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Abstract: This chapter provides an outline of consent in the history of medical ethics. In doing so, it ranges over attitudes towards consent in medicine in ancient Greece, medieval Europe and the Middle East, as well as the history of Western law and medical ethics from the early modern period onwards. It considers the relationship between consent and both the disclosure of information to patients and the need to indemnify physicians, while attempting to avoid an anachronistic projection of concern with patient autonomy too far back into the historical record. The chapter also includes a survey of the development of the social and intellectual infrastructure that underpins modern medical consent. It concludes with a brief discussion of possible future directions for ethical approaches to medical consent and competence that would depart from the models that arose in the twentieth-century.

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Introduction

The ethics of consent is conspicuous by its absence from much of the history of medicine. What we would now recognise as the practice of soliciting informed consent from competent patients has only seldom been taken to be a necessary condition of administering treatment or conducting medical research. Similarly, the surviving writings on medical ethics and doctoral etiquette rarely address the participation of patients in decision-making, and on this matter often confront us with a "stark silence" (Katz 2002: 3). These omissions are also reflected in the historiography: for instance, among its sixty-three chapters, there are no entries dedicated to consent in the monumental *Cambridge World History of Medical Ethics* (Baker and McCullough 2009).

Nevertheless, we can find various attempts to inform and secure the cooperation of patients in the history of medical treatment – even if they are rarely driven by concern for individual autonomy. Furthermore, it is possible to survey the development of the social and intellectual infrastructure that underpins modern medical consent, despite its progenitors not conceiving themselves as contributors to any such project. This chapter charts this history in broad brushstrokes as it appears in medical thought and practice in ancient Greece, medieval Europe and the Middle East, and the history of Western law and medical ethics from the early modern period onwards. It concludes with some brief comments about possible future directions for ethical approaches to medical consent and competence that would depart from the models that arose in the twentieth-century.

Medicine in Ancient Greece

Plato's discussions of law inadvertently reveal some salient features of the relationship between doctors and patients in 4th-century Athens. In *The Laws*, he contrasts two approaches

to medicine in order to illustrate by analogy the advantages of legislation which not only coerces but which persuades. Doctors who are slaves administer to slaves; they give orders "like a tyrant" and "never talk to their patients individually" (2000: IV.720). Whereas the freeman doctor attends to fellow freemen, "enters into discourse with the patient and with his friends", and "will not prescribe for him until he has first convinced him" (ibid).

Some commentators claim that Plato thereby recognises a requirement for consent from freemen that reveals an understanding of "the relation of consent to autonomy of the person as the expression of his right to self determination and free will" (Dalla-Vorgia et al 2001: 60). However, we ought to be cautious here. Plato says that the freeman doctor who talks to his patients is "at once getting information from the sick man, and also instructing him as far as he is able", which suggests a diagnostic and therapeutic function for dialogue rather than a primarily ethical one (IV.720). Furthermore, when Plato tells us that a freeman doctor will convince their patient before prescribing for him, this is to first bring "the patient more and more under his persuasive influences and set him on the road to health" (ibid). Indeed, the purpose of the medical analogy is to show that persuasion can serve as a tool to help legislators secure a prosperous *polis*, without implying that the legitimacy of this legislation depends upon the consent of the citizenry. Similarly, there is no indication that the patient who is the target of persuasion is granted a veto in the event that the doctor fails to win them around. Thus, there is a lack of textual evidence for the claim that Plato or his contemporaries recognised consent as a specifically ethical demand in medicine.

Plato earlier employs a medical analogy in *The Statesman* to discuss persuasion and force, which more definitively shows that he would have been no supporter of what we would understand as an ethical requirement for medical consent. He asks us to imagine that "a physician who has right knowledge of his profession does not persuade, but forces, his patient,

whether man, woman, or child, to do the better thing" (1925: 296). Plato says that irrespective of whether the physician acts lawfully, "the patient so forced might rightly say anything else rather than that he had been treated in a baneful or unscientific way by the physicians who used force upon him." (ibid) This expresses a strongly paternalistic understanding of the doctor-patient relationship, which Plato evidently expects his audience of educated Greek men to share.

