Full Article

MEDICAL LAW INTERNATIONAL

Should we criminalize a deliberate failure to obtain properly informed consent?

Medical Law International
1–24

DOI: 10.1177/09685332211060265
journals.sagepub.com/home/mli

Clark Hobson
University of Leicester, UK

José Miola
University of Leeds, UK

Abstract

This paper takes the form of a polemic and thought experiment. The starting point is that, if medical law's claims to place autonomy at the heart of the enterprise are to be taken seriously, then autonomy either needs to be considered a recoverable harm, or the most egregious infringements should be subject to the criminal law. This might particularly be the case where a doctor deliberately attempts to modify the patient's decision by failing to disclose information that they know that the patient would find significant. The article considers medical law's relationship with autonomy, before applying the criminal law – in the form of the analogous situation of defendants who deliberately fail to disclose HIV+ status to their sexual partners. What we find is a distinct difference in the way that autonomy is seen by medical and criminal law, although both are equally unsatisfactory.

Keywords

Informed consent, criminal law, medical law, trespass, autonomy

Received 15 September 2020; Revised 15 October 2021; Accepted 25 October 2021

Introduction

It is easy to get frustrated with medical law. Many bold statements are made in the course of its development, and one of these is that autonomy is *the* defining principle.[1] Yet how

Corresponding author:
José Miola, School of Law, University of Leeds, Leeds LS2 9JT, UK.
Email: j.miola@leeds.ac.uk

we go about protecting a person's autonomy when that autonomy has clearly been infringed is still much-discussed. This paper takes this frustration as a starting point. We begin to consider whether it would be feasible to protect autonomy in ways *other* than which it is purported to be currently protected in medical law. We do so by using the facts of the recent Supreme Court decision in *Montgomery v Lanarkshire Health Board*. We investigate the following idea: that if medical law is serious about protecting autonomy, whether the most egregious breaches might be most appropriately dealt with in the criminal sphere. We then consider how *Montgomery* might have fared there by using the reasoning in cases of deception and sexual intercourse. As mentioned above, we do so to begin to investigate if there are other ways to protect autonomy other than that purported by medical law.

This paper is structured into five parts. First, we chart the trajectory of medical law. This is to show how autonomy-respecting principles are now at the forefront of judicial thinking, in relation to aspects of informed consent. This also shows the willingness of final appellate courts to adopt a 'principles-first' approach in their decision-making. Second, we then go on to demonstrate that autonomy-respecting principles are less weighty in other areas relating to informed consent, namely proving causation as part of negligence. This inconsistency motivates the remainder of the paper. This part also demonstrates that even if trespass is considered, there is little clarity as to whether tort law or criminal law should be used. Even so, the facts of *Montgomery* suggest such an action might be considered criminal. Third, we theoretically substantiate our discussion by conceptualizing what it means protect and respect a person's autonomy. We then investigate whether there is any particular conception of autonomy used specifically in risk disclosure/informed consent. Fourth, we consider how the criminal law deals with fraud (which we use interchangeably with the word 'deception' in this paper) in relation to sexual intercourse. We show briefly how such fraud is only relevant to the ill effects of the act, as opposed to the nature of choice made in regards to the act itself (unless, as we note below, the deception is such that the nature and purpose of the act is different to what was consented to, such as where the defendant promises to use a condom and then removes it during intercourse). This produces an interesting result in applying a criminal law principles-first approach to the facts of *Montgomery.* However, in part five we analyse the implications of the criminal law conception of autonomy, with its differing emphasis on *bodily effects.* The analysis leads us to conclude that the use of criminal law would be *equally* unsatisfactory.

Finally, the paper concludes that the investigation has not been without merit. It highlights one route where we arguably should concentrate our energies if we are to be able to respect autonomy in a principled and defensive way. That is be reconsidering whether autonomy should be an actionable harm. This is bolstered by again considering the facts of *Montgomery*, and the sense that the tort of trespass may seem insufficient where a doctor has deliberately and successfully modified the decision that the patient has made.

---

1. See, for example, C. Foster, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Oxford: Hart, 2009)

Autonomy and the trajectory of medical law

The trajectory of medical law

Medical law has undergone a metamorphosis. This has been covered at length by many authors, including one of us.[2] However, a brief discussion is required. Essentially, medical law used to be a doctor-facing enterprise. Issues that were determined to be medical in nature were treated by the courts as being for doctors rather than judges to decide. When faced with a medico-legal question, the default mode of the courts was to ask 'what would other doctors do?' The medical norm was, in literal terms, privileged.[3] This can be seen through the lens of the infamous and, at one point ubiquitous, *Bolam* test, which was interpreted as holding that where a doctor could find some support from other doctors for the way that she acted, the court was prohibited from finding that course of conduct unreasonable.[4] However many of the decisions that doctors make, including those that end up being litigated, are not exercises of technical medical skill, but actually involve decisions of an ethical nature. Medical law as an enterprise grew out of a recognition that doctors were being treated (in tort) differently to other professionals, so that there was a separate jurisprudence applied to them; but also due to a push back by some academics against the assumption of medical expertise in issues that were not inherently medical.[5]

Judges eventually recognized this, and medical law has undergone a process of de-*Bolam*isation; issues that did not involve the use of technical medical skill were more closely scrutinized the courts. An excellent example of this can be found in information disclosure, which is discussed below. Even the law relating to negligence was brought back to what it was for all other professions in the form of the decision of the House of Lords in *Bolitho*.[6] *Bolam* was 'returned to its proper limits',[7] and the majority of the academic medical law community rejoiced.[8] The consequence of this is that a 'new', patient-centred medical law has emerged, where the question posed by courts is no longer 'what were the duties of the doctor, and did she comply with them?' so much as 'what are the rights of the patient, and have they been infringed?' The principle of autonomy has taken centre stage as the heart of medical law.[9] Nowhere is this more important

2. See, for example, J. Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas', *Medical Law Review* 17 (2009), p. 76 in the context of informed consent.
3. J. Harrington, 'Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment', *Legal Studies* 16 (1996), p. 348.
4. *Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582. See also M. Brazier and J. Miola, 'Bye *Bolam*: A Medical Litigation Revolution?', *Medical Law Review 8* (2000), p. 85.
5. I. Kennedy, *The Unmasking of Medicine* (London: George Allen and Unwin, 1981). For a modern counterpoint see J. Montgomery, 'Law and the Demoralisation of Medicine' *Legal Studies* 26 (2006), p. 185.
6. *Bolitho* v *City and Hackney Health Authority* [1998] AC 232.
7. Brazier and Miola, 'Bye Bye *Bolam*'.
8. "Eureka! The courts have got it at last" declared Andrew Grubb (A. Grubb, 'Negligence, Causation and *Bolam*', *Medical Law Review* 6 (1998), pp. 378, 380).
9. See Foster, *Choosing Life, Choosing Death*.

or evident than in the law relating to consent, in particular risk disclosure. That is the issue to which this article now turns.

