Essays

From Autonomy to Responsibility: a Levinasian Account of Relational Decision-making in Healthcare in England and Wales

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ABSTRACT: This paper examines patient autonomy, exploring its legal and ethical dimensions with a particular focus on England and Wales. It argues that the dominant view of autonomy as individual choice is too narrow and overlooks the relational and moral contexts. Drawing on British case law and the shift from medical paternalism to patient-centred care, the paper argues for a more nuanced, relational understanding of autonomy. Using the approach of Emmanuel Levinas, it emphasises vulnerability, responsibility and ethical obligations in human encounters. A Levinasian understanding of relational autonomy therefore shifts the focus of clinical ethics from protecting isolated choice to cultivating relationships of responsibility in which both patients and healthcare professionals can cooperate in the interests of better outcomes. Autonomy is reconceived as relational, grounded in care and interdependence. It is the fruit of an ethical encounter in which the patient and clinician together seek what is genuinely good for the person whose life is at stake.

KEYWORDS: patient autonomy; paternalism; relational autonomy; Emmanuel Levinas; english case law

SUMMARY: 1. Introduction – 2. Autonomy and Shared Decision-making in England and Wales: a Theoretical and Legal Overview – 2.1. A Theoretical Perspective – 2.2. A Legal Overview of Healthcare Practice in England and Wales – 3. Emmanuel Levinas and the Paradigm of the Face-to-face Encounter – 4. From Levinas' Interhuman Order to a Relational Paradigm of Clinical Decision Making – 5. Conclusion.

1. Introduction

Patient autonomy, the last bulwark against abuse, always takes centre stage when it comes to reforms in the healthcare setting. The NHS England is under pressure to deliver healthcare reforms which are deemed essential to respect autonomy and empower patient decision-making.[1] However, what autonomy truly means and entails is often in practice left unexplored

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[1] See I. BERTINI, *Martha's Rule: rebalancing power dynamics between patients or families and clinicians to improve patient outcomes*, in *JME Blog*, 2024, https://blogs.bmj.com/medical-ethics/2024/03/04/marthas-rule-rebalancing-power-dynamics-between-patients-or-families-and-clinicians-to-improve-patient-outcomes/ (last visted 7 June 2026); P. CURTIS, C. WOOD, *Martha's Rule. A new policy to amplify patient voice and improve safety in*

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or thought to concern only the possibility to choose freely from a set of options with the underlying assumption that the goal is constantly to expand that set. References to patient choice by healthcare and judicial decision-makers often fail to engage with tensions and nuances in this area.

The following analysis will examine the concept of patient autonomy within the healthcare context from both a legal and an ethical perspective.[2] The author will take into account the relevant jurisprudence in England and Wales, which informed the paradigm shift from 'doctor knows best' towards more patient-centred care. It will be argued that this shift marks a new view of personal autonomy: not individualistic, but relational. To better understand this passage, the ethical thought of Emmanuel Levinas will come in aid both at the ontological level and in the context of medical ethics.[3]

For Levinas, being relational individuals means, as he often argued, being in a position to share our own vulnerability and, consequently, not shielding ourselves from this. The encounter with the other person (the Levinasian *face of the other*) highlights the other's mortality and dependence (as an encounter with a small child can illustrate) which is reflected in the inclination to care. This ontological fabric is behind not only medical decision-making processes but social activities more generally. If acknowledged, it can bring a revolutionary dynamic that not only can challenge an individualistic idea of autonomy but has the potential to replace it with a concept of autonomy that fosters human responsibility and care as ontologically bound to human nature. This approach can surely have relevant effects in the way healthcare decisions and laws are shaped.

2. Autonomy and Shared Decision-making in England and Wales: a Theoretical and Legal Overview

Respect for patient autonomy has become one of the defining principles of contemporary healthcare law and ethics in England and Wales, and more generally. Traditionally understood as the right of competent individuals to make decisions about their own medical treatment, autonomy has increasingly been interpreted within a broader context that recognises the importance of collaboration and trust between patients and healthcare professionals. This shift has been reflected in the growing emphasis on shared decision-making, which seeks to combine respect for patients' values and preferences with clinicians' professional expertise.

The following analysis provides a theoretical and legal overview of autonomy and shared decision-making in healthcare in England and Wales. It begins by examining the ethical foundations of autonomy and the evolution from an individualistic conception towards more relational models of decision-making. It, then, considers the legal framework governing informed consent and treatment decisions, with particular attention to the impact of key judicial decisions and professional guidance. Finally, it explores how shared decision-making has become a central component of contemporary clinical practice

hospitals, in *Demos,* 2023, 1-15, https://demos.co.uk/wp-content/uploads/2023/08/Marthas-Rule_finalversion.pdf (last visited 7 June 2026).

[2] See RT HON LADY JUSTICE ARDEN, *Law of medicine and the individual: current issues; What does patient autonomy mean for the courts?*, in *Justice KT Desai Memorial Lecture 2017*, 1-19, https://www.judiciary.uk/wp-content/uploads/2017/12/arden-lj-medicine-and-the-law-oct-2017.pdf (last visited 7 June 2026).

[3] See M. CLIFTON-SODERSTROM, *Levinas and the Patient as Other: The Ethical Foundation of Medicine*, in *Journal of Medicine and Philosophy*, 2003, 447-460.

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while acknowledging the practical and ethical challenges that arise when patients' preferences, professional judgement and the realities of clinical care must be reconciled.