The Hippocratic Corpus echoes the medical paternalism that we find in Plato. Beneficence and non-malfeasance are said to be the guiding values of the physician, whereas there is no explicit discussion of consent (Faden and Beauchamp 1986: 61-2). While this does not prove that consent was not usually sought from patients, it does suggest that consent was not regarded as an important ethical prerequisite for medical treatment. Given comprehensive Hippocratic prohibitions on certain medical interventions, then the lack of discussion of consent also appears to indicate that neither was the consent of a competent patient to treatment by a skilled doctor considered sufficient to render those interventions ethically sound. For example, there are no exceptions identified to the commitments outlined in the Hippocratic Oath to refuse to provide pessaries for abortion or lethal drugs to those wanting to end their own lives (von Staden 2009: 354). Therefore, *a fortiori*, the consent of the patients cannot be sufficient to render these acts permissible.

Contemporary understandings of medical consent normally require that voluntary assent has been given in a context where a competent patient has been informed about any diagnosis, the proposed treatment, and available alternatives. In other words, valid consent must be informed consent. Yet, the Hippocratic texts endorse measures that actively impede the disclosure of information that would enable an informed consent to be given or refused. For

example, they recommend “concealing most things from the patient, while you are attending to him.” (1923: 297)

Despite its later prominence, Hippocratic medicine was only one amongst several approaches, with only a limited influence in Greek antiquity. Other understandings of the duties of doctors were less grounded in beneficence and more capacious in accommodating certain choices made by patients. For example, some doctors were willing to help people commit suicide despite Hippocratic injunctions against this (Faden and Beauchamp 1986: 62). Even those heavily indebted to Hippocratic teachings can be found stressing competing ideals. The towering Graeco-Roman physician Galen makes much of the importance of the physician’s truthfulness. He forbids major lies to the patient, and demands that doctors are completely honest with the patient’s carers; yet, he does concede that omitting truths and telling minor untruths can be justified if the patient benefits (von Staden 2009: 357). Nevertheless, despite this marginally more sanguine attitude towards truthfulness in how the patient is informed, it is still the case that consenting does not seem to have acted as a gatekeeper for the legitimacy of medical treatment in ancient Greece, nor is there an evident and sustained ethical concern with enabling or respecting such consent.

Medicine in Medieval Europe and the Middle East

While there is no single radical development in the ethics of medical consent in medieval Europe, we can begin to identify more clearly some emerging functions of the solicitation of consent that extend beyond the pragmatic benefits of doctors knowing they have willing patients. One of the most important is the use of consent in defensive medicine. This can be seen in a nascent but recurring consent ritual devised by doctors in order to protect themselves from being unfairly blamed for the fate of their patients. The ritual is first recorded in the late

sixth century, when Byzantine physicians were reluctant to operate on the gravely ill Emperor Justin II lest they be held responsible for his death. Despite his promise that they would not be punished, they reportedly asked that the Emperor personally hand them the scalpel as an explicit sign of his willingness to undergo surgery (Dalla-Vorgia et al 2001: 60). The public expression of consent through this scalpel-handing ritual serves an exculpatory purpose. It mirrors in more ceremonial fashion the practice recorded from the fourteenth century onwards of obtaining explicit documentation releasing surgeons from claims for blood money upon the death of their patients (Ajlouni 1995; Leclercq et al 2010). The need for public exculpation remains in modern law, where consent has been described as a 'flak jacket' for liability (*Re W (A Minor) (Consent to Medical Treatment) [1993] 1 FLR 1*). Consent manifested through the handing of the scalpel likewise acts as a kind of chainmail that protects the consent-seeker rather than simply the consent-giver.