Risk disclosure and the rise of autonomy

Risk disclosure is a good example of the change from the 'old' and 'new' medical law not just because it provides a good example of de-*Bolam*isation, but also because autonomy is at its heart: informed consent gets to the very essence of decision-making, as without sufficient relevant information it is impossible for patients to make the choices that they would have wanted to make had they received it.[10] Yet, initially, the courts were happy to use *Bolam* to ask the question: 'what should *the doctor* have told the patient'. This is evident in *Sidaway*, where 4 out of 5 judges in the House of Lords opted to use *Bolam* to assess the materiality of any given risk.[11] Shortly afterwards, in the Court of Appeal cases of *Blyth* and *Gold*, the courts were to apply an undiluted form of *Bolam* that simply did not consider patients at all.[12]

Reading these cases is shocking now, because what stands out is that there is not one single mention or acknowledgement, in either case, of the patient's right to make her own decision. The only question addressed by the court was whether the medical profession defined the doctor's duty in each case as requiring the disclosure of relevant information. Any entitlement on the part of the patient to the information is considered entirely immaterial, a point made explicitly in *Blyth*:

> [there is no] rule of law to the effect that where questions are asked by the patient, or doubts are expressed, a doctor is under an obligation to put the patient in possession of all the information . . . The amount of information to be given must depend on the circumstances, and as a general proposition it is governed by what is called the *Bolam* test.[13]

In other words, even where a patient asks specific questions, she is not necessarily entitled to full answers. Needless to say, there is no definition of patient autonomy that is met by such an approach. Nevertheless, the law changed – and the landmark case of *Montgomery* can be seen as the culmination of a process rather than a seismic shock to the law.[14] But this process can be charted through the increased recognition and prioritization of autonomy as what the law should be protecting. It is noticeable that the more that the law developed towards *Montgomery*, the more that the language of patients' rights and autonomy pervaded the judgements.[15] This reached its apotheosis

10. O. O'Neill, 'Some Limits of Informed Consent', *Journal of Medical Ethics* 29 (2003), p. 4.
11. *Sidaway* v *Board of Governors of Bethlem Royal Hospital* [1985] AC 871. It should be noted that this is something of a simplification, but one that is not relevant for the purposes of this piece.
12. *Blyth* v *Bloomsbury Health Authority* [1993] 4 Med LR 151; *Gold* v *Haringey Health Authority* [1987] 2 All ER 888.
13. Ibid., 160
14. *Montgomery* v *Lanarkshire Health Board* [2015] UKSC 11.
15. See Miola, 'On the Materiality of Risk'.

in the House of Lords in *Chester* v *Afshar*, and subsequently in *Montgomery*, to which we now turn.[16]

Like *Chester*, *Montgomery* is a decision based almost entirely on principle. Indeed, both judgements are notable examples of the highest court in the land not so much applying the law to the facts of a case, but looking at the principle that the law is supposed to protect and assessing whether the law adequately protects that principle. In *Chester* and *Montgomery* the principle to be protected was the protection of patient autonomy, and in both cases the law was deemed to be ineffective in this regard. As Lord Steyn noted in *Chester*,

> The *starting point* is that every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised.[17]

The courts' response was, quite simply, to change the law. In *Chester*, the House of Lords (by a majority of 3 to 2) decided that Mrs Chester's 'right of autonomy and dignity can and ought to be vindicated by a *narrow and modest departure from traditional causation principles*'.[18] The same approach is evident in *Montgomery*, which was a unanimous decision. Lords Reed and Kerr, in their joint judgement, made it clear that as autonomy respecting principles became more prevalent, so the law should follow. This is exemplified in two quotes which form the backbone of the decision to change the law:

> The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.[19]

> patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services.[20]

Lady Hale, in the other substantive judgement, then drove home the point that unless the issue is one of technical medical skill, then the test for whether the patient's rights

16. *Chester* v *Afshar* [2004] UKHL 41; *Montgomery* v *Lanarkshire Health Board* [2015].
17. *Chester* v *Afshar* [2004] at [14].
18. Ibid., at [24] per Lord Steyn.
19. *Montgomery* v *Lanarkshire Health Board* [2015], [81], per Lords Reed and Kerr.
20. Ibid., [75].

have been protected must be patient-facing rather than depend on any notion of the doctor's duty. Thus,

> once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear . . . that the Bolam test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite. A patient is entitled to take into account her own values.[21]

All of the above shows two key points. The first is the importance of autonomy to current judicial thinking. The second, which is related, is that they are also willing to change the law so as to give effect to the principles that they believe that the law should be prioritizing. Given these points, and the consideration of loss of autonomy as a harm below, this paper continues by assessing whether it might in some circumstances be more appropriate to use the criminal law than the civil law to publish failures of information disclosure if we adopt this 'principle first' approach. Here, we use the facts of *Montgomery*, where the Supreme Court found that Mrs Montgomery was not provided with the information about the risk of shoulder dystocia by Dr McLellan for the following reason:

> [Dr McLellan] said that her practice was not to spend a lot of time, or indeed any time at all, discussing potential risks of shoulder dystocia. She explained that this was because, in her estimation, the risk of a grave problem for the baby resulting from shoulder dystocia was very small. She considered, therefore, that if the condition was mentioned, 'most women will actually say, 'I'd rather have a caesarean section'. She went on to say that 'if you were to mention shoulder dystocia to every [diabetic] patient, if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections'.[22]

As this passage and the direct quotes from Dr McLellan make clear, Mrs Montgomery was not warned of the risk of shoulder dystocia for two reasons. First, because Dr McLellan felt that the relevant risk was not the risk of shoulder dystocia itself (which was as high as 9%), but rather the risk of injury to the baby resulting from shoulder dystocia, which was far smaller.[23] But, second, Dr McLellan also said that she did not mention the risk because if she did then she feared that Mrs Montgomery would request a caesarean, which she considered to be against her interests. In other words, she specifically omitted to mention the risk in order to steer Mrs Montgomery *away* from one course of action (requesting a caesarean) and *towards* a different one (attempting a vaginal delivery in the first instance). We consider, as part of a polemic, whether such conduct should be seen as vitiating consent and more appropriately dealt with by the criminal law. As mentioned above, we would stress that there are very good reasons why this should not be the case (some of which we mention later).

---

21. Ibid., [115], per Lady Hale.
22. Ibid. at [13].
23. It should be noted that this was accepted as being the correct approach by the lower courts in Scotland, but not by the Supreme Court (see R. Heywood, 'Negligent Antenatal Disclosure and Management of Labour', *Medical Law Review* 19 (2011), p. 140).

Space prohibits detailed consideration of the interesting question of whether steering a patient towards a particular choice by withholding information on alternatives is inherently problematic, or whether this steering is problematic in relation only to *reasonable* alternatives. We do comment on this later. However, what is sufficient for our purposes here is that we can, and do below, question whether medical law follows through on its purported purpose to protect patient autonomy. We do so by considering ways in which autonomy could be protected, and whether the law does so.[24] The next section shows that autonomy-respecting principles are less weighty in areas relating to informed consent.

Does medical law protect autonomy in areas related to informed consent?

Loss of autonomy as a harm in medical law

One option would be to declare that a loss of autonomy is itself a recoverable harm, and thus to use negligence as in any other informed consent case. Indeed, it has been argued before.[25] Tort law encourages claims in negligence rather than trespass.[26] While much of the case law (including *Montgomery*) focuses on the mechanics of risk disclosure and the materiality of risk, claimants must also prove causation. This is a requirement that gets to the heart of tort law, as it provides that the claimant must show that the defendant's poor conduct caused *harm*. Its centrality rests on the notion that the function of tort is not to punish wrongdoers, but to *compensate claimants for the harm suffered as a consequence of it*. In some respects, it is morally neutral in that regard. *Chester*, as we know, modified the usual causation requirements in order to give effect to the claimant's autonomy.[27] However, it was a controversial decision. To begin with, it was a bare 3-2 decision in the House of Lords, so even in *Chester*, there was no unanimity with regards to the 'principles first' approach.

Second, *Chester* (like *Montgomery*) adopted an Australian approach that had been law for some time and thus allows us to look there for likely developments. *Chester* utilized the case of *Chappel* v *Hart*.[28] However, subsequent developments in Australia

24. Lord Phillips MR in *R v Burke* [2005] EWCA Civ 1003, at [50] suggests that the ability to choose treatment is subject to the medical professionals view as to whether treatment is clinically indicated. We would argue that this is inconsistent with the 'principles first' approach adopted by *Montgomery*.
25. See, for example, D. Nolan, 'New forms of Damage in Negligence', *Modern Law Review* 70 (2007), pp. 59, 77; 80–86; T. Clark and D. Nolan, 'A Critique of *Chester v Afshar'*, Oxford Journal of Legal Studies 34(4) (2014), pp. 659, 688–689; T. Keren Paz, 'Compensating Injury to Autonomy: A Conceptual and Normative Analysis' in K. Barker, K. Fairweather and R. Grantham, eds., *Private Law in the 21st Century* (Oxford: Hart, 2017). Cf C. Pursehouse, 'Liability for Lost Autonomy in Negligence: Undermining the Coherence of Tort Law?', *Torts Law Journal* 22 (2015), p. 226.
26. *Chatterton* v *Gerson* [1981] 1 QB 432.
27. See S. Devaney, 'Autonomy Rules OK', *Medical Law Review* 13 (2005), p. 102.
28. *Chappel* v *Hart* (1998) 195 CLR 232.

seem to suggest that judges have become somewhat concerned about the claimant-friendly state of the law in relation to both breach of duty and causation, and have rowed back from *Chappel* to interpret causation more narrowly in order to rebalance the law.[29] The same seems to be happening in English law, where causation is also being used as a brake within the law designed to mitigate the advantage perceived to be given to claimants by *Montgomery*. Thus, where it has been argued that *Chester* renders the loss of autonomy as a recoverable 'harm', and that the philosophy in *Montgomery* supports that, courts have rejected that argument.

