meaning, even if there are arguments about the precise parameters of the concept.

43 See Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5 at 241–242. See also Raz, *supra* note 2 at 247, arguing that a right to personal autonomy would be unduly burdensome as it would impose on persons generally a duty to provide the right-holder with the conditions necessary for an autonomous life.

44 For the link with duty of care, see Purshouse, "Liability for Lost Autonomy in Negligence" *supra* note 5 at 247.

45 Similar overlap issues would arise if, for example, negligence law was to recognise "loss of dignity" as actionable damage, since dignitary interests partly underlie causes of action such as battery.

46 In the medical non-disclosure context, for example, it has been argued that for policy reasons a separate award for loss of autonomy should not be made where the procedure is a failure and recovery for the resultant personal injury is available: Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law", *supra* note 17 at 600.

is that allowing recovery for loss of autonomy could undermine restrictions on recovery in negligence for setbacks such as the suffering of pure economic loss or psychiatric illness, which can of course also have implications for a person's autonomy. This last concern is highlighted by Purshouse, who argues that, as a result, it would be impossible for negligence law to give direct recognition to an interest in autonomy "without distorting established and cogent legal principles" and creating inconsistency in the law.[47] In the *ACB* case, Andrew Phang JA referred to this as the "over-inclusiveness" objection, commenting:

> [T]he recognition of "loss of autonomy" as a head of damage would allow for the circumvention of existing control mechanisms in the tort of negligence. The problem is that any form of damage can, with some ingenuity, be reconceptualised in terms of a damage to autonomy.[48]

It may be that this concern has been somewhat overstated and that in most instances of, say, economic loss or psychiatric injury, no standalone autonomy claim would lie in any case.[49] Furthermore, as with the overlap concern, it would be possible for the courts to respond to this "over-inclusiveness" concern by placing limits on recovery for loss of autonomy at the duty of care stage, in this instance so as to prevent existing limitations on recovery being undermined. Nevertheless, there is a genuine risk of incoherence here, and obviating it would introduce additional complexity into what are already difficult areas of negligence law.

A final objection that can be made to recognition of loss of autonomy as damage is the difficulty of assessing the gravity of the autonomy interference for the purposes of awarding damages. This concern is linked to the more fundamental objection that the concept of autonomy is nebulous, because one consequence of that is that if it is decided that compensation should be paid for loss of autonomy, then it is not entirely clear what the compensation is for, and what considerations should determine the size of the award. The difficulties can be illustrated by reference to the medical non-disclosure context. Suppose that (as was the case in both *Daaka* and *Shaw*) the plaintiff's claim for autonomy damage arises out of a negligent failure by the defendant doctor to advise the plaintiff of the risks associated with a medical procedure that the plaintiff has undergone. And suppose further that the law recognises the possibility of a standalone negligence claim for autonomy loss in such a case, which is separate from any action for personal injury caused by the procedure. What considerations should determine whether a claim for such loss lies in these circumstances, and the quantum of damages where it does?

One obvious question that arises is whether an award for loss of autonomy should be made in a case of this kind even if the procedure was successful. If one takes seriously the idea of loss of autonomy as damage, then it seems that the answer to

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47 Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5 at 228.

48 *ACB*, *supra* note 17 at [123].

49 See Tsachi Keren-Paz, "Compensating Injury to Autonomy: A Conceptual and Normative Analysis" in Kit Barker, Karen Fairweather & Ross Grantham, eds, *Private Law in the 21st Century* (Oxford: Hart Publishing 2017) at 434–435 [Keren-Paz, "Compensating Injury to Autonomy: A Conceptual and Normative Analysis"].

that question must be yes, and that is indeed the view that some commentators have taken.[50] However, in the absence of a blatant autonomy violation of the kind that would ground a claim in battery, the prospect of substantive compensation awards to patients whose medical treatment at the defendant's hands has been successful is likely to prove very controversial.[51] In the words of Beinisch J, who dissented in *Daaka*:

> [F]ull acceptance of my colleague's approach allows compensation even in cases in which the treatment was successful and the patient satisfied, if it becomes clear that the patient was not initially presented with full details regarding the treatment. It is doubtful whether this result is desirable. It should be noted that other legal systems similar to our own have not accepted the rule that compensation can be granted by reason of violation of autonomy in the context of non-disclosure of information, regardless of the results of the medical treatment.[52]

Furthermore, if it is accepted that compensation ought to be awarded for autonomy loss where the medical procedure is successful, should the damages for that loss be the same as where the procedure went wrong, or should a lesser award be made?

A second issue concerns the patient's knowledge of the non-disclosure, and whether autonomy damage occurs in its absence (this issue is linked to the previous one, since in practice the patient usually finds out about the negligent non-disclosure because the risk that she was not warned about materialises). Of course, unless the non-disclosure comes to the patient's attention, no claim in respect of it will ever be made, but it is still worth asking whether there is autonomy damage in such a case, such that – if damage of this kind grounds a negligence claim – the patient has been wronged. Again, autonomy diehards give an affirmative answer,[53] and as a matter of principle that seems right: we do not need to know that our choices have been curtailed for our autonomy to be diminished, and there is no requirement that a plaintiff be aware of other forms of harm – such as personal injury or property damage – for them to count as "damage" for negligence purposes.[54] However, one commentator who is broadly supportive of awards for autonomy interference, Tsachi Keren-Paz, is more ambivalent on this point, questioning whether the autonomy violation should be evaluated according to a mixed subjective-objective test revolving around the distress (or anger) that the breach caused the claimant, or a purely objective test viewing choice as having objective value irrespective of the claimant's subjective feelings, or indeed even awareness that they were deprived of a choice.[55]

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[50] See, eg, Crisp, *supra* note 36 at 79. See also Keren-Paz, "Compensating Injury to Autonomy: A Conceptual and Normative Analysis", *supra* note 49 at 416 (who however concedes that the success of the procedure might affect the quantum of damages).