The scalpel-handing ritual is recorded numerous times in the following centuries, and not merely for powerful patients (Dalla-Vorgia et al 2001: 60). Significantly, it is sufficeintly widespread as to attract criticism from the 7th-century author of the *Miracles of St Artemios* for allowing surgeons to disavow responsibility for their mistakes. Nevertheless, its functions are relatively narrow, and it does not demonstrate that operating on someone without their consent was seen as wrong. Instead, the ritual of handing the scalpel implicitly invokes the principle *volenti non fit injuria*: that no injury is done to a willing person. It remains silent about the injuries done to the unwilling.

Medical paternalism was still alive and well in medieval Europe. For instance, in the late 13th-century, the French surgeon Henri de Mondeville tells us that patients "should obey their surgeons implicitly in everything appertaining to their cure." (1977: 15) Furthermore, he has no reservations about recommending that doctors lie about the prospects for a patient's

recovery when this would serve to promote their health. Again, if there are significant informational requirements for an ethically robust consent, then this advice actively undermines the ideal of voluntary and informed consent as we would presently understand it. Furthermore, while Mondeville does caution against coerced treatment, the reasons for this are not primarily ethical. Instead, they arise from concerns about reputational damage as well as the effectiveness of such treatments, which were naturally very risky or impractical in surgery undertaken without reliable general anesthetic.

We find similar attitudes towards noncompliant patients in the Middle East during this period. For Ibn Jumay, the 12th-century Arabic physician, there is a compelling therapeutic reason to ensure that the patient cooperates with the doctor, since the recalcitrant patient is given to imprudent behavior that can impede a cure (Weisser 2009: 368). The concern once more is the danger for the patient of disobeying the doctor rather than establishing that there are cases in which patients might legitimately refuse treatment or disregard medical advice. While doctors were expected to conform to the expectations of patients regarding their attire and demeanor, some considered themselves duty-bound to bring about the most salubrious behavior in those patients. For instance, al-Ruhāwī stresses the importance of educating patients, attendants, and visitors, so that they do not act in ways that disrupt the work of the physician (ibid: 398-9). The emphasis on cooperation throughout this medical literature is ultimately asymmetrical: its focus is securing obedience to the doctor rather than the doctor accommodating themselves to the will of the patient. What rudimentary consent there is in evidence therefore never seems to escape the limits of a pervasive medical paternalism.

Conceptual and Social Foundations of Modern Medical Consent

Why is consent now so integral to medical ethics when for millennia it was marginal at best? Its emergence as an ethical ideal rather than simply a pragmatic benefit was not foreordained. Instead, the ethical entrenchment of medical consent was dependent upon significant developments in how individuality, authority, and freedom came to be understood within much modern social life. This slow accretion of conceptual and institutional innovations from outside of medicine provided the cognitive and social infrastructure that has helped make the ethical demand for medical consent not only intelligible to us but also compelling.

Civil law has provided much of the architecture for the concept of individual consent. In particular, Roman law of contract crafted a sophisticated set of tools for enabling consensual agreements to be made legally enforceable (Johnston 2009: 39-41). This was an important step in beginning to normalize the idea that consensual transactions can create and alter rights and obligations (ibid: 41). Papal reform of marital law in the High Middle Ages provides a further legal foundation, with the free consent of bride and bridegroom becoming a necessary and sufficient condition for marriage when there were no clear impediments like consanguinity or bigamy (d'Avray 2005: 130). Importantly, to be authoritative, this consent had to be freely given, with the Church threatening to withdraw sacraments from those impeding or compelling the consent of another (Noonan 1973: 434). Thus, the notion that voluntary consent was required for the legitimacy of certain social relationships was established long before it was embraced within medical ethics.