This was most explicitly demonstrated by the Court of Appeal in the case of *Duce*, where the argument was put directly to the court.[30] The claimant's argument to the Court of Appeal sought to tie the decision in *Chester* to that in *Montgomery*. In particular, the philosophy behind *Montgomery* was seen as something that should guide judgements. Thus

> [a] broad reading of the causation test established in *Chester* is bolstered by the policy arguments identified by the Supreme Court in *Montgomery*

However, this argument was rejected by the court, which conducted a close textual analysis of the judgements in *Chester* (particularly that of Lord Hope), and concluded that much of the decision was based on the particular facts in that case.[31] It was also noted that in another case in the Court of Appeal a similar argument had been brought and rejected.[32] It would seem, then, that the English position seems to mirror that in Australia, where causation has been interpreted narrowly, perhaps to mitigate against the widening of the scope of breach of duty. Most interesting is perhaps the rejection of the philosophy behind *Montgomery* in this regard.

Trespass to the person in tort law

An alternative might be to use trespass against the person in tort law. This is both much easier for claimants to prove and a more efficient vehicle for the protection of patient autonomy, in that the lack of disclosure itself is enough for the claimant to succeed, irrespective of the effect (or lack of it) on their decision.[33] It is therefore important to ascertain, therefore, precisely when we can use trespass rather than negligence. Unfortunately, this is one instance (though, as we note below, not the only one), where *Chatterton* is vague.[34] The

29. M. Brazier and A-M. Farrell, 'Not So New Directions in the Law of Consent? Examining *Montgomery* v *Lanarkshire Health Board*', *Journal of Medical Ethics* 42 (2016), p. 89.
30. *Duce* v *Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307. See also *Shaw* v *Kovac and University of Leicester NHS Trust* [2017] EWCA Civ 1028.
31. Ibid. at [55]-[69].
32. See *Correia* v *University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356, in particular at [12]-[29].
33. Indeed, this is highlighted in *Chatterton* v *Gerson* [1981], at 442–443.
34. There is a particular lack of consideration regarding when – or even whether – the criminal law should be involved. Indeed, there seems to be a general presumption that it does not really apply to medical practitioners in the ordinary course of their jobs. For example,

court did emphasize that the vast majority of cases between doctor and patient should be litigated in negligence, so long as the patient was informed 'in broad terms' of the nature and purpose of the procedure,[35] but only provided two examples of when trespass would be appropriate. The first is administrative error, where one thing is consented to but another performed – even if by mistake. Here there is deemed to be no consent.[36] The second is the one of interest to this article, and it is where the patient's consent is obtained by fraud. However, this was not defined by Bristow J beyond a simple declaration that 'if information is withheld in bad faith, the consent will be vitiated by fraud'.[37] As such, there is not much said in *Chatterton* regarding protecting the patient's autonomy, or even what autonomy means. *Chatterton* is a product of its time, given it was decided *pre-Sidaway.*[38]

However, this does seem to be something of an undeclared 'medical exception' whereby situations where the criminal law would seem to apply in clearly analogous contexts outside of medicine do not seem to reach across to medical practice.[39] As Feng notes, the courts have been *very* clear that we should use negligence rather than trespass as a matter of policy, so long as the patient has been informed of and consented to the nature of the treatment.[40] It is also unclear whether what happened in *Montgomery* would be considered fraud in *Chatterton* – we suspect not. Yet even where we can agree that trespass is the correct avenue, there is a lack of clarity regarding whether tort or the criminal law is most appropriate. Feng goes on to argue that we should in fraud cases consider the *level of concealment* to differentiate between using tort and the criminal law.[41] We agree, but the basis of our investigation is to consider whether a *deliberate* concealment *designed* to modify the treatment choice made by the patient may, if we are

---

in their texts Emily Jackson does not mention it, while Jonathan Herring spends very little time on it, pausing only to note the unreported case of *Potts* v *North West Regional Health Authority* (1983, Unreported). See E. Jackson, *Medical Law: Text, Cases and Materials*, 5th ed. (Oxford: Oxford University Press, 2019) and J. Herring, *Medical Law and Ethics*, 7th ed. (Oxford: Oxford University Press, 2018).

35. *Chatterton* v *Gerson* [1981]. For a brief comment on the vague nature of this test, see J. Deveraux, 'Continuing Conundrums in Competency' in S. McLean, ed., *First, Do No Harm: Law, Ethics and Healthcare* (London: Ashgate, 2006) at pp. 242–244.
36. Bristow J provided the example of a boy in Salford whose parents had consented to a tonsillectomy but, due to an error of some sort, a circumcision was performed. Needless to say, the consent given was not deemed to cover what was done even though, as Bristow J noted, the doctor was as much a victim of the circumstances as the patient.
37. Ibid., at p. 443.
38. See our earlier discussion of the 'Trajectory of Medical Law'. See the discussion in *Chatterton* v *Gerson* [1981], concerning information disclosure and the role of the medical professional, at pp. 443–444.
39. S. Fovargue and A. Mullock, eds., *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (London: Routledge, 2017).
40. T. K. Feng, 'Failure of Medical Advice: Trespass or Negligence?', *Legal Studies* 7(2) (1987), pp. 149, 150–152.See also A Beever, *A Theory of Tort Liability* (London: Hart, 2016) Chapter 15, for an argument that battery should be used as opposed to negligence in cases of information non-disclosure.
41. Ibid., p. 155.

to place autonomy at the heart of medical law, nudge us towards the criminal law. Indeed, we have argued above that the law allows us to ask the question asked in *Montgomery* and *Chester* themselves: 'does the law adequately protect autonomy?', with a view to modifying it (or utilizing other avenues) if it does not. This is why we focus on medical law specifically, and compare medical to criminal law, rather than tort law more generally. We now turn to theoretically substantiating our discussion by conceptualizing what it means to protect and respect a person's autonomy.

What does it mean to protect and respect autonomy?

In order to answer whether medical law adequately protects and respect's a person's autonomy, we need a better understanding of what the 'thing' is to be protected when respecting a person's autonomy. We also need a better understanding of how such a 'thing' should be respected, when we respect a person's autonomy. We shall reflect on the purpose of respecting autonomy, to arrive at a justified concept of autonomy. This seems appropriate.[42] Faden and Beauchamp note autonomy has been variously identified with 'privacy, voluntariness, self-mastery, choosing freely, choosing one's own moral position, and accepting responsibility for one's own choices'.[43] This shows 'how multiply ambiguous claims about the value of autonomy may be'.[44]

This purpose-driven approach means we must guard against a danger. This normative concept of autonomy may have to straddle different areas of law, each with their own local priorities and purposes.[45] These have been partially defined above. Our starting point, as has already been highlighted, is that the purpose of medial law is to protect and respect patient autonomy. The purpose of tort law is to compensate claimants for the harm suffered as a consequence of wrongdoing Criminal law is concerned with punishing wrongdoing.[46] These goals are not entirely similar.[47]

---

42. For a similar use of a purposive approach in distinguishing between different *conceptions* of autonomy, See S. W. Smith, *End-of-Life Decisions in Medical Care* (Cambridge: Cambridge University Press, 2012), pp. 102–104. See also A. Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge: Cambridge University Press), pp. 23–29.
43. R. Faden and T. Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986), p. 27. Likewise, Gerald Dwokin notes on his seminal treatment of the subject that autonomy has been variously equated with: 'liberty (positive or negative) . . . dignity, integrity, individuality, independence, responsibility and self-knowledge . . . self-assertion . . . critical reflection . . . freedom from obligation . . . absence of external causation . . . and knowledge of one's own interests' (G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p. 6).
44. O. O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), p. 23.
45. See further R. Dworkin, *Law's Empire* (Cambridge, MA: Belknapp, 1986), pp. 250–254.
46. For further discussion on the distinction between tort and crime, see M. Dyson 'The State's Obligation to Provide a Coherent System of Remedies Across Crime and Tort' in A. du Bois-Pedain, M. Ulväng and P. Asp, eds., *Criminal Law and the Authority of the State* (Oxford: Hart, 2004), pp. 171–198, 173–175; K.W. Simons, 'The Crime/Tort Distinction: Legal Doctrine and Normative Perspectives', *Widener Law Journal* 17 (2007-2008), p. 179.
47. Feng, 'Failure of Medical Advice', pp. 154–155.