[51] For example, the medical lawyer John Coggon is sceptical, commenting that in the absence of physical harm "it seems hard to believe that a court would allow damages for the harm done to the patient's autonomy": Coggon, *supra* note 40 at 238.

[52] *Daaka, supra* note 15 at [14].

[53] See again Crisp, *supra* note 36 at 89.

[54] See, *eg*, *Cartledge v E Jopling & Sons Ltd* [1963] AC 758 (HL, Eng) (personal injury); *Pirelli General Cable Works Ltd v Oscar Faber & Partners* [1983] 2 AC 1 (HL, Eng) (property damage).

[55] Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law", *supra* note 17 at 601.

Another question that arises regarding standalone claims for lost autonomy in the medical non-disclosure context is whether such a claim should lie where the plaintiff would nevertheless have consented to the procedure if warned of the risk in question, and (if so) whether this should affect the size of the damages award.[56] This is yet another issue on which opinions are divided. According to the philosopher Roger Crisp, in such a case the doctor has still violated the autonomy of the patient "by omitting to provide him with the relevant information for making an important decision in the running of his own life", and what the patient would have chosen to do in the light of that information "seems to be quite unconnected with the nature of the [the doctor's] omission".[57] However, in *Shaw*, Davis LJ considered it "impossible … to see the justification" for an award in such circumstances,[58] and even counsel for the plaintiff in *Shaw* was reluctant to argue for an award of substantive damages in such a case, instead favouring nominal damages (though surely these would be out of place in a negligence claim, where damage is the gist of the action).[59] This scepticism tallies with Purshouse's contention that for a person's autonomy to be violated their desires must be interfered with, so that, for example, if a person would never have wanted children, then preventing them from having a child does not violate their autonomy.[60] (For what it is worth, my own view is that there is still an autonomy violation in such a case, but that it is less serious than if the patient would have made a different decision if warned.[61])

Finally, two more questions that arise are whether the quantum of damages for loss of autonomy in a non-disclosure case should depend on (1) the significance of the procedure (including the gravity of the risks); and (2) whether the information was withheld from the patient deliberately or inadvertently (since manipulation by the deliberate withholding of information would appear to be a particularly grave violation of autonomy[62]).

There are so many imponderables here that it is scarcely surprising that in *Shaw* Davis LJ was left wondering what the "applicable principles for assessing these novel (compensatory) damages" would be, and that in his view counsel for the claimant, while insisting that the quantum of the award for loss of autonomy might vary from case to case, "could identify no principled approach" which a court charged with fixing the damages might adopt for this purpose.[63] The difficulties in assessing damages for loss of autonomy in the medical non-disclosure context are

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56 In Keren-Paz's typology of interference with autonomy cases, this would be a "type 1" case (where the claimant "is deprived of the opportunity to consent to being moved from one state of affairs to another, although, had she been asked, she would have consented"), whereas the case where the patient would not have consented is a "type 2" case (where the claimant "is moved without consent to a subjectively inferior state of affairs", here the condition of having had the procedure that was unwanted in the light of the undisclosed risk). The third type of case ("type 3") is where "the claimant suffers autonomy loss consequent upon violation of a previously protected interest". See Keren-Paz, "Compensating Injury to Autonomy: A Conceptual and Normative Analysis", *supra* note 49.

57 Crisp, *supra* note 36 at 79. See also at 84 (Oxfam example).

58 *Shaw*, *supra* note 17 at [71].

59 *Ibid* (where Davis LJ said he was also puzzled by the suggestion of a nominal damages award).

60 Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5 at 238.

61 See Clark & Nolan, *supra* note 19 at 679–680.

62 See *ibid* at 678–679.

63 *Shaw, supra* note 17 at [72].

illustrated by the *Daaka* case, where the judges in the majority seem not to have been very sure what exactly it was that they were compensating the plaintiff for. Or J said, for example, that "the patient's particular subjective preferences" might lead the court to decide that there was no justification for making an award for violating the patient's "right to autonomy",[64] an apparent reference to a scenario where the patient was happy to accept the medical advice and had no interest in exercising any independent choice in the matter of their treatment. Furthermore, his Honour observed:

> In cases of the kind under discussion, the damage is expressed primarily in the plaintiff's psychological and emotional response to the fact that medical treatment was performed on the patient's body without his or her informed consent and the fact that risks materialised of which the patient was not informed prior to agreeing to the treatment … In assessing the amount of compensation for the damage, there is importance to the severity of the breach of the duty to receive the patient's informed consent prior to performing the treatment. Failure to provide any manner of significant information concerning the procedure about to be performed is generally more serious than failure to provide part of the substantive information.[65]

Meanwhile, on the vexed question of the relationship between the loss of autonomy claim and the success or failure of the procedure, Strasberg-Cohen J made it clear that while the autonomy award should not be regarded as in any sense a substitute for compensation for bodily injury:

> [T]here might certainly be reciprocity between the two heads of tort. In other words, the intensity of a person's feelings due to violation of his or her right to autonomy might change, inter alia, in accordance with the result of the treatment performed on the patient's body without obtaining informed consent, the extent of bodily harm caused, the importance of the information which was not given to the patient due to the doctor's negligence, etc. For example, where the failure of the treatment caused bodily harm to the patient, the intangible injuries due to the violation of the right of autonomy might be regarded as grave. And vice versa: the success of the medical treatment – despite the fact that it was performed without obtaining informed consent – might appease the patient and calm him or her to such an extent that the damage caused is minimal (*de minimis non curat lex*).[66]

In addition, Strasberg-Cohen J considered that the "extent of the violation might be more severe if the patient believes that the information not provided could have altered his or her position regarding performance of the medical treatment".[67] This suggests that the fact that the non-disclosure did not alter the patient's decision should not bar a claim for damages for lost autonomy altogether but might reduce

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64 *Daaka, supra* note 15 at [23].
65 *Ibid* at [28].
66 *Ibid* at [44].
67 *Ibid* at [47].