The increased prominence of consent within social institutions such as marriage reflected broader social and cultural changes in Europe in the twelfth and late eleventh centuries, which some scholars have called "the discovery of the individual." (Morris 1972; cf. Melve 2006). This is manifested politically in a shift towards greater numbers of individuals

being taken to possess the status of citizens rather than mere subjects. Likewise, the individual becomes a renewed focus in religious life, with "a new concern with self-discovery and psychological self-examination, an increased sensitivity to the boundary between self and other, and an optimism about the capacity of the individual for achievement." (Bynum 1982: 83) Both developments strengthen a conception of individuals as a primary locus of moral concern, which subsequently underpins an increased respect for their consent and dissent.

Deepening individualism is also a hallmark of early modern European thought and society. The social contractarian tradition associated with Hobbes, Locke, and Rousseau grounded legitimate political authority and obligation in the consent of the people – albeit consent that was typically historical, implicit, or hypothetical, rather than explicitly avowed and revocable by each individual (see Riley 1973). Furthermore, we find uneven but significant advances in religious toleration in early modern life, which gradually moves away from the sixteenth-century principle of *cuius regio, eius religio* – that whoever rules a region determines the religion – towards a more ecumenical ideal of respect for individual conscience in matters of religious confession. Similar ideas find a more expansive ethical expression in the late eighteenth-century with what Charles Taylor calls "the modern ideal of authenticity": the belief that we should be true to our own inner voice – not merely because it issues accurate guidance on how to act, but because fidelity to our own particular sentiments and convictions is independently necessary for human self-fulfillment and self-realization (Taylor 1992: 31; Trilling 1972). As John Stuart Mill put it in his hugely influential nineteenth-century treatise *On Liberty*: "the free development of individuality is one of the leading essentials of well-being" (Mill 1999: III.2). Indeed, Mill's conclusion that nothing other than preventing harm to others can ordinarily justify non-consensual interference with someone's self-regarding actions continues to animate contemporary liberal ideology.

Consent in Seventeenth- to Nineteenth-Century Medicine

The trend of increasing respect for individual liberty in the history of modern culture did not uniformly suffuse all aspects of medical practice for all people in all places. Some early modern legal regulation of medical practitioners sounds strikingly contemporary in its demands for the consent of individuals. For example, the 1665 Duke of York's Law in the British colonies made the use of experimental medical techniques on competent patients conditional upon their active consent. It forbade those engaged in healthcare

> to set forth or exercise any act contrary to the known approved rule of art upon or towards the body of any [...] without the [...] consent of the patient or patients if they be *mentis compotes*, much less contrary to such consent. (Walsh quoted in Baker 2013: 233-4)

Another significant episode in early modern experimental medicine illustrates professional conventions concerning the ethics of consent – namely, the 1767 English legal case of *Slater v. Baker and Stapleton* (95 Eng. 860, 2 Wils. KB 359). Slater sought treatment for a broken leg from the surgeon Baker and apothecary Stapleton, who reset his femoral fracture in an experimental device – a heavy steel contraption replete with teeth – without his consent and without giving him sufficient prior warning. Since it was customary amongst physicians to obtain consent before resetting fractures in these circumstances, then the judge ruled that in failing to do so then Baker and Stapleton were remiss in their professional conduct. While his reasoning foregrounds the importance of patients being forewarned of medical procedures so that they may "take courage", rather than emphasizing an independent right to self-determination, it is significant that the courts recognised some legal duties to respect treatment decisions in research contexts (cf. Faden and Beauchamp 1986: 116-7).

