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### Relational Theory and Health Law and Policy

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# RELATIONAL THEORY & HEALTH LAW AND POLICY

*Jocelyn Downie\* & Jennifer Llewellyn\*\**

## 1. Introduction

Relational theory starts from an understanding of human selves as relational. This theory informs some significant current developments in the areas of philosophy, ethics and legal theory that re-envision key concepts including autonomy, equality, rights, justice, memory, trust, judgment and identity. In this paper we introduce relational theory and begin to explore some of its implications for health law and policy. In doing so, we hope to show the relevance of each field to the other and to persuade those interested in health law and policy to take up the challenge to pursue the transformative potential of relational theory through their work.

## 2. The Project

To thoroughly explore the emerging paradigm of relational theory and how it can engage with health law and policy, one would have to attend to the following questions: what is relational theory?; what is the relational conception of the self?; what do identity, memory, judgment, autonomy, equality, justice, and rights look like through a relational lens? And then one would have to reflect on what all of this has to do with health law and policy.

Of course, what we have just described is a book and not a paper.<sup>1</sup> In this paper, we are less ambitious and focus only on a few of the questions asked

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1 Such a book project is underway. An edited collection bringing leading relational theorists together with leading scholars in health law and policy is planned for publication in September 2009.

above. First, we describe relational theory, paying particular attention to the central metaphysical concept of the self and focus on one of its derivative ethical concepts, autonomy. Second, we explore the possible implications of a relational conception of autonomy for a core issue in health law and policy, specifically consent to treatment.

We begin with a focus on the concept of the self as it is fundamental to relational theory. From here we could focus on any of a number of core values that flow from the concept of the self, for example, autonomy, equality, and justice. However, within the scope of this paper we focus only on autonomy. This should not be taken to mean that we believe that autonomy is the most important value to pursue in health law and policy nor that it is the best lens through which to analyse particular issues in health law and policy.<sup>2</sup> It is reflective merely of the limited space in which we can only do justice to one particular value. We chose to focus on autonomy because it is the most developed concept (beyond the concept of the self) in relational theory and because it is one of, if not the, dominant concept in health law and theory. It therefore offers an accessible and illuminating point of entry into the ultimately, and necessarily, broader conversation. In sum, our goal is to introduce relational theorists to a field that is ripe for the application of their work and to introduce health law and policy scholars to a powerful new paradigm.

Before moving on, it is important to offer some preliminary acknowledgements and caveats.

First, we acknowledge the foundation upon which this paper is built.<sup>3</sup> It is quite remarkable how much of the groundbreaking work in relational

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2 See, e.g., Sanda Rodgers' arguments in support of viewing state intervention in relation to reproduction through an equality rather than an autonomy lens. Sanda Rodgers, "Women's Reproductive Equality and the Supreme Court of Canada" in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court* (Toronto: Irwin Law Inc., 2007) 189.

3 See, e.g., Susan Sherwin, "A Relational Approach to Autonomy in Health Care," in *The Politics of Women's Health: Exploring Agency and Autonomy*, The Feminist Health Care Ethics Research Network, Susan Sherwin, coordinator, (Philadelphia: Temple University Press, 1992) 19 [*Relational Approach*]; Christine Koggel, *Perspectives on Equality: Constructing a Relational Theory* (Lanham: Rowman and Littlefield, 1998); Nedelsky, "Reconceiving Autonomy: Sources, Thoughts, and Possibilities" (1989) 1 *Yale J. L. & Feminism* 7.

theory has been done by Canadian feminist scholars. We owe them a real debt and we hope to do their work justice.

Second, we note explicitly that not all relational theory is feminist<sup>4</sup> and not all feminist theory is relational.<sup>5</sup> While there is considerable overlap in the content and authorship between these two theoretical frameworks, they are not identical. That said, what we present in this paper can be fairly characterized as feminist relational theory. We believe this to be a theoretical framework with extraordinary potential for health law and policy.