2.2. A Theoretical Perspective

The term 'autonomy' originates from the ancient Greek word *αὐτονομία* (*autonomia*), which is a combination of 'auto' (*αὐτός*), meaning 'self', and 'nomos' (*νόμος*), meaning 'law'. Together, these components convey the idea of self-governance. Initially, the term was used to describe the political status of cities, but it was also applied to individuals.[4] It was closely associated with the concept of *ἐλευθερία* (*eleutheria*), which means 'liberty'. While the terms share similar meanings, *eleutheria* specifically refers to freedom from external control, whereas *autonomia* emphasizes the capacity for self-rule, sometimes with a pejorative connotation. As Lucas Swaine notes, over time, the concept of individual autonomy within democracy has evolved from having potentially negative associations to being widely embraced as a fundamental principle of democratic society: "Pressures both sharp and gradual moved Western societies to institute protections for individual rights and liberties, with democratic countries continuing to become more permissive and inclusive in several notable respects.[…] Such developments appear to correlate with a widespread belief that people are entitled, at the individual level, to enjoy their lives under their own direction".[5]

When it comes to healthcare settings, patient autonomy is seen, in a traditional way, as "the ability to make individual, fully-informed and independent decisions".[6] This perception can be seen, for example, in the British Medical Association's formula according to which: "In medical practice, autonomy is usually expressed as the right of adults with capacity to make informed decisions about their own medical care".[7] This formula means that healthcare professionals and interested third parties (such as close relatives) cannot impose interventions or treatments on patients without their informed consent unless there is an emergency or the patient is considered unable to make autonomous decisions.[8] So, here, is the tension: on the one hand, patients can be *actively* involved in their own care – which implies for both sides that autonomous decisions are taken in partnership, leaving behind a paternalistic stance. As Pellegrino argues, this principle of patient autonomy can be considered as a shield against medical paternalism, "which considered the duty of physicians to decide what was best because the patient lacked medical knowledge and might lose hope if he knew the whole truth about his options and prognosis".[9] On the other hand, patients who are deemed capable of making autonomous decisions can be described as captains of their own ship. Yet when health deteriorates, the ship itself may strongly influence the direction in which the captain can steer. In these circumstances, good and trustworthy collaborators become essential, as usually happens when a ship cannot be sailed autonomously. This is the idea behind relational autonomy, also highlighted by feminists thinkers, which is opposed to the idea of autonomy portrayed by the 'captain-in-control' model. As Walter and Ross suggest "[b]eing autonomous is not

[4] L. Swaine, *Ethical Autonomy: The Rise of Self-Rule*, New York, 2020, 4.
[5] L. Swaine, *The Origins of Autonomy* in *History of Political Thought*, 37(2), 2016, 235.
[6] A. Głos, *Solidarity in Healthcare – The Challenge of Dementia* in *Diametros*, 49, 2016, 2.
[7] BMA, *Autonomy or self-determination as a medical student*, 28 June 2024.
[8] *Mental Capacity Act*, 2005.
[9] E. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, in *Journal of Contemporary Health Law and Policy*, 10(1), 1994, 50.

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perceived to be in conflict with valuing the input of others or engaging them in important decisions. […] An individual's interests are developed in conjunction with others. They are re-described and re-examined during challenging times".[10] Hence, patient autonomy can be seen both as a shield against paternalism and, more positively, as "an obligation to foster the human capacity for self-determination, to enhance it, and to remove the obstacles to its full operation".[11] In this light, autonomy is not viewed as an absolute, but rather as a value embedded within the broader context of the patient's overall wellbeing, which is best realized through a collaborative relationship between patients and physicians. This vision also reflects the feminist critique of autonomy which generally holds the view that persons are socially embedded.[12] In the latter case, this approach may suggest that women have internalised oppressive cultural norms.[13] Therefore relational autonomy understands self-determination as shaped by both the network of personal relationships and institutional contexts in which the individuals are situated, with autonomy being fostered or limited, depending on how those relationships function in the specific circumstances.

Beauchamp and Childress introduced the concept of autonomy as the pillar of medical ethics in particular when it comes to *autonomous choice*. According to them, autonomous actions need to reflect *intentionality, understanding* and *freedom from control*. Firstly, an autonomous action has to be 'wanted', 'planned' and not just fortuitous even though its outcome can differ from the original idea. Secondly, "an autonomous action needs only a substantial degree of understanding and freedom from constraint, not a full understanding or a complete absence of influence".[14] Lastly, the person in order to make autonomous choices needs to be free from both external and internal *controlling* influences. Hence, the principle of autonomy in the healthcare setting carries both positive and negative obligations: on the one hand, "the principle requires that autonomous actions not be subjected to controlling constraints by others"; while, on the other hand, "the principle requires both respectful treatment in disclosing information and actions that foster autonomous decision making".[15]

While there is common agreement that paternalism in healthcare ('doctor knows best') is not only obsolete but harmful to patients since it obstructs the doctor-patient relationship and all the insights that can come from it, there is also a risk of 'abandoning' the patient if a too individualistic view of autonomy is adopted. The doctor may, for instance, feel compelled to propose a series of possible treatments and talking a neutral approach toward the patient's choice. The doctor does not explicitly back any approach in order to guarantee that the patient's choice has not been influenced but, at the same time, the patient is not accompanied through the process. In fact, autonomy is often understood as freedom from interference as if also the clinician should assume a neutral stance before the patient.[16] However, pa-

[10] J.K. WALTER, L. FRIEDMAN ROSS, *Relational Autonomy: Moving Beyond the Limits of Isolated Individualism*, in *Pediatrics*, 133, 2014, 19.

[11] E. PELLEGRINO, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, cit., 49.

[12] See C. MACKENZIE, N. STOLJAR (ed. by), *Relational Autonomy*, New York, 2000.

[13] See L.A. MARTIN, *Toward and Expressivist View of Women's Autonomy*, in *Ergo*, 11(14), 2024, 373-395.

[14] T.L. BEAUCHAMP, J.F. CHILDRESS, *Principles of Biomedical Ethics*, *7th Edition*, New York, 2009, 104.