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the quantum of the award. By contrast, if the patient "is not interested in receiving the information and making an autonomous decision", then there is no basis to the claim of an autonomy violation at all.[68] Finally, the outcome of the treatment "could be of significance when evaluating the damage caused by the violation of autonomy", so that while the success of the treatment "might render the [autonomy damage] theoretical or negligible (*de minimis*)", its failure "may exacerbate the injury to the patient and his sensibilities".[69]

A possible response to the difficulties of assessing damages for lost autonomy in cases of medical non-disclosure might be to award a "conventional sum" regardless of the circumstances, a technique which the House of Lords employed in the reproductive negligence case of *Rees v Darlington Memorial Hospital NHS Trust*.[70] However, in my view this is not a very satisfactory solution in the non-disclosure context, since once the principle of autonomy damage caused by medical non-disclosure is accepted there seems to be a strong argument for distinguishing between more and less severe autonomy violations using at least some of the factors that have been flagged above, in which case it is hard to see how the award of a fixed sum across the board can be justified.[71]

For all these reasons, it would in my view be a mistake for negligence law to recognise loss of autonomy *per se* as damage. At the same time, however, it is important to emphasise that this conclusion does not exclude the possibility that autonomy as an underlying value can "point the direction in which the tort of negligence should develop" or be used as a justification for the recognition of new protected interests in the law of tort.[72]

C. *Specific Forms of Autonomy Interference*

I should also make it clear that I have no objection to the recognition of specific forms of autonomy interference as grounding claims in negligence, and indeed I think that this is a potentially desirable move for the law to make. In these sorts of case, the specific nature of the autonomy loss that the plaintiff has suffered may serve to allay (at least to some extent) the concerns raised by recognition of interference with autonomy as a form of damage at a more general level.

One example of a specific form of autonomy interference that should (and increasingly does) amount to a form of damage for negligence purposes is loss

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68 *Ibid*.

69 *Ibid* at [48].

70 [2004] 1 AC 309 (HL, Eng) [*Rees*]. See *infra* note 73.

71 The suggestion by counsel for the claimant in *Shaw, supra* note 17 that the court should award a conventional sum for the infringement of personal autonomy was roundly rejected by Davis LJ, who considered that *Rees* was a very different kind of case, since there the claimant was being deprived on policy grounds of damages to which she might well otherwise have been entitled.

72 Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5 at 242, drawing a parallel with privacy, and citing Lord Hoffmann's remark in *Wainwright v Home Office* [2004] 2 AC 406 at [31] (HL, Eng) that there is a "great difference between identifying privacy as a value which underlies the existence of a rule of law (and may point the direction in which the law should develop) and privacy as a principle of law in itself".

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of reproductive autonomy, meaning the choice whether and in what circumstances to have a child.[73] In this instance, it is possible to hone in on a particular form of autonomy loss and then to differentiate it at least to some extent from other harms that may arise out of the same act of negligence (such as an unwanted pregnancy, or the financial cost of bringing up a child conceived as a result of a failed contraceptive procedure). In arguing for the recognition of interference with reproductive autonomy as a principled head of damage, Stephen Todd observes:

> Decisions about whether to have children certainly should take their place among those that are the most important or significant throughout a person's life. Further, now that the techniques of in vitro fertilisation are well established and advancing, prospective parents have choices about the circumstances of conception … If we class decisions about such matters as all falling within the concept of reproductive autonomy, then claims alleging injury to or interference with such decisions can be recognised as founded upon a coherent and readily identifiable type of injury or damage.[74]

The objections to recognition of loss of autonomy *per se* as damage lose much or all of their force when it comes to loss of reproductive autonomy.[75] The specific nature of the loss obviates any concerns that potential defendants will be over-burdened, and the fact that the deprivation of autonomy has resulted in a particular undesired outcome (such as a child) means that the difficulty of pinning down the meaning of autonomy as an abstract concept loses much of its significance.[76] It is also relatively easy for the courts to establish clear boundaries to liability in this context. As for the problem of disentangling loss of autonomy from other forms of damage, this is also likely to be less of an issue in the reproductive autonomy context, though this depends to some extent on whether other forms of loss or damage are recoverable. For example, courts in both Singapore and the UK have refused to compensate the

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[73] For a recent overview, see Stephen Todd, "Common Law Protection for Injury to a Person's Reproductive Autonomy" (2019) 135 Law Q Rev 635. The leading Commonwealth cases are *Rees, supra* note 70, where a conventional sum of £15,000 was awarded to the parents of a child in a wrongful conception case, and *ACB*, *supra* note 17, where compensation was given for loss of "genetic affinity". I have previously argued that the award in *Rees* is best understood as resting on the recognition of loss of reproductive autonomy as damage (see Donal Nolan, "New Forms of Damage in Negligence" (2007) 70 Mod L Rev 59 at 77–80 [Nolan, "New Forms of Damage in Negligence"]. It also seems clear from the judgment in *ACB* that the award of damages for loss of genetic affinity in that case was in effect an award for a particular form of autonomy loss, namely the ability to choose with whom to have a child: see especially at [126] ("the Appellant has suffered a severe dislocation of her reproductive plans") and [130] (referring to "the frustration of the Appellant's decisional autonomy").

[74] Todd, *supra* note 73 at 648 [Todd].

[75] A similar point is made by Purshouse specifically as regards loss of genetic affinity. He argues that "this new interest does not suffer from the same problems as protecting an interest in autonomy" (Purshouse, "Liability for Lost Autonomy in Negligence"), *supra* note 5 at 688), because, for example, it is defined narrowly and so does not threaten to undermine other rules of tort law.