English law of the nineteenth-century was explicit about the need to both inform experimental patients and obtain their consent. For instance, we are told by J.W. Willcox's treatise on medical law in 1830 that:

> When an experiment of this kind is performed with the consent of the party subjected to it, after he has been informed that it is an experiment, the practitioner is answerable neither in damages to the individual, nor on a criminal proceeding; […] But if the practitioner performs his experiment without giving such information to, and obtaining the consent of, his patient, he is liable to compensate in damages any injury which may arise from his adopting a new method of treatment. (Willcox quoted in Howard-Jones 1982: 1430)

While it may be tempting to conclude that we have a clear articulation of the doctrine of informed consent here, it is important to distinguish the responsibilities to both tell the patient of the experiment and elicit their consent from the responsibility to ensure that the patient sufficiently understands and appreciates the implications of their treatment decision, such that their consenting itself qualifies as informed (Howard-Jones 1982: 1430). It is furthermore worth noting that in all three examples we have considered, the juridico-ethical function of consent is not to authorize ordinary medical treatments which would otherwise wrongfully trespass upon the body. Instead, consent indemnifies practitioners when they depart from the uncontroversial background norms of medical treatment by administering an as yet untested technique. Therefore, no comprehensive requirement for medical consent is implied.

In non-experimental medicine, the sick also sometimes enjoyed considerable *de facto* latitude in their treatment as a result of their economic or social relationship to medical practitioners. Medicine that was practiced at the domestic bedside – before the dominance of the clinic – strengthened the hand of patients, their friends, and families to shape treatment

(Lindemann 2009: 397). An educated seventeenth- or eighteenth-century patient would likely proffer their own thoughts on their diagnosis and its remedies rather than merely passively acquiescing to those of their medical practitioner. For example, we find Samuel Johnson recounting that he bullied and bounced his apothecary into changing the production of a salve to a formulation he believed would be superior (Porter and Porter: 78). Furthermore, wealthy individuals could and did summon several doctors – enabling them to follow the prescriptions that they deemed most congenial or salubrious. For instance, Andrew Fletcher writes to John Locke to say that his sister in law luckily decided to follow Locke's medical advice in preference to that of two other physicians who were sent for (Porter and Porter 1989: 80). However, the sick poor were often at the mercy of infirmaries, where they might fall prey to the scientific pretensions of young doctors keen to make a name for themselves, who could all-too-readily deem patients incurable in their haste to commence experimenting upon them (McCullough 2009: 404-5).

In early modern mental health, non-consensual detention and treatment was typically taken to present even fewer social, legal, or ethical difficulties. Domestic care and confinement was commonplace, as it had been for millennia, and many others with psychosocial disabilities found themselves in prison or the workhouse (Porter 2002: ch. 5). Consider later developments in nineteenth-century England, where the public financing of institutions precipitated a steady increase in patient admissions and the widespread use of mechanical restraints (Fennel 1996). The 1840s saw the growth of a non-restraint movement, and the Lunacy Commission was mandated to conduct inspections requiring each use of restraint to be recorded and a rationale for it given. In reaction to the decline in restraint resulting from this regulation, medication without consent then became the so-called 'sheet anchor' for subduing disruptive patients (ibid: 41). Arguably, this presented little to no advance, since the extensive use of powerful

sedatives – such as opium, ether, and bromide – could be equally debilitating, shackling the mind and not merely the body.

Dissatisfaction with the side-effects and addictive properties of sedatives towards the end of the nineteenth-century in England allowed the pendulum to swing back to physical management of behavior, such as the 'wet packing' of mental health patients in sheets (ibid: 47). Concerns about abuse of these techniques arose from the knotty relationship between their punitive, custodial, and therapeutic employment – leading them to be removed from the discretion of orderlies and mandating medical supervision for their use. However, now that these techniques were understood as medical treatments founded upon the authority of psychiatric expertise, this legitimized them in the eyes of wider society. Thus, non-consensual treatments of highly dubious value were still commonplace in late nineteenth century mental health care.