[15] *Ivi*, 107.

[16] See S. SHERWIN, *A relational approach to autonomy in health care*, in S. SHERWIN *et al.*, *The politics of women's health: Exploring agency and autonomy*, The Feminist Health Care Ethics Research Network, Philadelphia, 1998,

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tients when confronted with their diagnosis and prognosis are not expected simply to go shopping for medical treatments but need the physician's perspective to assist them, not only to tackle their condition, but also to make sure their values are respected. As Childress argues, the paternalist paradigm can be dismantled by the concept of relational autonomy where "health care professionals are part of the relational context":[17] patients and doctors are in an interdependent relation which also shows an imbalance of power and knowledge; however, this imbalance "gives rise to the positive obligations of respect for and promotion of autonomy".[18]

2.2. A Legal Overview of Healthcare Practice in England and Wales

How does this principle play out in reality? In the context of healthcare, personal autonomy can be understood as the ability to comprehend and consent to medical treatment, as well as the capacity to refuse treatment or propose a treatment – perhaps a treatment not suggested by the doctor for some reason, a non-standard treatment or one not legally recognized in a given country.

To understand patient autonomy in the context of English common law and the swing from paternalism to the promotion of individualism, *Bolam v Friern Hospital Management Committee*[19] can be seen as the leading case that started this paradigm shift; followed by *Montgomery v Lanarkshire Health Board*[20] and by *McCulloch v Forth Valley Health Board*,[21] which is a Scottish case but relevant to understand the limit of the doctrine. While a more recent case law may help to see how that paradigm shift has consolidated in the jurisprudence with a particular focus on *JJ v Spectrum Community Health CIC*,[22] *Winterbotham v Shaharak*[23] and *Tosh v Gupta.*[24]

The first landmark case concerns Mr Bolam, a patient with mental illness who suffered severe injuries due to electroconvulsive therapy. The relevance of this case lies in the fact that in his decision Justice Mc Nair had the occasion to set up the so-called "negligence test" according to which "doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".[25] In other words, a doctor is not liable for negligence if a competent body of practitioners takes a different view on the matter and doctors have complete discretion in relation to warning the patient about potential risks of medical treatments.

It was not until the decision in *Montgomery* – a later case on medical negligence in the context of injuries caused to a child during labour – that a real shift could be seen toward a medical approach that promotes personal autonomy and gives patients greater control over their healthcare decisions.

25; J. LEWIS, *Does shared decision making respect a patient's relational autonomy?*, in *Journal of Evaluation in Clinical Practice*, 25(6), 2019, 1064.

[17] J.F. CHILDRESS, *Needed: A More Rigorous Analysis of Models of Decision Making and a Richer Account of Respect for Autonomy*, in *The American Journal of Bioethics*, 17, 11, 2017, 53.

[18] *Ivi*, 53.

[19] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[20] *Montgomery v Lanarkshire Health Board* [2015] AC 1430.

[21] *McCulloch v Forth Valley Health Board* [2023] UKSC 26.

[22] *JJ v Spectrum Community Health CIC* [2023] EWCA Civ 885.

[23] *Winterbotham v Shaharak* [2024] EWHC 2633 (KB).

[24] *Tosh v Gupta* [2025] EWHC 2025 (KB).

[25] [1957] 1 WLR 582, §3.

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The Court argued that doctors should offer to patients different treatment options so that also the patient can be made aware of possible risks.[26] And the doctor's duty is not merely to list the risks of a treatment but to make sure that the patient is taking a decision in line with their personal priorities (when these are expressly suggested) so that the treatment chosen will perhaps align with them.

The great relevance of *Montgomery* lies in formulating a *test of materiality* to identify doctors' medical negligence where the doctor needs to make sure that the patient is aware of any relevant material risk involved in a precise medical treatment.[27]

Medical decisions often require careful consideration of various available options. Each potential course of action comes with its own set of benefits and drawbacks, and a thorough understanding of these alternatives is essential for making an informed choice. A medical procedure, therefore, must always be assessed in the broader context of its possible alternatives,[28] bearing in mind also that patients are not merely consumers of treatments (a "pick and choose" approach).[29]

It is also necessary to concede that patient autonomy is a dynamic concept: the doctor's duty to disclose information and the patient's autonomy are fundamental elements of the doctor-patient relationship. However, other factors – particularly trust – also play a crucial role, extending beyond the scope of the *Montgomery* decision. In reality, the dynamic is not always a straightforward binary between paternalism and autonomy.[30]

The pivotal shift from *Bolam* to *Montgomery* resides in the recognition that the professional practice test – which shields clinicians from liability where their conduct aligns with that of a responsible body of medical opinion – is no longer applicable to the doctor's advisory role.

This position was further clarified by the more recent case of *McCulloch v Forth Valley Health Board*,[31] a Scottish case that is relevant to understanding the limits of the *Montgomery* doctrine, i.e., when an alternative medical treatment can be considered "reasonable." The Supreme Court held that determining which alternatives are reasonable remains an exercise of clinical judgment, to which the professional practice test applies.[32] In Mr McCulloch's case, the cardiologist's decision not to offer NSAIDs was supported by a responsible body of medical opinion and therefore did not amount to negligence.[33] *McCulloch* thus preserves the role of clinical expertise within the patient-centred care framework established by *Montgomery*: clinicians must inform patients of reasonable alternatives, but are not required to offer

[26] [2015] AC 1430, §83.
[27] *Ivi*, §87.
[28] *Ivi*, §109.
[29] See E. CAVE, C. MILO, *Informing patients: The Bolam legacy* in *Medical Law International*, 20(2), 2020, 120.
[30] RT HON LADY JUSTICE ARDEN, *Law of medicine and the individual: current issues; What does patient autonomy mean for the courts?*, cit., 19.
[31] [2023] UKSC 26. The case concerns Mr McCulloch who died shortly after being admitted to Forth Valley Royal Hospital at the age of 39 after a cardiac arrest suffered at home. According to the claim brought by his wife against the hospital, Dr Labinjoh, the cardiologist in charge of her husband's care was liable for medical negligence since she should have offered the patient the option of a treatment with a non-steroidal anti-inflammatory drug (NSAID) for pericarditis. Treatment that the patient would surely have accepted had he been aware of this option and which would have prevented his death.
[32] *Ivi*, §56.
[33] [2023] UKSC 26, §81.