[76] This also provides a ready solution to the problem of fixing the point at which the autonomy loss occurs (*viz*, when the child is born) which might otherwise give rise to difficulties when it comes to limitation of actions and the like.

parents in such cases for the cost of bringing up a child,[77] which avoids any possible overlap between recovery for economic loss and for loss of autonomy. And while admittedly quantification of the loss remains troublesome, at least the loss of autonomy now takes a relatively standardised form (an "unwanted" child, loss of genetic affinity, etc) so that the quantification challenge is less acute than in the medical non-disclosure context, and can more appropriately be met by the making of a conventional award.[78]

There are in addition two positive advantages of recognising interference with autonomy as damage in the reproductive negligence context. One is that the possibility of treating the loss of autonomy as a form of damage may enable the courts to recognise the existence of a wrong, and to give substantial compensation for it, while at the same time moving the focus away from the "burden" of bringing up a particular child (with all the negative connotations which that has for the child's dignity) and refusing to shift the economic component of that burden from the parents to a healthcare provider. The award of a fixed sum to mark the substantial impact on the parents' life choices of the healthcare provider's negligence may therefore be thought to represent a reasonably balanced solution to the difficult issues raised by such cases. And while the use of such an award has been criticised on the ground that it "standardises" the loss of autonomy involved, and hence fails to acknowledge the severity of that loss in the particular case,[79] this seems to me to be a good thing, not least because it is likely to be impossible to arrive at an agreed basis on which to measure the gravity of that loss in the first place.[80]

The second advantage of recognition of lost autonomy as damage in this context is that it more accurately reflects the essential nature of the plaintiff's complaint than alternative characterisations of the plaintiff's injury. For example, in cases where the defendant has negligently damaged or destroyed sperm that represented the plaintiff's only hope of biological fatherhood,[81] focusing the award of damages

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77 See *McFarlane v Tayside Health Board* [2000] 2 AC 59 (HL, Eng); *ACB*, *supra* note 17. In the UK the additional costs of upkeep of a disabled child are however recoverable: *Parkinson v St James and Seacroft University Hospital NHS Trust* [2002] QB 266 (CA).

78 As it was in *Rees*, *supra* note 70. The use of a conventional award in *Rees* is defended by Craig Purshouse, "Judicial Reasoning and the Concept of Damage: Rethinking Medical Negligence Cases" (2015) 15 Medical L Intl 155 at 168, but attacked by Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law", *supra* note 17 at 603–604, who thinks such awards are more suitable to cases where the autonomy interference has not brought about an outcome adverse to the subjective preferences of the claimant. On balance I find the arguments of Purshouse on this issue more persuasive. The response to the quantification difficulty in *ACB*, where a percentage of the upkeep costs of the child was awarded as compensation for loss of genetic affinity, is in my view less satisfactory, since it ties the award for loss of autonomy to a quite separate interest of the parents (their financial well-being). For criticism of that aspect of the decision, see Purshouse, "Liability for Lost Autonomy in Negligence", *supra* note 5 at 689–690, who considers that a conventional award would have been a better solution.

79 See, *eg*, Tsachi Keren-Paz, "Gender Injustice in Compensating Injury to Autonomy in English and Singaporean Negligence Law" (2019) 27 Fem Leg Stud 33 at 44–45 [Keren-Paz, "Gender Injustice in Compensating Injury to Autonomy"].

80 For example, Keren-Paz suggests, *ibid*, that the loss of autonomy is less severe where the motivation for not having a child is purely financial, but on the assumption that upkeep costs are not recoverable that is surely open to doubt.

81 See *Yearworth v North Bristol NHS Trust* [2010] QB 1 (CA) [*Yearworth*] (where liability for lost sperm was based on a bailment analysis); *Holdich v Lothian Health Board* [2014] SLT 495 (Outer House of

squarely on the loss of reproductive choice brought about by the negligence seems much preferable to artificially stretching existing forms of damage (such as personal injury and property damage) to encompass what has occurred, and provides a more transparent basis on which to assess damages that compensate for the gist of the injury done.[82] Similarly, it may be preferable for the law of negligence to treat an unwanted pregnancy as a form of *sui generis* autonomy harm, rather than to treat it as a "personal injury", a characterisation which is problematic for various reasons.[83] Put simply, direct protection of the interest in reproductive autonomy may be preferable to indirect protection of that interest via liability for other forms of damage, an approach which threatens to "distort the interest in choice, subjecting it to inappropriate analytic and remedial restraints".[84]

Although reproductive autonomy is the most obvious example of a specific form of autonomy interest that we might wish to protect against negligent interference, it is not necessarily the only one. It is arguable, for instance, that a claim should lie for the loss of autonomy that occurs when a defendant negligently exposes the claimant to a type of food consumption of which is contrary to the claimant's religious or ethical beliefs, as where a dish served in a restaurant is described as vegan but in fact contains animal milk. In *Bhamra v Dubb*,[85] the caterer at a Sikh wedding unintentionally sourced food incorporating eggs, the consumption of which is forbidden by the Sikh religion. The claim in the case was brought in respect of the death of a guest at the wedding who had a severe egg allergy, and who had assumed that the meal would be egg-free. But there is, in my view, force in Keren-Paz's argument that all the observant Sikh guests who inadvertently consumed egg at the meal should have had a claim for autonomy loss, as the negligence of the caterer undermined both their "control over the bodies (what to eat) and their freedom of conscience".[86]

IV. Medical Non-Disclosure

That takes me to the final aspect of the relationship between negligence and autonomy that I wish to consider, namely the law of medical non-disclosure. The modern

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the Court of Session, Scot). This type of case does give rise to some problems of quantification of the loss, though these seem to me to be surmountable: see further, Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law", *supra* note 17 at 606.

82 See also Keren-Paz, "Gender Injustice in Compensating Injury to Autonomy", *supra* note 79 at 50 (the nub of the litigation in *Yearworth* was the "lost chance to become a father" and the negligence in the case "obviously interfered" with the claimants' reproductive autonomy).

83 Nolan, "New Forms of Damage in Negligence", *supra* note 73 at 76; Margaret Fordham, "The Protection of Personal Interests: Evolving Forms of Damage in Negligence" (2015) 27 Sing Ac LJ 643 at 648.

84 Marjorie Maguire Shultz, "From Informed Consent to Patient Choice: A New Protected Interest" (1985) 95 Yale LJ 219 at 276, 279 (referring to the medical non-disclosure context). On the need to avoid shoehorning new forms of damage into older, more established categories, see Nolan, "New Forms of Damage in Negligence", *supra* note 73 at 88.