Another controversial question is the relationship between different areas of law and to what extent, for example, medical law should stay as a discrete area with its own values that best justify central features of that practice. Space precludes a detailed analysis of this.[48] But it also suggests that medical law is now a sufficiently discrete sphere, and that autonomy-respecting principles enjoy a weighty priority in certain areas of that sphere.[49] For our purposes, the important comparison is between medical and criminal law. We do recognize that medical law suits within a framework of tort, but space prevents a detailed examination of this relationship. Again, what is under investigation is whether it is appropriate to criminalize egregious breaches of respecting autonomy, given the inconsistency in protecting and respecting autonomy in medical law identified earlier.

However, the danger is that that the concept of autonomy may allow for different or competing conceptions of autonomy *within* medical law.[50] Judges may then be forced to choose between competing conceptions of autonomy. This is not purely theoretical. *Montgomery* generally commits to the idea that respecting autonomy is the dominant principle underpinning risk disclosure, as seen above. However, no consideration is given to whether a single conception of autonomy is preferable and/or legally workable, or whether *different* conceptions should be promoted.[51] The failure to address these questions has meant that the autonomy-respecting principles which underpinned the development of risk disclosure and were made explicit in *Montgomery*, have been both *expanded and* contracted in subsequent case law.[52]

Bearing in mind the above, we can provide a brief sketch[53] of a defensible, and informative, concept of autonomy.[54] The importance of respecting an individual's autonomy and

48. See further J. Miola 'Taking Autonomy Seriously? Loss of Autonomy as a Legal "Harm"' in S. W. Smith et al., eds., *Ethical Judgments: Re-Writing Medical Law* (Oxford: Hart, 2017), pp. 187–192; K. Veitch, *The Jurisdiction of Medical Law* (Aldershot: Ashgate, 2007), chapter 1; D. Morgan, *Issues in Medical Law and Ethics* (London: Cavendish, 2001). In Contrast, see C. Pursehouse, 'Liability for Lost Autonomy in Negligence: Undermining the Coherence of Tort Law?', *Torts Law Journal* 22(3) (2015), p. 226.
49. For a discussion regarding the role of the state in ensuring a degree of coherence across tort and crime, and the basic remedial issues the state must address, see Dyson, "The State's Obligation'.
50. See J. Coggon 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?', *Health Care Analysis* 15(3) (2007), p. 235. See also G. Turton 'Informed Consent to Medical Treatment Post-*Montgomery*: Causation and Coincidence', *Medical Law Review* 27 (2018), p. 108; Veitch, *The Jurisdiction of Medical Law*.
51. For a discussion regarding the relationship between different conceptions of autonomy and different political societies and specifically different healthcare systems, see Maclean, *Autonomy, Informed Consent and Medical Law*, chapter 1.
52. S. Devaney et al., 'The Far-Reaching Implications of Montgomery for Risk Disclosure in Practice', *Journal of Patient Safety and Management* 24(1) (2019), p. 25.
53. Important works on autonomy include O'Neill, *Autonomy and Trust in Bioethics*, Dworkin, *The Theory and Practice of Autonomy*, J. B. Schneewind, *The Invention of Autonomy* (Cambridge: Cambridge University Press, 1998), R. Lindley, *Autonomy* (Atlantic Highlands, NJ: Humanities Press, 1986).
54. This sketch aims to build upon, and complement, the conceptualisation of autonomy provided in J. Coggon and J. Miola, 'Autonomy, Liberty, and Medical Decision-Making',

autonomous decisions is substantiated from connected principles of dignity and equal concern and respect. It is objectively important we can take pride in the lives we have lived; we recognize we *should* live well, rather than the other way around. And so, we must take this ethical responsibility seriously to make something of our lives, and make ethical and moral decisions for ourselves.

However, in order to take this responsibility seriously, not only must we recognize that this *is* a *responsibility* to make something valuable of our lives but that this responsibility reflects the universal importance of all human life. Respecting ourselves entails a parallel respect for the lives of all human beings.[55] The point of autonomy here, the reason why respect for ourselves and others means we must respect others autonomous decisions, derives from the capacity it protects. That is the capacity for an individual to express their own character in the life they lead. Respecting autonomy allows us to develop as moral agents, and be ascribed moral responsibility.[56] The value of autonomy, on this view, derives from the capacity it protects. This is the capacity to express one's own character in life, though the values, commitments, convictions and interests one holds.[57]

But, that is only half the story. We need to ensure that those capacities for exercising autonomy *are* properly protected by respecting moral actors. People would not be able to take their ethical responsibility seriously if we unjustifiably interfered with their capacity to form life plans and express their character-values, even if we do not always agree with those decisions which express their character values, or their life-plans.[58] But, on this

---

Cambridge Law Journal 70(3) (2011), p. 523, 524–530, and Coggon, 'Varied and Principled Understandings of Autonomy in English Law', pp. 242–244.

55. R. Dworkin, *Justice For Hedgehogs* (Cambridge, MA: Belknapp, 2011), pp. 13–14; 196; 255–256. See further chapters 9 & 11. Tom L. Beauchamp James F. Childress encapsulate similar demands, and draw upon the Kantian idea of treating persons as ends, in *Principles of Biomedical Ethics*, 8th ed. (Oxford: Oxford University Press, 2019), pp. 104–106. For an account of autonomy that is located in obligations dictated by reason, see O'Neill, *Autonomy and Trust in Bioethics*, pp. 83–95. See finally, John Rawls' idea of free and equal persons having two 'moral powers' (a capacity for a sense of justice, and a capacity for a conception of the good). Persons with these powers are, as Rawls notes, 'self-authenticating sources of valid claims'. Their decisions should thus be respected just in virtue of having these two powers (J. Rawls, *Justice as Fairness: A Restatement* ((Cambridge, MA: Belknapp, 2001), pp. 18–23). For a further application of this conceptualisation of respect for autonomy to informed consent procedures, see J. Wilson, 'Is Respect for Autonomy Defensible?', *Journal of Medical Ethics* 33 (2007), pp. 353, 355–356.
56. Maclean, *Autonomy, Informed Consent and Medical Law*, pp. 23–27.
57. R. Dworkin, *Life's Dominion* (London: HarperCollins, 1993), p. 224.
58. The idea of "unjustified interference" with life plans inevitably raises questions regarding as to a general justification for, and limits to, interference with life plans. Space precludes a detailed discussion of such political-moral questions, but it is clear that Derek Morgan is right in nothing that 'a *package* of conceptual questions' must be answered when considering the relationship between medical law and other areas of law (Morgan, *Issues in Medical Law and Ethics*, p. 5). For an attempt to answer questions of when it is legitimate to exercise political power in light of different life plans, and how such a political order remains stable and generally obeyed, see J. Rawls, *Political Liberalism* (New York: Columbia, 1993). Another route to justifying

account, we cannot realize the value of autonomy, without recognizing the negative and positive obligations that come with respecting the autonomy of moral actors. Negatively, this means autonomous actions should not be subject to unjustified controlling constraints by others, so as to affect the agency of the autonomous individual.[59] Positively, this means both respectful treatment in disclosing information, and at an abstract level, actions that foster autonomous decision making. The autonomous individual must also possess sufficient competence,[60] as well as be allowed sufficient time, relative to the decision to be made, to reflect on the decision, and the material, foreseeable implications of that decision.[61]

Autonomy's conception in risk disclosure/informed consent

Having outlined this concept with autonomy, we can begin to examine if there is any particular conception of autonomy used specifically in risk disclosure, and whether this conception is coherent[62] with this concept.[63] Therefore, this discussion builds upon the above, by explicitly drawing out the conceptual foundations of the trajectory of medical law and risk disclosure. This is still explicitly worthwhile discussing for comparative purposes to the criminal law.