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every possible treatments.[34] In fact, doctors cannot list to patients all possible treatments (even those deemed inappropriate) because the risk would be to instil more doubt than assurance and "diminish rather than enhance their [patient] autonomy".[35] But if this circumstance does not apply, as in *Montgomery*, where the patient should have been informed not only of the risks connected to vaginal delivery, but also of the alternative of a caesarean section, the doctor may be liable for medical negligence.[36]

If paternalism is understood as acting against or without due regard for patients' wills and desires in order to promote their own good,[37] the cases described reveal a clear shift from this paradigm. However, even *McCulloch* fails to show a fully-virtuous doctor-patient relationship, one that not only goes beyond paternalism but also promotes patient autonomy in a context of reciprocity. In particular when it comes to more long-term diseases or conditions (as opposed to a one-off visit to an A&E department for a minor issue) what can make a great difference is the doctor's ability to *see* the patient beyond his clinical charts, and the patient's ability to *know* the doctor as a person to relate to, rather than as a mere executor of medical decisions. Let us consider the final 36hrs before Mr McCulloch's death. The day he was planned to be discharged Dr Labinjoh, his cardiologist, was working at another hospital so she had to rely on Dr Wood's clinical decision. That same evening, as the patient was leaving the hospital, his wife – who was very unhappy about the decision to discharge him – described him as very unwell and experiencing chest pain (one red flag for pericarditis). The following day, Mr McCulloch suffered a fatal cardiac arrest. He was previously active and able to engage in conversations and to care for himself (showering independently etc.).[38] So he could be considered a patient whose actions clearly reflected his symptoms. This was clear for his wife, but should have been clear for his doctors too since he was known to them. Hence, if we go beyond the negligence tests and the legal issues around them, discarding paternalism should mean not only empowering the patient's decision from a legal and medical standpoint, but also investing in the professional relationship with the patient. Hence, as Hirsch suggests, "the focus shifts from the question of the violation of individual autonomy rights to the nature and quality of the physician-patient relationship".[39]

Investing in the patient's input, however, does not mean giving a blank cheque to their requests. *As JJ v Spectrum Community Health CIC*[40] illustrates, patient autonomy does not extend to requiring a clinician to provide a treatment or intervention that is not clinically indicated. The case concerned JJ, a quadriplegic and toothless prisoner with a genetic condition, who had a specific feeding plan because eating

[34] "The narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgment to which the professional practice test should be applied. The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the other three reasonable alternative options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options". *Ibid*. See M. DUNN *et al*., *Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Treatment*, in *Health Care Analysis,* 27(2), 2019, 110-127.

[35] D. SOKOL, *What should you tell patients about alternative treatment options?*, in *The Bulletin of the Royal College of Surgeons of England*, 106(1), 2024, 13.

[36] [2023] UKSC 26, §62.

[37] See A. HIRSCH, *Relational autonomy and paternalism – why the physician-patient relationship matters*, in *Zeitschrift für Ethik und Moralphilosophie*, 6, 2023, 239-260.

[38] [2023] UKSC 26, §§24-25.

[39] A. HIRSCH, *Relational autonomy and paternalism – why the physician-patient relationship matters*, cit., 257.

[40] [2023] EWCA Civ 885.

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ordinary food posed a risk of death or serious injury.[41] JJ nevertheless sometimes supplemented his diet with boiled sweets, which, in themselves, presented a significant risk of choking, causing considerable concern among his care team. JJ argued that he should be free to decide what to eat and to accept the consequences of his choices.[42] The judge recognised, on the one hand, that, following *Montgomery*, respect for patient autonomy includes allowing patients to choose between clinically available treatment options, including options that clinicians may consider less preferable. On the other hand, JJ's situation was particularly complex because, given his physical disabilities, he could not feed himself. Providing him with boiled sweets would therefore require active assistance from a healthcare professional, potentially exposing that professional to responsibility if JJ choked or died from asphyxia. This was especially significant given JJ's advance decision of refusing basic life-saving interventions should such circumstances arise.[43] The case, therefore, illustrates an important boundary to patient autonomy: respecting a patient's choice does not necessarily require healthcare professionals to actively facilitate a choice that they consider medically unsafe and that may expose them to professional or legal responsibility for the resulting harm.

The following two cases, *Winterbotham v Shahrak*[44] and *Tosh v Gupta,*[45] shed further light on the shared decision-making process and emphasise the need to *invest in* and *make space for* the professional doctor-patient relationship. The case of *Winterbotham* takes the patient's right to know about treatment options and material risks a step further. The case concerned Mrs Winterbotham, who had a partially erupted wisdom tooth that had been causing her pain and discomfort for some time. She decided to proceed with extraction, believing that this would resolve her symptoms. Although she signed an informed consent form, she was not made aware that the extraction was considered 'high risk' because of the proximity of the tooth's roots to the lingual nerve, nor that a less invasive alternative treatment was available.[46] The case therefore illustrates that significant patient participation requires more than obtaining formal consent: patients must be given sufficient information about material risks and reasonable alternatives within a dialogue exchange to enable them to *participate meaningfully* in the treatment decision and understand whether the patient has a more conservative approach or not to the risk-benefit factor.[47] The case of *Tosh* similarly confirms the patient-centred character of the assessment of material risk. Ms Tosh, who was referred to a colorectal surgeon because of rectal bleeding agreed to undergo a surgical treatment that resulted in life-changing complications. The doctor diagnosed Grade 2/3 haemorrhoids and recommended a surgical haemorrhoidectomy[48] which subsequently resulted in anal stenosis, a rare but serious complication with significant consequences for the applicant. Ms Tosh argued, among other things, that the surgeon had failed to discuss non-surgical alternatives and had failed to adequately explain the risks of the surgery itself.[49] After a detailed examination of evidence, the court concluded