85 [2010] EWCA Civ 13.

86 Keren-Paz, "Compensating Injury to Autonomy in English Negligence Law", *supra* note 17 at 596–598. Keren-Paz cites an Israeli case in which claimants who consumed a foodstuff marketed as Kosher recovered damages for interference with autonomy after doubts emerged about the Kosher credentials of the product: see *Barzillay v Prinir Ltd* [2014] CA 8037/06 (Supreme Court Sitting as the Court for Civil Appeals, Israel).

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view of this area of law firmly grounds the obligation to disclose medical risks in concerns over patient autonomy, and indeed it is the law on this subject that provides us with the most obvious intersection between negligence and autonomy. However, it is increasingly clear that this issue cannot comfortably be located within the framework of negligence law, and indeed a yet stronger claim is possible, namely that in many Commonwealth jurisdictions liability for medical non-disclosure is no longer negligence liability at all.

A. *The Uneasy Fit between Liability for Medical Non-disclosure and Negligence*

Before I turn to that stronger claim, I want to highlight just how uneasy the fit is in common law systems between the law on liability for medical non-disclosure and the broader framework of the negligence tort. The first thing to note here is that while in every other negligence case the fault of the defendant consists of exposing the plaintiff to unreasonable risks of injury or other harm in totality, in medical non-disclosure cases the patient's essential complaint is rather that the doctor's conduct was negligent because it deprived the patient of the opportunity to make an informed choice as to whether or not to run a *particular* risk. This is demonstrated by the fact that even if the totality of the risks associated with the patient not having a particular procedure clearly outweigh the totality of the risks of having it, the doctor may still be negligent in not disclosing one or more of those latter risks.

Another aspect of the law of medical non-disclosure that demonstrates the lack of fit with general negligence doctrine is the departures from orthodox causation principles that have been felt necessary in this type of case. Beginning with factual causation, there are well-recognised concerns arising out of the need for the patient in a medical non-disclosure case to establish that if properly informed of the risks she would not have gone ahead with the procedure in question. Those concerns are, first, that the patient has an obvious incentive to give self-serving testimony, and, secondly, that (even if honest) her testimony as to what she would have done may in hindsight be affected by the fact that the risk in question materialised and caused her injury. Courts and legislatures have responded to these concerns in different ways, but some of the responses have involved a departure from general negligence principles, as in the Supreme Court of Canada's decision in *Reibl v Hughes*[87] that in medical non-disclosure cases, recovery is conditional on the patient establishing that a reasonable person in her position would have chosen not to undertake the procedure if warned. This approach to a question of factual causation (which was also adopted by the US Circuit Court of Appeals in *Canterbury v Spence*[88]) is unique as far as negligence law is concerned, and alters the nature of the enquiry in a quite fundamental way.[89] It is also somewhat incoherent, since necessarily the "objective"

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87 (1980) 114 DLR (3d) 1 (SC, Can) [*Reibl*].

88 64 F 2d 772 at 791 (DC Cir, 1972) [*Canterbury*]. As in *Reibl*, the adoption of an objective approach to causation in *Canterbury* coincided with the adoption of a patient-centred "material risk" test of disclosure. This seems to me to be no coincidence: see *infra* text to note 119.

89 The inconsistency between this approach and fundamental negligence principles is emphasised by McLachlin J in *Arndt v Smith* [1997] 2 SCR 539 at 563 (SC, Can) [*Arndt*]. See also Gemma Turton,

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approach must accommodate at least some of the plaintiff's actual circumstances, and yet it is hard to see how a court can draw a sensible line between those circumstances pertaining to the plaintiff of which account can be taken and those (such as the patient's approach to risk) of which account cannot be taken without the test collapsing back into a subjective one.[90]

Difficult questions can also arise in medical non-disclosure cases when it comes to remoteness of damage, or "scope of liability". The leading UK decision in this area is the controversial case of *Chester v Afshar*,[91] where a majority of the House of Lords departed from orthodox remoteness principles to enable a patient to recover for injury that was factually caused by a negligent failure to warn, even though she admitted that, if warned, she would eventually have submitted to the procedure (and hence been exposed to the risk in question) in any case. In *Chester* the majority expressly justified this departure from causal orthodoxy by reference to autonomy considerations, arguing – unconvincingly in my view – that if liability were not imposed in this type of case the doctor's duty to warn would be largely emptied of content, with the result that the law would fail adequately to protect patient autonomy.[92]

B. *Is Liability for Medical Non-disclosure Still Negligence Liability?*

While causation decisions like *Reibl* and *Chester* demonstrate the tensions that arise when the problem of medical non-disclosure is resolved within a negligence framework, developments at the fault stage of the negligence enquiry in cases of this kind represent a more radical shift away from the negligence model, such that it is now arguably incorrect to describe the liability that arises in medical non-disclosure cases as negligence liability at all.

The making good of that claim must begin with the rather basic point that the one thing that unites the entirety of negligence law is, unsurprisingly, "negligence". While the scope of the older nominate torts, such as private nuisance and defamation, generally tracks particular interests of the plaintiff, the potential scope of

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"Informed Consent to Medical Treatment Post-*Montgomery*: Causation and Coincidence" (2019) 27 Med L Rev 108 at 116–118 [Turton, "Informed Consent"].