As noted above, the post-*Sidaway* cases of *Gold*[64] and *Blyth*[65] refuse to recognize the inherent ethical content in risk disclosure practices. Patient choices were subject to what

---

the enforcement of obligations comes from analyses of authority. See J. Raz, *The Morality of Freedom* (Oxford: Oxford University Press, 1986) Part 1: The Bounds of Authority; *The Authority of Law*, 2nd ed. (Oxford: Oxford University Press, 2009), Part 1: Law and Authority; L. Green, *The Authority of the State* (Oxford: Oxford University Press, 1988).

59. *Re T* [1992] 4 All ER 649
60. Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making', pp. 527–528; Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 112–118. For an argument that in the legal context autonomy delegates too much to the idea of capacity, see C. Foster, 'Autonomy in Medico-Legal Courtroom: A Principle Fit for Purpose?', *Medical Law Review* 22 (2013), pp. 48, 58–59.
61. Beauchamp & Childress, *Principles of Biomedical Ethics*, pp. 102–103. See further Smith, *End-of-Life Decisions in Medical Care*, pp. 107–110, and more specifically in relation to consent, Maclean, *Autonomy, Informed Consent and Medical Law*, pp. 134–143.
62. In the sense of that conception being consistent with the concept, concept and conception are in some sense mutually explanatory, and that conception has a low number of anomalous features not explained by the concept. See further L. BonJour, *The Structure of Empirical Knowledge* (Cambridge, MA: Harvard University Press, 1988), pp. 93–100.
63. See Coggon, 'Varied and Principled Understandings of Autonomy in English Law'; Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making'; Veitch, *The Jurisdiction of Medical Law*; Foster, 'Autonomy in Medico-Legal Courtroom; C. Foster and J. Miola 'Who's In Charge? The Relationship between Medical Law, Medical Ethics, and Medical Morality?', *Medical Law Review* 23 (2015), p. 505; G. Turton, 'Informed Consent to Medical Treatment Post-Montgomery: Causation and Coincidence', *Medical Law Review* 27 (2019), p. 108.
64. [1988] QB 481
65. [1993] 4 Med LR 151

the doctor thought best for them.[66] Both cases go further than Lord Diplock in *Sidaway* by holding that *Bolam* applies to the disclosure of risks even when a patient asks specific questions in order to exercise their autonomy.[67] However, since *Sidaway, Blyth, and Gold*, the law has become more sensitive to the ethical rationale behind standards of disclosure and has promoted a conception of autonomy coherent with the concept outlined above. This conception of autonomy relates to a particular type of decision: sufficiently informed, given adequate time for reflection, based on understanding by a competent/capacitous chooser. We see this initially in *Smith v Tunbridge Wells Health Authority.*[68]

The non-disclosed risk in *Smith* was small, and the procedure was therapeutic. Smith is important first because *every single passage* Morland J quotes from *Sidaway* refers, in one form or another, to principles of respect for autonomy underpinning legal standards of disclosure.[69] What is also noticeable, however, is that *Smith* says *as much* as *Montgomery* about how to ensure the disclosed risks are *understood*.[70] This is a more specific instantiation of the positive obligations of respecting the autonomy of moral actors discussed above.[71] This perhaps also emphasizes the relative brevity in *Montgomery* in exploring this constituent component of autonomy and how it should influence risk disclosure standards. Morland J states that

> [w]hen recommending a particular type of surgery or treatment, the doctor, when warning of the risks, must take reasonable care to ensure that his explanation of the risks is intelligible to the particular patient. The doctor should use language, simple but not misleading, which the doctor perceives from what knowledge and acquaintanceship that he may have of the patent . . . will be understood by the patient so that the patient can make an informed decision whether or not to consent to the recommended surgery or treatment.[72]

66. Brazier and Miola, 'Bye Bye *Bolam*', p. 91.
67. Lord Diplock states in *Sidaway* that '[n]o doubt if the patient in fact manifested [an autonomous] attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know' (above n4, at p. 895). However, see Kerr LJ in *Blyth*: '[t]he question of what a plaintiff should be told in answer to a general inquiry cannot be divorced from the *Bolam* test, any more than when no such inquiry is made' (above n64, at p. 157). See further ibid. at p. 160, per Neill LJ. See how Lloyd LJ elides the distinction between therapeutic and non-therapeutic treatments (of which the failure to disclose certain risks in relation to the latter type of procedure was the subject of the appeal) in *Gold*, above n63, at p. 489. See finally M. Brazier 'Patient Autonomy and Consent to Treatment: The Role of the Law?', *Legal Studies* 2(7) (1987), pp. 169, 182, for strong criticism relating to the attempt to distinguish therapeutic from non-therapeutic procedures for the purposes of non-negligent risk disclosure practices.
68. [1994] 5 Medical Law Reports 334. In Smith, it was held Mr Smith had a right to recover damages resulting from his consultant surgeon's negligent failure to provide a sufficiently clear warning of the risk of impotence from the operation, given he was under such a duty to warn and that risk did eventuate (at p. 334).
69. Ibid., at pp. 336–337. See also *McAllister v Lewisham and North Southwark Health Authority* [1994] 5 Medical Law Reports 343.
70. See *Montgomery*, above n14, at [90].
71. See further Beauchamp and Childress, *Principles of Biomedical Ethics*, pp. 104–106.
72. Smith, *End-of-Life Decisions in Medical Care*, at p. 339.

Morland J concludes that one fact that demonstrates the lack of clarity in communication was the *speed* of consent of the patient.[73]

We further see the use of a conception of autonomy as relating to a particular sort of informed, reflective, non-controlled decision made by competent choosers that accord with their life-plans in cases post-*Smith*. These include *Wyatt v Curtis*,[74] *Jones v North West Strategic Health Authority*,[75] *Birch v University College London Hospital NHS Foundation Trust*,[76] and *Chester.*

We see in *Wyatt* a reflection upon the *subjective* nature of risk perception in determining whether a risk is significant. Again, relative to *Montgomery's* discussion of the subjective nature of risk[77] *Wyatt* is as detailed. Sedley LJ states that

> what is substantial and what is grave are questions on which the doctor's and the patients perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient's perception. To the doctor, a chance in a hundred that the patient's chickenpox may produce an abnormality in the foetus may well be an insubstantial chance, and an abnormality may in any case not be grave. To the patient a new risk which . . . at least enhances the background risk of a potentially catastrophic abnormality may well be both substantial and grave.[78]

We also see a concern with risk perception in *Jones. Jones* concerned a remarkably similar set of facts to *Montgomery*.[79] The claimant had cerebral palsy resulting from shoulder dystocia, and claimed his mother should have been warned of those risks. The claimant failed on the grounds of causation. However, Nicol J held the mother should have been warned of the possibility of the risk of shoulder dystocia, despite the risk of cerebral palsy because of shoulder dystocia being put at around 1-2%. He stated 'despite these arguments, I have concluded there was significant risk associated with vaginal birth . . . I appreciate that the incidence of shoulder dystocia is not the same as the risk of harm to the baby. But there is undoubtedly a risk of harm'.[80] The risk of shoulder dystocia was relevant to the mode of delivery, precisely because of its traumatic effect on the patient.[81]

---

73. Ibid., at p. 341. See also similarly *Lybert v Warrington Health Authority* [1996] 7 Medical Law Reports for a finding of negligence whereby the timing and conditions under which the warning of risk (itself not sufficiently emphatic and clear) was unreasonable. Finally, see *Jones v Royal Devon and Exeter NHS Foundation Trust* (unreported) whereby it was held that the NHS Trust, by informing the patient as to the identity of the surgeon performing the operation (a material factor for the patient) just before the surgery, had breached its duty by informing the patient at too late a stage.
74. [2003] EWCA Civ 1779.
75. [2010] EWHC 178.
76. [2008] EWHC 2237.
77. See *Montgomery's* discussion of risk in the abstract at [89], and the application of this subjectivity of risk at [94].
78. *Wyatt*, above n74, at [16].
79. Indeed, Jones was relied upon by Nadine Montgomery in the Outer House Court of Session. See *NM v Lanarkshire Health Board* [2010] CSOH 104, at [150].
80. *Jones v Royal Devon and Exeter NHS Foundation Trust*, at [50].
81. Ibid., at [51].