[41] *Ivi*, §§9-10.
[42] *Ivi*, §16.
[43] *Ivi*, §57.
[44] [2024] EWHC 2633 (KB).
[45] [2025] EWHC 2025 (KB).
[46] [2024] EWHC 2633 (KB), §§11, 61.
[47] *Ivi*, §154.
[48] [2025] EWHC 2025 (KB), §2
[49] *Ivi*, §4.

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that the doctor conveyed to Ms Tosh both the material risks of the surgical procedure and the possible alternatives through a mixture of oral conversations and written forms.[50]

Taken together, *Winterbotham* and *Tosh* suggest that the post-*Montgomery* conception of patient autonomy, further clarified *in McCulloch*, is not simply exhausted by the patient's formal right to accept or refuse treatment. Rather, it requires a communicative process through which the clinician seeks to understand what matters to the particular patient and provides information that enables that patient to participate meaningfully in the decision-making process. In this sense, the emerging case law brings the legal conception of informed consent closer to shared decision-making, while preserving the clinician's responsibility to determine what treatments are clinically appropriate to offer (JJ case). Moreover, these cases show that the legal requirement of dialogue does not necessarily entail lengthy conversations. Rather, it requires *meaningful* interactions through which patients are given adequate opportunities to discuss material risks and possible alternatives. Ultimately when disputes arise, the courts are called upon to determine whether the communication process was sufficient to satisfy the requirements of the informed consent.

This understanding of the relationship between patient's autonomy and shared decision-making is also reflected in professional and policy guidance. The General Medical Council Guidance on decision making and consent[51] explicitly enlists seven principles of decision making and consent. Among them it is relevant to highlight that "[d]ecision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient", clinicians "must try to find out what matters to patients" in order for this dialogue to be tailored and fruitful.[52] It also emphasises that, on the one hand, patients "have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it";[53] while, on the other, "obtaining a patient's consent needn't always be a formal, time-consuming process".[54] Also the National Institute for Care and Excellence guideline on shared decision making[55] is explicitly grounded in *Montgomery* emphasising that "[h]ealthcare professionals should discuss the risks and benefits of each course of action that are meaningful to the particular person".[56] Therefore this frameworks reinforce the emerging picture from the case law: patient autonomy is exercised through communication and relationship: "This joint process empowers people to make decisions about the care that is right for them at that time".[57]

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[50] *Ivi*, §§ 140-146.

[51] GMC, Professional standards. Decision making and consent, 9 November 2020 (last update on 3 August 2026). https://www.gmc-uk.org/cdn/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf. Accessed 30 September 2026.

[52] *Ivi*, 5.

[53] *Ibid*.

[54] *Ivi*, 7.

[55] NICE, Shared decision making, Guidance NG197, 17 June 2021 https://www.nice.org.uk/guidance/ng197/resources/shared-decision-making-pdf-66142087186885. Accessed 30 September 2026.

[56] *Ivi*, 33.

[57] *Ibid*.

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Alongside the jurisprudence and the policies aforementioned, it is worth noting that the UK government has committed to fully implementing 'Martha's Rule' within the NHS England trusts by 2026/27[58] to further foster patients' autonomy and safety in medical decision-making. Its aim is to give patients a preferred formal route to obtaining a second medical opinion in urgent/unclear cases.[59] This could surely boost patient-centred care and patient autonomy. However, as Graham and colleagues maintain, when a *duty* (a responsibility to offer a second medical consultation in complex and urgent cases) is framed as a *right* this framing may create an adversarial imbalance between patients and healthcare professionals. In contrast, if Martha's Rule is implemented as a means of encouraging patients and families to raise concerns and contribute their knowledge of the patient's condition, it has the potential to enhance patient safety, support healthcare professionals, and improve the quality of care across the healthcare system.[60] Here again, the concept of patient autonomy is understood not as 'deciding alone' or 'in a vacuum,' but as a process grounded in relationships, dialogue, and reciprocity. This approach is not only essential for helping patients to better understand their circumstances and make informed decisions, but it also reflects a fundamental aspect of human nature: its inherent relationality. The analysis thus far has argued that legal instruments and policy decisions are not merely neutral frameworks; rather, they often embody a specific, and sometimes narrow, conception of autonomy. By doing so, they convey clear social messages – both intentional and unintentional – that shape public perceptions, influence clinical practice, and affect how individuals understand their rights, responsibilities, and relationships within the healthcare context. Legal articulations of autonomy can reinforce certain values, such as individualism or self-determination, while potentially overlooking or marginalizing more relational or context-sensitive understandings of personhood and decision-making. As a result, the impact of legal norms extends beyond the courtroom or consultation room, contributing to broader cultural accounts about what it means to be autonomous, responsible, and cared for.