90 See *Reibl*, *supra* note 87 at 16–17, where the Supreme Court struggles to articulate a clear approach to these matters. For some of the complexities, see Margaret A Somerville, "Structuring the Issues in Informed Consent" [1981] 26 McGill LJ 740 at 800–801 [Somerville, "Issues in Informed Consent"]. Part of the problem with the reasoning on causation in *Riebl* is that the court seems to assume that the usual subjective approach necessarily involves acceptance of the plaintiff's testimony as true. Surely a more sensible solution is to apply a subjective test in the usual way but to adopt a degree of scepticism towards that testimony, particularly where the "reasonable patient" would clearly have gone ahead with the treatment (for analysis along these lines, see the judgment of McLachlin J in *Arndt*, *supra* note 89; and *Rosenberg v Percival* (2001) 205 CLR 434 (HC, Aust)). Some Australian legislatures have taken the scepticism about the plaintiff's testimony as to what she would have done to an extreme by making it inadmissible except insofar as it is contrary to her interest: see, *eg*, Civil Liability Act 2002 (NSW) s 5D(3)(b). That seems to me to go too far, but unlike the *Reibl* test it is at least coherent, and formally consistent with negligence orthodoxy.

91 *Chester*, *supra* note 17.

92 See, further, Clark & Nolan, *supra* note 19.

negligence law is limited only by the characterisation of the defendant's conduct as negligent. This simple truth explains the extraordinary flexibility of the cause of action, the ease with which it can respond to new social problems, and an expansionist tendency encapsulated in the title of Tony Weir's essay "The Staggering March of Negligence".[93] Nevertheless, even negligence has its limits, and developments in the law of liability for medical non-disclosure mean that it may no longer fall within them.

In the UK, the most important such development was the 2015 decision of the Supreme Court in *Montgomery v Lanarkshire Health Board*.[94] Before *Montgomery*, the leading authority on the doctor's duty to warn had been *Sidaway v Bethlem Royal Hospital*,[95] where a majority of the House of Lords rejected what they called the "transatlantic" doctrine of "informed consent", and held that a test of peer professional practice (the so-called "*Bolam*" test[96]) determined the fault issue in cases of medical non-disclosure of risks as well as in cases of alleged medical negligence in diagnosis and treatment. In *Montgomery*, however, the Supreme Court abandoned the *Bolam* test in this context, holding instead that a doctor had a duty to "take reasonable care to ensure that a patient is aware of material risks of injury that are inherent" in any proposed treatment,[97] and of any reasonable alternative or variant treatments. According to the court, a risk was material for these purposes if, in the circumstances of the particular case, either (a) a reasonable person in the patient's position would be likely to attach significance to it; or (b) the doctor was or should reasonably have been aware that the particular patient would be likely to attach significance to it. A doctor was entitled to withhold information relating to a material risk only if she reasonably considered that its disclosure would be seriously detrimental to the patient's health (the "therapeutic exception") or in circumstances of necessity, as where the patient is unconscious or otherwise unable to make a decision. The duty of care in question could "be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided", but was also "the counterpart of the patient's entitlement to decide whether or not to incur that risk".[98]

Several reasons were given in *Montgomery* for abandoning the *Bolam* test in the medical non-disclosure context, all of which focused on the need to give adequate protection to patient autonomy. In particular, the court emphasised three considerations. The first of these was that the relative importance attached by patients to quality as against length of life, etc, will vary, and that this might affect their attitude towards a proposed treatment and the reasonable alternatives. The second was that placing the burden on patients to put direct questions to doctors about risks

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93 Tony Weir, "The Staggering March of Negligence" in Peter Cane & Jane Stapleton, eds, *The Law of Obligations: Essays in Celebration of John Fleming* (Oxford: Oxford University Press 1998). There was a double meaning attached to the word "staggering" in the title of Weir's paper, but that need not concern us here.

94 *Montgomery*, *supra* note 16.

95 [1985] AC 871 (HL, Eng) [*Sidaway*].

96 Named after the decision in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (HC, Eng) [*Bolam*].

97 *Montgomery*, *supra* note 16 at [82] (*per* Lord Kerr and Lord Reed).

98 *Ibid*.

(as *Sidaway* did) disregarded the "social and psychological realities" of the doctor/patient relationship.[99] And the third was that perceptions of the doctor/patient relationship had changed away from a model based on medical paternalism towards a model based on patient autonomy and rights. As the court pointed out, the choice between a doctor-centred peer professional practice test and a patient-centred material risk test rests on whether the disclosure issue is seen as an aspect of treatment, falling within clinical judgment, or instead as an entitlement of the patient to be told of risks so as to make an informed choice whether or not to run them. And in decisively opting for the latter analysis, the court was following in the footsteps not only of Commonwealth courts such as the Supreme Court of Canada (in *Reibl v Hughes*[100]) and the High Court of Australia (in *Rogers v Whitaker*[101]), but also of its predecessor, the House of Lords, in *Chester v Afshar*.[102]

Now I should make it clear that I am not necessarily opposed to the abandonment of the *Bolam* test in the medical non-disclosure context. That test is in my view rooted in considerations of judicial competence to second-guess specialist professional opinion as expressed by expert witnesses, and there are reasons to suppose that those institutional competence concerns have less traction in non-disclosure cases than in cases concerned with diagnosis and treatment. Nevertheless, by adopting a patient-centred material risk test, rather than simply defaulting to a generic "reasonable doctor" test, the Supreme Court arguably abandoned negligence analysis altogether, in that for liability to arise it may no longer need to be shown that the defendant acted unreasonably in all the circumstances of the case.

Whether in fact the *Montgomery* approach is consistent with a negligence analysis is surprisingly difficult to say, and it is important to distinguish carefully between what the Supreme Court decided and how its decision seems to have been understood. The actual test laid down by the court appears to be one of negligence, since the duty of the doctor is not to achieve a particular outcome (the disclosure of material risks) but to *take reasonable steps* to achieve that outcome. This is a potentially important distinction, for at least three reasons. First, a risk may be material, but nevertheless not one of which a reasonable doctor would be aware. Here it seems clear that no liability would arise applying *Montgomery* and that has in fact been held to be so.[103] Secondly, it could also be argued applying *Montgomery* that a reasonable doctor may not in the circumstances have been able to discern what a reasonable patient would want to know, since with the benefit of hindsight a court may be able to factor into its assessment of whether a risk was material considerations of which a reasonable doctor would have been ignorant at the relevant time. Unlike in the previous scenario, in this case the reasonable doctor would have known of the risk but would not have believed it to be material. Whether this argument would be accepted is more doubtful, and a commentator who noticed this complication with the patient-centred approach to risk disclosure seemed to assume that it would not:

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99 *Ibid* at [58] (*per* Lord Kerr and Lord Reed).