As Maclean notes about *Wyatt* (also a redeeming feature of *Montgomery*) these passages at least 'coherently [express] the *spirit* behind the recognition that information disclosure should not be fully determined by clinical judgment'.[82] Focussing on this concept of risk significance allows us to recognize explicitly that perceptions of what constitutes a significant risk may differ between patients and practitioners in relation to both the magnitude and type of harm. Different perceptions may reflect the psychological makeup of patients[83] and more generally might mirror different approximate assessments of certain risks. This may include various factors, such as whether the risks are voluntary, novel, dreaded, highly salient, and controllable.[84] The meaning of that type of harm risked by a particular action and whether it is significant can only be fully determined by the affected person. Though these arguments are based on the concept of risk, they also promote a patient's capacity for autonomous choice. Recognizing the question of risk significance is only fully determinable by the affected person and altering the legal standard to reflect this, can give a greater degree of control to the patient over information provision. This may further ensure patient understanding, as this may prompt a correlative focus on ensuring the likelihood and nature of the harm risked is brought home to them in a meaningful way.[85]

Birch can be read as authority for the proposition that patients have a legitimate claim when something untoward happens as a result of a decision to proceed with a riskier procedure when there is a reasonably available less risky option that is not disclosed.[86] As explained by Cranston J, '[t]he obvious rationale is patient autonomy and respect for the reality that it is the patient who must bear any consequences if a risk transforms itself into a reality'.[87]

Perhaps the conception of autonomy that is most coherent with the above comes from Lord Steyn's endorsement of Ronald Dworkin's purpose of autonomy being the expression of one's character in the life one leads.[88] All the foregoing emphasizes two points. First that the conception of autonomy promoted in risk disclosure cases goes beyond thin

82. A. Maclean, 'From *Sidaway* to *Pearce* and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?', *Medical Law Review* 20 (2012), pp. 108, 121 (emphasis added).
83. A Maclean, 'Giving the Reasonable Patient a Voice: Informational Disclosure and the Relevance of Empirical Evidence', Medical Law International 7 (2005), pp. 1, 5.
84. Beauchamp and Childress, *Principles of Biomedical Ethics*, p. 249 (footnote omitted).
85. B&C 105; Maclean, 'From *Sidaway* to *Pearce* and Beyond', p. 120.
86. *Birch v University College London Hospital NHS Foundation Trust*, [74]; [77].
87. Ibid. [72]. See further R. Heywood 'Medical Disclosure of Alternative Treatments', *CLJ* 68 (2009), p. 30. The emphasis on the disclosure of alternative treatments is echoed in *Montgomery* v *Lanarkshire Health Board* [2015], at [109];[111] per Lady Hale. See also R. Heywood and J. Miola, 'The Changing Face of Pre-operative Medical Disclosure: Placing the Patient at the Heart of the Matter', *Law Quarterly Review* 296 (2017), pp. 307–310 for a good discussion of the principles in *Birch* relating to when a treatment is reasonable and must be disclosed. Importantly, this does require reliance on *Bolam*, or a professional practice standard. Cf *MeikleJohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120.
88. See *Chester* v *Afshar* [2004], at [18].

conceptions of autonomy as merely self-determination.[89] Second, this conception of autonomy fits with the above: the emphasis here is on the protection given to a particular type of decision, and the obligations that stem from protecting that particular type of decision: one that is sufficiently informed, reflective, and based on understanding by a competent chooser.

Needless to say, being steered away from your preferred course of action and towards another by the deliberate withholding of information does not fulfil any of the criteria for the protection of any robust definition of autonomy. However, two points need to be made here. First, that a person in Ms Montgomery's position would only be able to claim *subject to causation being satisfied*, which might be seen as unsatisfactory. Again, loss of autonomy is not (yet) a recoverable harm in medical law.[90] Second, and relatedly, we are therefore compensating her for the *effects* of that infringement of autonomy, rather than punishing the lack of concern expressed for it. With respect to the latter point, this motivates the investigation as to whether the criminal law might be a more appropriate mechanism for redress, or that it might provide a solution to the question of how best to emphasize and protect the patient's right to autonomy. We will now consider this.

Non-disclosure of information and the criminal law: consent to sexual intercourse

The criminal law position

A closely analogous situation is fraud in relation to sexual intercourse, and how it is dealt with in the criminal law. In part, as we note below, this is because there is an analogy relating to deception and a body of case law that explores it. But it is also due to the fact that the process that led to the Sexual Offences Act 2003 involved discussions of consent and autonomy.[91] There is no need to consider the law in great detail here, as it is covered elsewhere.[92] The key cases all share the same basic facts: a defendant with a sexually transmissible disease – be it gonorrhoea or HIV – engages in sexual intercourse with their partner, but does not inform that partner of this salient fact.[93] The question for the courts has been: does this constitute an absence of consent which would lead to the defendant being guilty of rape? The analogy between the cases can be justified in the following way: in each case the defendant has not just steered the claimant/victim towards a certain decision, or persuaded them to adopt it, but rather *deliberately* withheld

89. Maclean, *Autonomy, Informed Consent and Medical Law*, pp. 11–13; CF Foster, 'Autonomy in Medico-Legal Courtroom'.
90. See, outside of a medical law context, *Bharma v Dubb* [2010] EWCA Civ 13. See also footnote 25 above, for further discussion.
91. For discussion of this, see J. Temkin and A. Ashworth, 'The Sexual Offences Act 2003: (1) Rape, Sexual Assaults and the Problems of Consent', *Criminal Law Review* 5 (2004), p. 328.
92. See, for example, S. Kyd, T. Elliott and M. Walters, *Clarkson and Keating: Criminal Law - Text and Materials*, 10th ed. (London: Sweet and Maxwell, 2020).
93. See *R* v *Clarence* (1889) 22 QB 23, *R* v *Dica* [2004] EWCA Crim 1103, *R* v *Konzani* [2005] EWCA Crim 706 and *R* v *EB* [2007] EWCA Crim 2945.

information for the specific purpose of preventing them from making a certain decision. In other words, the entire purpose of the omission was to deprive the claimant/victim of information *that they would find significant* in order to *deliberately* prevent them from making the decision that they would make if they were in possession of all of the facts. It is, to all intents and purposes, a deception.

It might be argued that Dr McLellan did not inform Ms Montgomery of the risk of shoulder dystocia as she did not consider a caesarean to be a reasonable alternative – and so was only informing her patient of reasonable options. Nevertheless, we would argue that this would not invalidate the comparison, for several reasons. First, there remains a recognition that Ms Montgomery would have wanted to have been told, and a deliberate withholding of it. If the purpose of the law is to protect autonomy, then it must protect poorly made choices as much as those that we consider wise. Second, Dr McLellan's determination that a caesarean would not be in Ms Montgomery's best interests is not sacrosanct. The decision was Ms Montgomery's to make, and the fact that had she asked for a caesarean she would have received one – and Dr McLellan knew this and withheld the information as a result – means that Dr McLellan also knew that other doctors would take a different view.

In both cases, therefore, there is a deliberate attempt to modify what would be the decision of another party in relation to interference with their bodies by withholding information that they felt would lead to a different choice being made. Dr McLellan's intervention will be made with the best of intentions, but it is just as much an infringement of autonomy achieved via an identical mechanism. If medical law claims to place autonomy at its heart, as it does, would a criminal sanction not be more appropriate than negligence or even trespass to the person in tort? If so, it is worth exploring the criminal law position, and how the facts of *Montgomery* might have mapped on to it.