3. Emmanuel Levinas and the Paradigm of the Face-to-face Encounter

To better understand the original reciprocity between the self and the other, the following analysis will further explore the concept of relational autonomy in the work of Emmanuel Levinas (1905-1995), one of the most relevant ethical thinkers of the past century. Levinas was a French philosopher born in Lithuania to a Jewish family. Following displacement in the First World War, the family emigrated to France, where Levinas became a citizen and for which he fought in the Second World War. His work very much reflects the horrors of the Holocaust which he personally experienced, as he spent four years as a prisoner of war in German camps while his family was killed by Nazis in Lithuania. These experiences shaped

[58] See I. BERTINI, *Martha's Rule: rebalancing power dynamics between patients or families and clinicians to improve patient outcomes*, cit. See also NHS England, *Martha's Rule*, https://www.england.nhs.uk/patient-safety/marthas-rule/ - implementingmarthasrule (last visited 28 July 2026).

[59] "Martha's rule would mean that in the event of a suspected deterioration or serious concern on the part of a patient on a hospital ward, or their family or carer, they would have the right easily to call for a rapid review or second opinion from an ICU/HDU doctor within the same hospital". P. CURTIS, C. WOOD, *Martha's Rule. A new policy to amplify patient voice and improve safety in hospitals*, in *Demos*, 2023, 11.

[60] See M. GRAHAM *et al.*, *Getting rights right: implementing 'Martha's Rule'*, in *Journal of Medical Ethics*, 51(3), 2025, 154.

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his philosophical engagement with ethics, human relations and the notions of responsibility and vulnerability.

In Levinas the concept of relational autonomy begins with the exploration of the 'alterity' or otherness. The other, as Levinas named the person before us, whose epiphany is her *face*, invites the fellow human to develop a sense of responsibility in the *face-to-face* relationship. Such a stance means that it is through the encounter with another person that we discover something greater than ourselves. This relationship takes us beyond our own needs and interests, inviting us to care for and take responsibility for the other person.[61]

The 'face', which typically reflects the uniqueness of the person, resists possession and constraint, as the other can never be fully defined or grasped – their humanity calls to us precisely because they are always more than what can be known or contained. Hence the relation with the other as a relation with something different from ourselves introduces a factor that goes beyond the mere spontaneity. This relationship introduces a sense of responsibility, compassion and moral duty.[62] This transcendence is reflected in the 'resistance' of the other which has a positive, *ethical*, structure.[63] Ethical because the other person is always more than the way we see or understand them.[64] Consequently, the 'face' is not just a physical element of the other, though a particularly personal one in terms of its individuality, but is the medium for an encounter that carries a feeling of responsibility and "makes the relationship ethical".[65]

This aspect of the relationship can be clearly understood by looking at parental dynamics: as soon as the child is born it becomes clear that he or she is a different 'entity' from the parents, but at the same time this difference calls out for care and responsibility, which can be translated into an ethical bond of reciprocity between the child and the carers. A reciprocity which is fundamentally asymmetrical: since the child would not survive without someone who takes care of him/her, while his or her sheer presence makes certain moral demands. Then, the child becomes an adult who may even commit a terrible crime. At that point, again, the parents' challenge will be to continue to see the 'face of the other' no matter how many times and how badly that person has negated others (including the parents). What may allow those parents to love their now adult son or daughter despite what they have done is again this tension, tempered by love, toward "recognising the other's difference and avoiding subsuming the other within my [the parents'] experiences, understanding and categories".[66]

While "Levinas' idea of relationality challenges totalizing systems of thought that seek to reduce the other to the same",[67] it also challenges an idea of an autonomous self as detached from reality and ultimately lonely in a vacuum. Instead, the person is originally ethical in the sense that in the encounter with the other they discover, mirrored in them, their nature as infinite (and thus vulnerable since unable

[61] E. LEVINAS, *Totality and Infinity*, Pittsburgh, 1969, 193.
[62] *Ivi*, 203.
[63] *Ivi*, 197.
[64] *Ivi*, 194.
[65] I.E. GOZUM, C.C.D. FLAKE, *Encountering the Other in the Digital Sphere: Emmanuel Levinas' "Ethics of the Face" and the Implications for Virtual Healthcare Ethics in Contemporary Society*, in *Journal of Religion and Health*, 2025, 8.
[66] L. SECOMB, *Levinas: Love, Justice and Responsibility*, in L. SECOMB, *Philosophy and Love: From Plato to Popular Culture*, Edinburgh, 2007, 61.
[67] I.E. GOZUM, C.C.D. FLAKE, *Encountering the Other in the Digital Sphere: Emmanuel Levinas' "Ethics of the Face" and the Implications for Virtual Healthcare Ethics*, in *Contemporary Society*, cit., 8.

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to be grasped in its entirety) – and their own tendency to consider this fact through the dynamic of responsibility towards the other.[68]

For Levinas responsibility means "the impossibility of being indifferent to the other":[69] the other, simply because *before me*, interrogates (directly and/or indirectly) my being. 'Face-to-face' encounters between doctors and patients exemplify a society woven from a network of relationships.[70] These relationships may flourish, weaken, or even break, but ultimately, they cannot dissolve the ontological bond that unites human beings, as this bond is embedded in the very nature of the relation (as is archetypally the case with the parental bond). It is not merely about interactions, but about authentic encounters. "The face is ethically compelling, Levinas claims, because within its finite perimeter there are infinite number of possible responses".[71]

Here responsibility assumes a new degree of importance: it is not only responsibility in legal terms which means, for instance, in a healthcare context following specific rules and policies that regulate patient-clinician interactions. The sense of responsibility in question originates in a relation that Levinas describes as more fundamental because it comes before medical practices and interrogates human nature: "The Other appears, and I experience a difference between her and myself. This initial difference is the first moment in ethics, in the acknowledgment of another who obligates me".[72] The other individual before one is a testament that one is neither autonomous (in the sense of detached from other relations) nor dominant and, according to Levinas, this fact implies that individuals cannot usurp fellow humans in any way.[73] This kind of relationship promotes responsibility in a more original sense, since responsibility is not seen as a mere exterior moral command but it stems from the very nature of the subject: an individual's conscience compels them to respond to the needs of the other (as normally happens between the mother and her newborn child). As Perpich puts it "[t]o have a moral conscience means owing an account of myself to the other. It is to be oriented toward others in a way that leaves one unable to turn one's back".[74] This account perfectly depicts Levinas' *interhuman order*: the relationship with another person is based on caring for them without expecting anything in return. This attitude comes before societal norms and the introduction of mutual rights and responsibilities.[75] Consequently humans are more or less *naturally inclined* to reach out to the fellow human to provide assistance and support, and this *human attitude* comes before any law aimed at supporting this inclination.