Consent in Twentieth-Century Medicine

Cardozo J makes a landmark judgment in 1914 which articulates the requirement that the decisions of competent patients who withhold consent for treatment should be respected:

> Every adult person of sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. (*Schloendorff v. Society of New York Hospital [1914] 105 NE 92.*)

This championing of individual consent has resonances with Mill's defence of self-sovereignty: "Over himself, over his own body and mind, the individual is sovereign. […] Each is the proper guardian of his own health, whether bodily, or mental and spiritual." (Mill 1999: I.9 and I.13) Despite the important implications for consent that arise from such a right

to determine what happens to one's own body, this does not itself impose substantial informational obligations on others. It is only in later U.S. bioethical and legal thought that we begin to find much more stringent requirements concerning the extent to which valid consent must be highly informed.

The ethics of systematic medical research further drove the development of medical consent in the twentieth-century. While the Department of Health under the Weimar Republic issued strict *Richtlinien* in 1931 mandating consent in medical research (Sass 1983), the German state soon oversaw medical experimentation of extreme cruelty and brutality in the concentration camps, including deliberatively infecting wounds with gangrene and tetanus, attempting to conjoin twins by sewing, and conducting hypothermia experiments in tanks of ice water (Berenbaum 1993: 194-5; Bogod 2004: 1155). At the subsequent Nuremburg war crimes tribunals, those indicted sought to defend themselves by arguing, unsuccessfully, that genuinely voluntary consent was not obtained by other physicians in their medical research. The tribunal's judges subsequently drew up the 1947 Nuremberg Code, which outlined in a non-legally binding form the fundamental principles that were to govern human subject research – foremost among these being a requirement for consent that was voluntary, competent, informed, and comprehending. Despite the Code often being taken to mark a turning point in medical research ethics, its immediate influence was limited, with Katz astutely describing how it was received among medical practitioners: "It was a good code for barbarians but an unnecessary code for ordinary physicians" (1992: 228).

The Declaration of Helsinki relaxed the Nuremberg principles and allowed greater scope for medical research by requiring consent only "if at all possible, consistent with patient psychology" (World Medical Association 1964: II.1). Yet, even these looser standards were periodically transgressed. Most prominently, the Tuskegee syphilis study withheld information

and life-saving treatment from hundreds of infected black men, who were falsely led to believe participation was beneficial for their health. The study was only finally shut down when its existence was widely publicized in 1972 – after over a hundred people had died of syphilis-related complications (Reverby 2009). The combination of public outrage about Tuskegee with earlier influential work by Henry Beecher (1966) recounting problematic post-war human subject research has contributed to the U.S. spearheading extensive efforts to validate consent to medical research.

The first explicit formulations of requirements for "informed consent" in medicine more widely are also concentrated in the U.S., where this term initially appears in *Salgo v Leland Stanford Jr University Board of Trustees et al.* ([1957] 154 Cal App2d 560). We find two ethical imperatives for the physician in this judgment that can stand in tension: the duty to ensure that consent is "intelligent" by disclosing relevant information, and the duty to "place the welfare of his patient above all else" by exercising discretion in how far beyond minimum disclosure requirements to go if it will cause apprehension or psychological distress. This discretion has become circumscribed by a shift in the justificatory grounds for disclosure in juridico-ethical reasoning, where U.S. courts are said to have

> explicitly repudiated the traditional beneficence-based rationale for disclosure in stating that the duty to disclose does not arise from "medical custom and practice" (as it would be if it were done as part of the doctor's role to promote the patient's welfare), but instead arises from "the patient's prerogative to decide." (Kim 2010: 8)

The increased emphasis upon disclosure by medical practitioners was subsequently accompanied by a focus upon the nature of the competency to employ this information in deciding to grant or withhold consent. The much-vaunted right to refuse medical treatment

therefore has not been extended to the many patients deemed to lack the requisite functional abilities. For example, these are often taken to include the ability to understand relevant information, as well as to appreciate and reason with it, or otherwise use or weigh the information in decision-making (ibid: 12-4).