Like medical law, the criminal law has undergone something of a metamorphosis. The 'old' approach, exemplified by the case of *Clarence*,[94] dismissed the prosecution's case on the simple basis that the victim had consented to sexual intercourse and that is what had occurred. The defendant had not informed his wife of the fact that he had gonorrhoea, and the court accepted that had she known of this fact she would not have consented to having intercourse with him. Nevertheless, the Court of Appeal quashed his conviction for rape, in large part due to the problematic sexual politics of the time, where they believed that as his wife she had a duty to consent to sex with her husband.[95] Thus, the idea that fraud vitiates consent was given short shrift by Wills J:

> That consent obtained by fraud is no consent at all is not true as a general proposition either in fact or in law. If a man meets a woman in the street and knowingly gives her bad money in order to procure her consent to intercourse with him, he obtains her consent by fraud, but it would be childish to say that she did not consent . . . If intercourse under the circumstances now in

94. *R* v *Clarence* (1889).

95. As was noted by the prosecution in the Court of Appeal in *Dica*, the defendant in *Clarence* was not even charged with rape, "because on the then understanding of the principle of matrimonial privilege, sexual intercourse by a husband with his wife could never be unlawful" (*Dica*, [36])

> question constitute an assault on the part of the man, it must constitute rape . . . it seems a strange misapplication of language to call such a deed as that under consideration either a rape or an assault. The essence of a rape is, to my mind, the penetration of the woman's person without her consent . . . if coition, under the circumstances in question, be an assault, and if the reason why it is an assault depends on any degree upon the fact that consent would have been withheld if the truth had been known, it cannot the less be an assault because no mischief then ensues to the woman, nor indeed where it is merely uncertain whether the man be infected or not.[96]

However, the latter case law has struck a very different tone, again almost certainly due to updated sexual attitudes, even within the judiciary. Hence in *Dica* the Court of Appeal held that while the withholding of information about having a sexually transmitted disease was not enough to vitiate the victim's consent to the sexual act itself, it *did* mean that there was no consent to any injury that might have arisen from those sexual acts. *Dica* concerned a man who knew that he was HIV positive had sexual intercourse with (at least) two women, who he did not inform of this fact. The Court of Appeal held that as a consequence a charge of rape could not therefore be sustained, but a charge of assault occasioning actual bodily harm due to the transmission of HIV was appropriate.[97] This is because the absence of this information meant that the victims could not have been seen to consent to the injuries suffered as a consequence of the sexual act – namely the transmission of HIV.

The cases of *Konzani* and *EB* cemented both the rejection of *Clarence* as out of date, as well as the general approach in *Dica*.[98] Indeed, in *EB* the court was at pains to point out that the operative deception in relation to a sexually transmitted disease *was* relevant to the question of consent, but again it was limited to consent to *injury* rather than the sexual act itself:

> Where one party to sexual activity has a sexually transmissible disease which is not disclosed to the other party any consent that may have been given to that activity by the other party is not thereby vitiated. The act remains a consensual act. However, the party suffering from the sexual transmissible disease will not have any defence to any charge which may result from harm created by that sexual activity, merely by virtue of that consent, because such consent did not include consent to infection by the disease.[99]

In *Konzani*, a case where the defendant knew that he was HIV + failed to inform his sexual partners (and had unprotected sex with them) the Court of Appeal went even further and made an explicit link with autonomy and informed consent. The key paragraph is worth quoting in full:

> the public interest also requires that the principle of personal autonomy in the context of adult non-violent sexual relationships should be maintained. If an individual who knows that he is suffering from the HIV virus conceals this stark fact from his sexual partner, the principle of her

96. Ibid., [34].
97. This was under the Offences Against the Person Act 1861, s.20.
98. *Konzani* and *EB*, n95.
99. *R* v *EB*, n95, [17].

> personal autonomy is not enhanced if he is exculpated when he recklessly transmits the HIV virus to her through *consensual* sexual intercourse. On any view, the concealment of this fact from her almost inevitably means that she is deceived. Her consent is not properly informed, and she cannot give an informed consent to something of which she is ignorant. Equally, her personal autonomy is not normally protected by allowing a defendant who knows that he is suffering from the HIV virus which he deliberately conceals, to assert an honest belief in his partner's informed consent to the risk of the transmission of the HIV virus. Silence in these circumstances is incongruous with honesty, or with a genuine belief that there is an informed consent.[100]

We find, as medical lawyers, that passage extraordinary. We cannot understand how, given everything that is said in the extract about deception and informed consent, sexual intercourse is summarily dismissed as 'consensual'. If deception leads to a lack of ability to provide informed consent to the risk of transmission of HIV and thus consent to that transmission is vitiated, we argue that a consistent application of *whatever* model of autonomy and consent is used by the court should lead it to similarly conclude that the consent to sexual intercourse is vitiated. It may be argued that there are sound policy reasons to make that distinction, but that does not affect the ethical incoherence in relation to autonomy – and indeed no distinction made on the basis of policy is evident in the judgement. But the recent decision in *R* v *Lawrance* reopened this issue, providing the Court of Appeal with an opportunity to provide ethical coherence.[101]

In *Lawrance*, the defendant lied about his fertility: falsely telling the victim that he had undergone a vasectomy. She then consented to unprotected sexual intercourse, and became pregnant. The appeal centred around the question of whether that deception vitiated the consent to sexual intercourse – the pregnancy not being seen as 'harm' or 'injury' – the trial judge having found that it had, thus convicting Lawrance of rape. In quashing the conviction, the Court of Appeal clarified that there was a distinction between *acts* and *risks* thus distinguishing cases where defendants, for example, agree to use a condom and then remove it, or agree to withdraw before ejaculation but then not do so.[102] Thus,

> [in both cases] the complainant agreed to sexual intercourse with the appellant without imposing any physical restrictions. She agreed both to penetration of her vagina and to ejaculation without the protection of a condom. *In so doing she was deceived about the nature or quality of the ejaculate* and therefore of the risks and possible consequences of unprotected intercourse. The deception was one which related not to the physical performance of the sexual act but to risks or consequences associated with it.[103]

---

100. *Konzani*, n95, [42]; emphasis added.
101. *R* v *Lawrance* [2020] EWCA Crim 971.
102. See *Assange v. Swedish Prosecution Authority* [2011] EWHC 2849 (Admin) and *R (F) v. DPP* [2014] QB 581 respectively.
103. *R* v *Lawrance* [2020], [37], emphasis added. The same can be said for the case of *R* v *McNally* [2014] 1 QB 593, where the female appellant pretended to be male and used a strap-on dildo. In the Court of Appeal Leveson LJ, while offering a vague discussion of whether *any* deception could vitiate consent, nevertheless held that a deception as to gender would do so as it

The criminal law, then, appears to be clear: deception will not vitiate consent to the sexual act itself, but deception in relation to the risks will vitiate consent to any *injury* suffered as a consequence. In part, this is based on the wording of the Sexual Offences Act 2003, which states that deception in relation to the 'nature and purpose' of the act will vitiate consent under s.76(2). However, we would argue that such wording is wide enough to allow ethically coherent judicial interpretation. Moreover, the definition of consent under s.74 the act (that the person consents 'by choice, and has the freedom and capacity to make that choice') is meaningless unless that choice is made on the basis of sufficient information to be truly autonomous. We return to this point after mapping the facts of *Montgomery* on to the law as applied in these cases.