[68] E. LEVINAS, *Totality and Infinity*, cit., 178.
[69] D. PERPICH, *The ethics of Emmanuel Levinas*, Stanford, 2008, 89.
[70] See L. BURNS, *What does the Patient Say? Levinas and Medical Ethics*, in *Journal of Medicine and Philosophy*, 42(2), 2017, 214-235.
[71] See J.Y.C. EDGOOSE, J.M. EDGOOSE, *Finding Hope in the Face-to-Face*, in *Annals of Family Medicine*, 15(3), 2017, 272-274.
[72] M. CLIFTON-SODERSTROM, *Levinas and the Patient as Other: The Ethical Foundation of Medicine*, cit., 451.
[73] See M. MAY-HOBBS, *Facing the Other: Emmanuel Levinas on the Face-to-Face Encounter*, in *The Collector.com*, 2023, https://www.thecollector.com/emmanuel-levinas-face-to-face-encounter/ (last visited 7 June 2026).
[74] D. PERPICH, *The ethics of Emmanuel Levinas*, cit., 89.
[75] E. LEVINAS, *Totality and Infinity*, cit., 100.

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4. From Levinas' *Interhuman Order* to a Relational Paradigm of Clinical Decision Making

The question that now arises is how the *interhuman order* described so far, with the help of Levinas' philosophical thought, applies to clinical practice. Rather than asking how concepts such as responsibility, vulnerability, shared-decision making etc. interact in the doctor-patient relationship a more fundamental question emerges: should autonomy remain the organising principle of clinical ethics or should responsibility constitute its ethical foundation? While the paradigm of relational autonomy has challenged the individualistic conception of the autonomous patient by recognising the importance of relationships, it maintains patients' autonomy as the primary ethical principle in clinical decision making. However a Levinasian perspective suggests a more radical reordering of objectives is now needed: *responsibility for the other precedes autonomy* while autonomy becomes relevant in the relationship with the other characterized also by vulnerability and care. Autonomy, in this case, becomes the reflection of the impossibility of reducing the other to ourselves and not merely the guiding principle in the relationship of care.

This perspective can be illustrated by the case of a woman diagnosed with breast cancer (grade 3, invasive ductal carcinoma) at 24 weeks into her second pregnancy, as described by Messina and Remoundus.[76] The options presented by her doctor would possibly have been 1. Deliver the baby very early (limiting its chances to survival to 60-70% due to the very premature birth) and start the usual treatments (most successful outcome for the mother); 2. Surgery followed by treatments most compatible with continuing the pregnancy (which may mean the optimal treatments are not used); 3. Wait until the foetus can be safely delivered and then start the standard treatments (outcome for the mother unlikely to be good). The patient decides to continue the pregnancy and undergo the treatments most compatible with the safe development of her baby (option 2).

Taking this decision is not like playing Russian Roulette with the patient's life but is working out the best option in accordance with very specific and personal circumstances (for instance, the patient's priorities), when there is more than one treatment pathway and there is a lack of consensus on the best course of action. As Messina and colleagues argue "[t]he current lack of consensus on a standard treatment is such that care is tailored to suit the medical, ethical, legal, personal, emotional, psychological, and religious circumstances of each case, with the patient at the centre of and actively contributing to the decision-making process".[77] Thus, not only are the perspectives of both patient and clinicians crucial, but also their relationships. Perhaps there is also involvement of a third party, such as a spouse, partner, child or parent who may have a great deal of weight in the patient's decision-making and overall wellbeing because they have a substantial role in her life. In this case the woman may be at the same time a patient, a mother, a partner and a member of a wider community. These relationships are not external influences that undermine autonomous decision-making but they contribute to who she is. However, as Dove and colleagues maintain "[r]elational autonomy does not require the patient to suffer harm in or-

[76] See G. MESSINA, D. REMOUNDOS, *A case of Triple Negative Breast Cancer diagnosed during Pregnancy: Case Study*, in *Journal of the Nuffield Department of Surgical Science*, 1(3), 2020.
[77] *Ibid*, 2.

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der to respect the preferences of a third party, but rather to understand those preferences and take them into account".[78]

People are fundamentally shaped, whether positively or negatively, by their human interactions which contribute to what the person is. Consider the importance of genetic relationships – those based solely on shared DNA sequences – especially in cases where someone was adopted at birth or conceived through egg or sperm donation. Many in those circumstances go to some lengths to discover their biological parents and relatives because ultimately, they hope to understand better who they are, both at a superficial and at a deeper level, or simply because that relation matters.[79]

When those relations are lived and experienced to the point that there is a sense of belonging, cutting them off during such crucial moments as life and death decision-making in the name of a fictional autonomy (the idea that to make *independent* decisions someone should be left *alone* and *detached* from too close relations) seems counterintuitive and may do more harm than good. There is also a further layer of relationality that goes beyond familial and personal relationships: the broader social context in which individuals are embedded. Returning to the example of the pregnant woman with stage 3 breast cancer, her decision may be better understood if it is situated within her societal and value-based context.[80] It may be that she cannot contemplate option 1 because her expectations, ethical norms and values shaping her perception of what is morally and practically right and wrong point her in a different direction. This means that relational autonomy can be understood as a relational power which not only reflects in possibly better patient care – multifaceted since it encompasses different perspectives – but also implies a shared responsibility of care.