The implicit rationale for such functional accounts of competency can be understood in one of two ways. Firstly, the absence of decision-making competence might *justify overriding* a person's right to autonomy. So understood, incompetence provides a warrant for giving less weight to their autonomy than their health or wider best interests. Secondly, the absence of decision-making competence might be thought to *preclude* autonomy itself. Making decisions for someone would not override or breach their autonomy rights, since achieving such autonomy depends on capacities which they already lack. So understood, deciding on behalf of those without decision-making capacity does not deprive them of autonomy for sake of some more important good, since a meaningful autonomy was never available to them in the first place.

Detention and involuntary treatment for mental health conditions in common law jurisdictions is often governed by criteria other than someone's capacity to make competent decisions. The formalization of grounds for compulsory admission begun in the late nineteenth-century has focused upon risk to self or others. For instance, English law in the twentieth-century settled on the necessary and sufficient grounds that the patient has a mental disorder of a nature or degree that means treatment in hospital is both appropriate and necessary for the health or safety of the patient, or for the protection of other people (*The Mental Health Act 1983*: §3.2). The ethical justifications for these criteria are a mixture of paternalism and respect for the liberty of others. While detention and involuntary treatment on the grounds of the health or safety of the patient might seem to depart from Mill's defence of

self-sovereignty, his qualification that "this doctrine is meant to apply only to human beings in the maturity of their faculties" rather than "those still in a state to require being taken care of by others" (1999: I.10) can appear to render them consistent. Whatever the implication of Mill's own position, there remains concern about the extent of paternalistic intervention in both formal and informal mental health care, as well as restricting liberty on the grounds of assessments of risk to others rather than harms actually committed.

The Future of Medical Consent

We have encountered the model of respect for informed and competent consent for physical treatment and the prohibition on involuntary mental health detention and treatment for those not a danger to themselves or others. Its rise is historically intelligible without being historically inevitable – nor is it necessarily an end-point for ethico-juridical thinking about consent in medicine. We can conclude by considering two challenges to the competency model of informed consent recounted here.

The first challenge comes from critics who believe that consent requirements became overly entrenched in bioethics and medical law in the second half of the twentieth-century (Foster 2009). One sceptical explanation for the prominence of consent requirements holds that an excessive reliance on the value of autonomy in medical ethics has stemmed from the fact that "only autonomy is easily codified into a set of rules and regulations pertaining to day-to-day clinical health care" (Wolpe 1998: 47). Furthermore, some question whether appeals to autonomy have been genuinely patient-driven, with empirical research appearing to suggest that patients often simply want a relationship of personal concern wherein they are kept informed, without a "mandatory autonomism" that forces them to decide for themselves even if they would rather voluntarily defer to others (Schneider 1998: xii). Others doubt consent is

meaningfully solicited in modern medicine and suspect that the consent-seeking practices codified in the twentieth-century are predominantly function as a way of "producing assent" for actions which medical workers have already decided upon (Anspach 1993: 24). From these perspectives, the late twentieth-century has seen an unnecessary and unpopular increase in bureaucratised consent requirements which represents a wrong turn in medical ethics.

The second challenge is to the requirement for decision-making capacity as a condition of respect for medical consent or other decisions. Critics claim that such approaches deny equal recognition before the law to people with disabilities – who will be disproportionately affected by competency requirements. These critics take inspiration from Article 12 of the recent *UN Convention on the Rights of Persons with Disabilities*, which mandates "that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" (2007: §12.2). They propose that we dispense with demanding tests of decision-making abilities. All they require for attributing legal capacity, and therefore grounding respect for a person's consent, is that some meaningful human agency can be identified – i.e. that a person "act in a way that at least one other person who has personal knowledge of an individual can reasonably ascribe to one's actions, personal will and/or intentions, memory, coherence through time, and communicative abilities to that effect." (Bach and Kerzner 2010: 66). This would constitute a radical break with the individualistic competence-based model of medical consent that has been fundamental to medical ethics in the twentieth-century – where it remains to be seen whether such a transition is a necessary step in advancing equality or would leave those with illnesses and impairments even more vulnerable.

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