Applying the criminal law relating to sexual offences to the facts of montgomery

So the criminal law provides that in cases where consent is obtained through the deliberate withholding of information, this fraud *does* make a difference, but only to the *ill effects* of the act rather than the act itself. In other words, a defendant who did not disclose his HIV + status to his putative sexual partner, who consented to unprotected intercourse but would not have done so had the information been disclosed, is not guilty of rape but *is* guilty of inflicting grievous bodily harm.[104] One perhaps striking element in this is the lack of discussion, in the cases described above, of the principle of autonomy *as it applies to the victim*. This might be seen as somewhat perplexing, although it should be noted that such arguments had been aired – and rejected – by the Law Commission a decade earlier.[105] That said, the catalyst for the report was the case of *Brown*, which concerned consensual conduct that was nevertheless judged to be unlawful (homosexual BDSM practices), and as such there were no 'victims' or a lack of informed consent.[106] Indeed, only two short paragraphs are dedicated to the provision of information in the document, mentioning but not engaging substantively with *Chatterton* and *Sidaway*.[107] It is therefore evident that the Law Commission did not see information disclosure as an important part of the issues that were relevant to the criminal law – although it is fair to say that they thought it a more appropriately civil law matter

---

is "commonsense" ([25]) that the *nature of the act* of sexual intercourse with a male is different to that with a female ([26]). This is a view supported by both Kyd, Elliott and Walters, *Clarkson and Keating*, [7-121] and J. Herring, *Criminal Law: Text, Cases and Materials*, 9th ed. (Oxford: Oxford University Press, 2020), who also notes the explicit support for this view in the subsequent case of *R (on the Application of Monica)* v *DPP* [2018] EWHC 3508 (Admin) (at p. 451).

104. This is under s.20 Offences Against the Person Act 1861.
105. Law Commission, *Consent in the Criminal Law: A Consultation Paper* (Law Com 139, 1995).
106. Law Commission, *Consent and Offences Against the Person: A Consultation Paper* (Law Com 134, 1994)
107. Law Commission, above n44 at [6.22-6.23].

Nevertheless, even within this narrower definition of the relevance of fraud and information disclosure, applying the facts of *Montgomery* to the criminal law in *Dica*, *Konzani, Lawrance* and *EB* brings an interesting result. It will be remembered that Dr McLellan did not inform Ms Montgomery of the possibility of an elective caesarean due to the fact that she feared that, had she done so, Ms Montgomery would have requested one, and Dr McLellan did not consider that to be in her interests. In other words – just like in the criminal law cases discussed above – she deliberately withheld information from Ms Montgomery in order to steer her towards a certain course of action. More specifically, her omission was *designed* to encourage Ms Montgomery to make a *different* decision to the one that she thought that she would make if she provided the information *that she knew Ms Montgomery would find significant*. Using the framework within the criminal law cases, the consent to the obstetric treatment involved in the vaginal delivery would not be vitiated (as it was in substance the same as what was provided), Dr McLellan would be liable for any injuries sustained by Ms Montgomery. These were significant, including but not limited to an attempt to saw through Ms Montgomery's public bone, and would certainly constitute GBH.[108]

For the criminal law, the mischief in relation to consent was the *injury* to the victim, rather than the right to make an autonomous decision. Even if medical law applies the concept of autonomy poorly, insofar as it does have a conceptualization of the principle it is about decision-making and not the effect of that decision. What we can see in cases such as *Duce* is a *policy* decision to use causation to limit claimants rather than a *principled* one.

So what does this mean?

It seems clear that medical law and the criminal law conceptualize autonomy in different ways. Medical law is concerned with the actual decision that is made and is closer to Dworkin's conception as described above. The reasons for its conservatism in relation to causation – which sabotages its ability to effectively protect this right that they wish to protect – are to do with *policy* rather than *principle.* The criminal law, in contrast, sees autonomy as more about the bodily harm than decision-making. This much is made clear in the cases that we have discussed above. Nevertheless, the consequence of all of this is that, had the criminal law relating to sexual offences applied, the auspices under which liability fell would be different, and Mrs Montgomery would still not be able to obtain redress for failing to make the *decision* that she would have wanted to have made.

What our analysis has also highlighted is the ethical incoherence of the criminal law position. Indeed, it is worth noting that the government's review of sexual offences, *Setting the Boundaries*, which preceded the Sexual Offences Act 2003, itself recommended that a separate offence of 'obtaining sex by deception' be created by the Act.[109] This was principally due to a recognition of the importance of sexual autonomy, which

108. See *Montgomery* v *Lanarkshire Health Board* [2015], [10].
109. Home Office, *Setting the Boundaries: Reforming the Law on Sex Offences* (2000), [2.18].

the report refers to as a 'fundamental concept'.[110] This, and the importance of consent, were made explicit:

> We thought that rape and sexual assault are primarily crimes against the sexual autonomy of others. Every adult has the right and the responsibility to make decisions about their sexual conduct and to respect the rights of others. No other approach is viable in a society that values equality and respect for the rights of each individual. We concluded consent was the essential issue in sexual offences, and that the offences of rape and sexual assault were essentially those of violating another person's freedom to withhold sexual contact.[111]

Unfortunately, this proposal was not taken forward and included in the legislation. The consequence, in our view, is that an Act that is supposed to be based on consent and the principle of autonomy cannot be said to achieve this aim. As we have demonstrated above, judges have interpreted the wording narrowly to leave a large gap: autonomy is considered only in relation to bodily harm rather than decision-making.

This is important; if we are to properly give effect to a right to autonomy then the starting place should be a coherent and well-defined conception of what autonomy is. We can defend a system where the criminal law and medical law conception are different, as the two are designed to do different things. However, we would also argue that under the law as it stands the medical law concentration on decision-making is more ethically robust than what exists in the criminal law. Put simply, if information is deliberately withheld in order to manipulate someone into making a decision that is different to the one that they would otherwise make, we believe this to constitute a breach of autonomy. Our initial inquiry into the use of the criminal law was borne out of the failure of medical law to adequately protect the right; but that inquiry has demonstrated that the adoption of the criminal law conception would be equally, if not more, unsatisfactory.

The question therefore becomes, *should* we seek to use the criminal law? Under our own view of autonomy, deliberate manipulation would serve to vitiate consent fully. In this context we would define 'deliberate' as constituting intention on the part of the doctor – as defined by the criminal law.[112] In other words, the doctor must directly intend that the withholding of information modifies the patient's decision. She must also know that the patient would consider the fact being withheld to be significant to the patient. Indeed, if the claimed purpose of medical law is the protection of autonomy, then it might be said that a criminal sanction would serve to send a strong message regarding how seriously the principle is to be taken. However, there are also good reasons not to do so, as we noted before. To that we would add another one: tort law is about compensation for the victim, while criminal law is about punishing the offender. If we wish to emphasize the rights of patients in relation to their interactions with doctors, then arguably the better message is sent by compensating the patient rather than punishing the doctor. This ought to lead us back to trespass in tort law but, as we argued above, that may in itself seem

110. Ibid., [2.13.7]
111. Ibid., [2.7.3].
112. See *R* v *Woollin* [1999] AC 82 for the boundary between intention and recklessness.

insufficient where a doctor has deliberately and successfully modified the decision that the patient has made.

Conclusion

The genesis of this piece was dissatisfaction with the way in which autonomy has been claimed by the new medical law to be its dominant principle – and in particular in relation to informed consent – while its infringement is not seen as constituting actionable harm. We were also taken by the lack of interest in *Montgomery* in the fact that Dr McLellan deliberately withheld information for the purposes of steering Ms Montgomery's decision *away* from one direction and *towards* a different one. We wondered whether the criminal law principles might provide a more suitable mechanism by which we could address such issues, while providing a more effective and convincing account of autonomy. We knew that our choice of comparator would be provocative, but felt that the similarity in relation to decision-modification being the mischief and the fact that autonomy and consent had been the bedrocks of the construction of the current law made it appropriate.

However, we found that the conception of autonomy in the criminal law not only differed significantly from that in medical law; and also that we found it to be just as unsatisfactory. If we are to seriously and adequately go about protecting autonomy, then the starting point has to be a robust definition of what it is. This has yet to take place in medical law, as has been argued before.[113] It has taken place in the criminal law, but we find its focus on bodies rather than decisions to be inadequate. So, should we criminalize informed consent? Almost certainly not, although our enquiry has strengthened our view that autonomy, while claimed as a guiding light in medical law, is insufficiently protected in that space. It has also made it clear to us that the same can be said of the criminal law. Both medical and criminal law can, and should, do better.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

José Miola https://orcid.org/0000-0001-9682-2284

113. Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making'.