Levinas' philosophy deepens this account by shifting attention from autonomy to responsibility. The patient's vulnerability is not simply a clinical condition requiring management but the ethical event that calls the clinician into responsibility. The encounter with the other person (the Levinasian 'face of the other') highlights the other's mortality and dependence which is reflected in the inclination to care. Awareness of one's own physical and psychological wounds (the term *vulnerability* comes from the Latin *vulnus*, meaning 'wound', highlighting the possibility of harm) can deepen one's capacity to empathise with the suffering and fragility of others. Such vulnerability becomes the ground of relationality, reminding both patients and clinicians that autonomy is never exercised in isolation but emerges within a shared condition of mutual exposure and interdependence. And, more importantly, patients remain irreducibly more than their disease. Hence, shared decision-making becomes more than an exchange of information or a way to get informed consent: it is an ethical practice through which clinicians tend *responsibly* to the person entrusted to their care.[81] This approach benefits doctors too: "They view themselves as ethical professionals who intertwine scientific evidence and patient-centredness, guided by a

[78] E.S. Dove *et al.*, *Beyond individualism: Is there a place for relational autonomy in clinical practice and research?*, in *Clinical Ethics*, 12(3), 2017, 155.

[79] See A. Ravelingien, V. Provoost, G. Pennings, *Donor-conceived children looking for their sperm donor: what do they want to know?*, in *FVV in ObGyn*, 5(4), 257-264.

[80] See C. MacKenzie, N. Stoljar (ed. by), *Relational Autonomy*, cit.

[81] See E. Gauthier-Mamaril, *Reframing patient-doctor relationships: relational autonomy and treating autonomy as a virtue*, in *Journal of Global Ethics* ,18(1), 2022, 44.

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wish to support autonomy".[82] And, it may also mitigate the burden of responsibility, resisting the expectation that clinicians assume a god-like position of total control or ultimate authority. Relational autonomy may prompt healthcare professionals to develop a deeper understanding of their patients and to tailor their care according to their personal histories and values, recognising that the clinical relationship remains open-ended: the other cannot be ultimately defined, but only supported.

Within this framework vulnerability – understood in a Levinasian sense – has a deeper connotation than its traditional meaning of susceptibility to harm or impaired decision-making capacity. It expresses the condition of human interdependence, insofar as it entails exposure to the other as carrying responsibility for their suffering without ever fully grasping or comprehending them. Patients and clinicians are equally vulnerable: the patient because of their disease and the clinician because care requires openness to the suffering of the other without being able to fully understand and control it.

Neither paternalism nor individualism can then really offer a full account of the reality of clinical practice. In contrast, the Levinasian perspective has the great advantage of reordering the ethical priorities. Autonomy is no longer the starting point of ethical practice but is one of its fruits. It emerges in the relationship of responsibility, trust and care and not as an isolated exercise of individual choice.

5. Conclusion

Clinicians and patients are linked by an ontological bond where autonomy is fostered (and not diminished) by their relationality. As the case law mentioned above (*Bolam, Montgomery* and *McCulloch*) shows, the principle of autonomy is the bulwark against unwanted treatments and bodily harm; therefore, society has the duty to foster legal systems that implement this fundamental ethical norm. Nonetheless, as this analysis has argued, personal autonomy goes beyond the mere ability to choose freely from a set of options – a set that constantly expands. Relational autonomy calls for a revolutionary view of autonomy as not individualistic but existing in relationship with society in many different respects.

The subsequent cases of *JJ, Winterbotham* and *Tosh* further illustrate that relational autonomy requires both meaningful patient-doctor relationship and appropriate clinical boundaries. *JJ* demonstrates that respect for autonomy does not entail patients to demand that clinicians accommodate choices that are not considered clinically appropriate. *Winterbotham* shows that autonomy cannot meaningfully exercised through formal consent alone: patients need a genuine opportunity to understand and discuss material risks and alternative treatments. *Tosh* indicates that such dialogue can be both oral and written and does not need to be lengthy as long as it offers meaningful participation. Taken together, these cases suggest that autonomy should neither be understood as individualistic choice nor as the transfer of clinical responsibility to patients. This relational and communicative understanding of autonomy is further reflected in policies frameworks. Both the GMC's decision making and consent guidance and NICE's shared decision-making guidance place meaningful dialogue, attention to patients' personal circumstances, and discussion of reasonable options at the centre of the doctor-patient deliberative process. In some circumstances, also input from close relations may be very relevant – as illustrated by the con-

[82] G. ELWYN *et al*., *A return on investment. How shared decision-making benefits doctors: a key informant interview study*, in *BMJ Open*, 15, 2025, 4.

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cerns raised by Mr McCulloch's wife about his deteriorating condition before he was discharged from the hospital.

A Levinasian perspective enables this legal development to be understood within a broader ethical framework. Levinas does not merely provide additional support for relational autonomy but he challenges the assumption that autonomy should be the starting point of ethics while instead responsibility should be. The patient is not simply an autonomous decision-maker embedded in a societal context and managed by clinicians. Patients and clinicians have a reciprocity: the clinician's responsibility arises in response to patient's vulnerability, while the patient's involvement in the shared decision-making enables the clinician to cater for the uniqueness of the person before them. However, such an approach should be actively developed and nurtured through education and professional training, rather than left to individual clinicians' inclination or personal attitude, if significant patient participation is to become a consistent feature of healthcare practice. Doctors and patients are not simply two factors of the equation that need to be balanced against one another; rather, both participate in a relationship of responsibility that provides the condition for meaningful autonomy to be exercised.

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