100 *Reibl*, *supra* note 87.

101 (1992) 175 CLR 479 (HC, Aust) [*Rogers*].

102 *Chester*, *supra* note 17.

103 "[A] clinician is not required to warn of a risk of which he cannot reasonably be taken to be aware": *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] PIQR P18 at [43] (CA, Eng) (*per* Hamblen LJ).

> [H]ow are doctors supposed to know in advance what the abstract hypothetical reasonable patient would want to know? Since the standard of care in a particular case could only be conclusively determined *retrospectively* by the courts, the doctor will have to second guess a future court's assessment of what a reasonable patient would consider material.[104]

And finally, it seems that on the test as set out in *Montgomery* it would in theory be possible to bring resources issues to bear on the breach analysis, so that it could be argued, for example, that it was not unreasonable for a time-starved medical professional to skip over relatively minor (but nevertheless "material") risks, particularly in the case of a non-elective procedure where it was extremely unlikely that risk disclosure would make any difference to the patient's decision whether or not to give her consent.[105] However, my guess is that this argument is unlikely to be accepted, as it is easy to characterise it as antithetical to the supposedly "patient-centred approach" adopted in *Montgomery*.

As far as I am aware, these last two scenarios have not been tested in the courts since *Montgomery* was decided, and to that extent the jury is still out on whether in fact that decision represents an abandonment of negligence analysis in the medical non-disclosure context. But the resultant uncertainty puts doctors in a potentially difficult position, as was pointed out in a report commissioned by the Singapore Ministry of Health following a decision of the Singapore Court of Appeal[106] adopting a modified version of the *Montgomery* test:

> Doctors are genuinely unsure of when and how to take informed consent to an extent that they confidently believe would fulfill the standard of care. Doctors are unsure what considerations will be taken into account to determine materiality from the *particular patient's point of view*, especially when they are faced with real challenges on the ground, such as when the patient is seen in a busy clinic setting, when the doctor is seeing a new patient or covering another doctor's clinic, etc. Due regard also needs to be given to prioritising adequate and timely access to care, including ensuring that wait times are well-managed and within acceptable limits. Factors such as language barriers and the patient's age may also impede the patient's level of understanding. As a result, practitioners face difficulties coming up with effective and defensible work processes that can reliably and consistently provide material information to the spectrum of patients they may encounter in their practice, within the limited time allocated for them to attend to each patient.[107]

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[104] Emily Jackson, "'Informed Consent' to Medical Treatment and the Impotence of Tort" in Sheila AM Maclean, ed, *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate Publishing 2006) at 280.

[105] Note that in this instance it might be very difficult for a patient to establish causation, but that is of course a quite different question from the breach of duty one.

[106] *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 (CA) [*Hii Chii Kok*].

[107] Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process, *Report on Recommendations* (Singapore: Ministry of Health, 2019) at [40] (emphasis in original).

Whatever answer the courts ultimately give to these questions, there is no shortage of evidence that *Montgomery* has been treated as laying down a straightforward outcome-based test of "material risk" disclosure, shorn of the subtleties involved in a reasonable conduct standard. According to one commentator, for example, in place of the *Bolam* test, the court "imposed a duty to disclose any material risks",[108] while another described the general gist of the decision as a move away "from asking what a reasonable doctor would warn about" and towards asking "what a reasonable patient, or indeed the actual patient, would want to know".[109] The extent to which *Montgomery* is implicitly regarded as having departed from a negligence analysis is shown by an article on medical non-disclosure in the aftermath of that decision, where it is said that the issue of risk disclosure is an exemplar of a broader shift in medical law from a doctor-facing approach, with a starting point of "what the reasonable doctor would do in the circumstances", to a patient-focused approach, where the starting point is the rights of the patient.[110] According to the authors, two leading medical lawyers:

> The law [of risk disclosure] has, since the 1980s, developed from requiring that the doctor must provide the patient with information that the reasonable doctor would give, without judicial oversight, to stating that the test remained that of the reasonable doctor, but this time with judicial oversight, and then to a test where the doctor must disclose everything that the reasonable patient would want to be informed of.[111]

Furthermore, the Commonwealth decisions that influenced *Montgomery* are also indicative of a move away from a reasonableness standard in this context. In *Reibl v Hughes*, for example, Laskin CJ said that "the relationship between surgeon and patient gives rise to a duty of the surgeon to make disclosure of what I would call all material risks attending the surgery which is recommended".[112] Furthermore, his Honour expressly stated that the issue in non-disclosure cases was not "whether the doctor carried out his professional activities by applicable professional standards" but rather "the patient's right to know" what risks were involved in the procedure in question.[113] Moreover, in the leading Australian case of *Rogers v Whitaker* (the analysis in which was relied on heavily by the Supreme Court in *Montgomery*) the High Court held simply that "a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment".[114] By contrast, while also endorsing a

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[108] CP McGrath, "'Trust me I'm a Patient …': Disclosure Standards and the Patient's Right to Decide" [2016] Cambridge LJ 211 at 213. See also *Thefaut v Johnston* [2017] EWHC 497 at [53] (under the *Montgomery* test, "the doctor must communicate material risks").

[109] Turton, "Informed Consent", *supra* note 89 at 109.

[110] Rob Heywood and José Miola, "The Changing Face of Pre-operative Medical Disclosure: Placing the Patient at the Heart of the Matter" (2017) 133 Law Q Rev 296 at 299.

[111] *Ibid*. See also at 304 (material risk test "very different from *Bolam*'s reasonable doctor standard") and 320 (*Montgomery* approach "looks at issues from the perspective of the patient's rights rather than the doctor's duties").

[112] *Reibl*, *supra* note 87 at 5.

[113] *Ibid* at 13.

[114] *Rogers*, *supra* note 101 at 490.

"material risk" test of disclosure, the court in the seminal American non-disclosure case of *Canterbury v Spence* had been at pains to emphasise that the conduct of the medical practitioner must be unreasonable for liability to arise:

> Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's information needs. If, but only if, the fact-finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.[115]

The express recognition in *Canterbury* of the need for consistency with general negligence doctrine is helpful, as is the court's clear response to the first and (implicitly) the second of the three scenarios canvassed above. Unfortunately, however, as we have seen, subsequent Commonwealth decisions adopting a "material risk" approach to non-disclosure have generally failed to follow the clear lead given by this judgment.[116]

Considerable doubt therefore surrounds the precise import of the *Montgomery* decision. What is clear, however, is that if that case is understood as mandating disclosure of material risks regardless of reasonableness, then there may be circumstances where a doctor has reasonably failed to disclose such a risk (so that her conduct cannot be characterised as negligent) but where liability is nevertheless imposed. Were this to happen, then the link between medical non-disclosure and negligence would have been broken and this area of law would be more appropriately classified as a *sui generis* head of liability, falling somewhere between battery and negligence.

I should make three final points about the relationship between negligence and autonomy in this context. The first is that I am only highlighting a possible rupture between the law on liability for medical non-disclosure and negligence, and not necessarily condemning it. Indeed, there might be advantages to such a development, as it would leave the courts free to develop a set of rules governing such cases that might achieve a more appropriate balance between patient autonomy and any countervailing considerations, shorn of the constraints of fitting the liability within the four corners of the negligence tort.[117] My concern is simply that if that is what is

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[115] *Canterbury*, *supra* note 88 at 787.

[116] In *Hii Chii Kok*, *supra* note 106, the Singapore Court of Appeal did however emphasise the need for unreasonable conduct on the doctor's part. According to Sundaresh Menon CJ (delivering the judgment of the court) at [135], the modified *Montgomery* test established in that decision "is intended merely to *reflect* – in the form of a more specific test tailored to the context of advice – what an ordinary and reasonable doctor would have done in the circumstances" and it is later emphasised (at [154]) that when applying that test, it should be borne in mind that "the duty of the doctor is a duty to take *reasonable* care" (all emphasis in original).

[117] The choice of negligence over battery in this context inevitably compromised the ability of the law to vindicate patient autonomy, since "[t]he very notion of reasonableness of conduct that lies at the core of negligence signifie[s] a distancing from the concerns of genuine personal self-determination" (Izhak Englard, "Informed Consent: The Double-Faced Doctrine" in Nicholas J Mullany & Allen M Linden, eds, *Torts Tomorrow: A Tribute to John Fleming* (Sydney: LBC Information Services 1998) at 156.

going on, then we should at least call a spade a spade. The second point is that whatever the correct interpretation of *Montgomery*, the tensions that I have highlighted between negligence orthodoxy and the law of medical non-disclosure remain, and indeed have been accentuated by that decision. For even if the Supreme Court succeeded in formally reconciling a patient-focused test of disclosure with a negligence analysis, the statement of the particular outcome that the doctor must take reasonable steps to achieve (namely, disclosure of material risks), along with the spelling out of the precise circumstances in which that outcome need not be attained (namely, in cases of necessity and where the "therapeutic exception" applies) stand in marked contrast to the more open-ended approach that governs the breach of duty enquiry in the rest of negligence law, where the courts have consistently held that what amounts to "reasonable care" is a question of fact which is heavily dependent on the circumstances of the individual case, with the result that no firm rules can be laid down in advance as to what amounts to reasonable conduct in a given situation.[118] Finally, there is a real possibility in this context that the further the law moves away from a defendant-centred reasonableness test of disclosure towards a patient-centred "material risk" test, the greater the pressure will be to redress the balance at the causation stage, by adopting the objective approach to factual causation set out in the *Reibl* decision.[119] Hence one departure from negligence orthodoxy in the non-disclosure context threatens to trigger another, with the result that the gulf between medical non-disclosure cases and the rest of negligence law may yet grow wider still.

V. Conclusion

The rise of autonomy as a central value in contemporary liberal societies is a relatively recent phenomenon.[120] This phenomenon poses many challenging questions for private law and its future development. In this article, I have focused on the interaction between autonomy and one of the most significant areas of private law, the law of negligence. The picture is a complex one, and it has not been feasible to explore every aspect of that inter-relationship, but it is possible to observe in the different sections of the article three different forms of interaction.

In the first section of the article, I highlighted the way in which autonomy considerations (broadly interpreted) are deeply embedded in core aspects of negligence doctrine. In the second part of the article, I argued that negligence law is capable of adapting itself so as to recognise particularised types of autonomy interference

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See also Jay Katz, "Informed Consent: A Fairy Tale? Law's Vision" (1977) 39 U Pitt L Rev 137 at 165 [Katz, "Informed Consent"]. The tort of battery is not however a plausible alternative to negligence, for the reasons given in Clark & Nolan, *supra* note 19 at 685–688. Hence the appeal of a *sui generis* form of liability falling somewhere between the two.

118 See *Qualcast (Wolverhampton) Ltd v Haynes* [1959] AC 743 (HL, Eng).

119 An explicit connection between the two issues is often drawn in the Canadian case law and literature: see, *eg*, *Arndt*, *supra* note 89 at 553; Somerville, "Issues in Informed Consent", *supra* note 90 at 796.

120 As recently as the 1970s, for example, commentators framed the issue of "informed consent" in the medical context as a question of *dignity*, rather than *autonomy*: see, *eg*, Katz, "Informed Consent", *supra* note 117 at 161.

(such as loss of reproductive autonomy) as forms of damage that ground a negligence claim, while cautioning against such recognition in the case of autonomy loss *per se*. And in the third section of the article, I emphasised the tensions between orthodox negligence doctrine and a law of medical non-disclosure rooted in patient autonomy, and raised the possibility that the move to a patient-sided approach to liability in that context may in fact have broken the link with negligence altogether.