Third, we note that some of the endpoints of the relational approach might be realized through other theoretical approaches. For example, some non-relational frameworks also recognize the embodied nature of the self<sup>6</sup> and others recognize the need to expand the scope of health law issues from the physician-patient relationship to oppressive social structures.<sup>7</sup> We do not discount these alternative approaches. Nor do we set out in this paper to argue for relational theory as the superior path to these endpoints. Rather, we seek to demonstrate the potential fruitfulness of bringing relational theory together with health law and policy.

### 3. Relational theory

A literature search on “relational theory”, reveals thousands of articles and books on a dizzying multiplicity of topics: desire and dread; competence; physical space; capital; leadership; information and learning in social networks; demography; confidentiality; forensic mental health; addiction; authority; genericity; calculus and algebra; knowledge representation; space-time; emotion; gender; biological systems; behaviour dynamics; datatypes; public relations; model management; the body; self-organization; corporate governance; sexuality; computing; database theory; and happiness. Relational theory across all of these topics is grounded in a shared core belief that the object/subject of attention should be understood in relation to others and as *being in relation to* others.

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4 Examples of non-feminist relational theorists include Martin Buber and Emmanuel Levinas.

5 Examples of non-relational feminist theorists include Susan Moller Okin, Susan Wolf, and Martha Nussbaum.

6 See, for example, Elizabeth Grosz and Luce Irigaray.

7 See, for example, Susan Wolf and Virginia Held.

This mass of topics can be organized into clusters that relate to traditional disciplines: physics, mathematics; computer science; business; psychology; anthropology; philosophy; and law. We focus in this paper on philosophy and law as, for obvious reasons, these have the most relevance for and direct potential impact on health law and policy. In the subspecialties of philosophy with the most relevance for this project, we find relational theory playing out in metaphysics, epistemology, ethics, political and legal theory, and applied ethics. Metaphysics, for example, asks questions about the nature of the self, personhood, and identity. Ethics asks questions about autonomy and equality to name but two core values. Applied ethics takes us to principles/rules/policies that govern conduct in specific situations, as, for example, consent and confidentiality.

We turn now to a brief exploration of how relational theory engages the concepts of self and the implications this has for thinking about the concept of autonomy.

### a. The relational self

To get to the practical implications of relational theory for health law and policy, we must start with a metaphysical concept, specifically, the concept of the self. The conception of the self that dominates contemporary Canadian health law and policy is a liberal individualistic one. It is isolated, independent, socially unencumbered, rational, and self-created.<sup>8</sup> In contrast, a relational conception of self is socially connected, interdependent, socially encumbered, emotional, relationally constructed, socially constituted, and embodied.<sup>9</sup>

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8 See, e.g., Immanuel Kant, *Foundations of the Metaphysics of Morals and What is Enlightenment?* (Lewis White Beck trans., Bobbs-Merrill Company, 1959) (1785); John Locke, *An Essay Concerning Human Understanding* (Peter H. Niddich ed., Ward, Lock & Co., 1982) (1883); John Rawls, *A Theory of Justice* (1971). It must also be acknowledged that contemporary liberals have attempted to respond to the communitarian and feminist critiques of the atomistic conception of the self. See, e.g., Will Kymlicka, *Liberalism, Community, and Culture* (Oxford: Oxford University Press, 1989). However, the dominant version in health law and policy and bioethics remains the traditional one and so we set the relational concept up in contrast to that. Also, while some contemporary liberals have moved some distance from traditional liberalism, they are still not proposing a relational conception of self or autonomy such as will be described in this paper.

9 For a general introduction to the relational self see Catriona Mackenzie and

It is sometimes easier to convey the concept of the relational self through expressions that are almost more intuitive than rational in their appeal. So, in the spirit of relational theory<sup>10</sup>, we offer the following expressions about the relational conception of the self:

- We are creatures and creators of our social context.
- We are beings in and of our social context.<sup>11</sup>
- The self exists in and through relationships.
- Selves are both individuated and integrated.<sup>12</sup>
- I am because you are (*ubuntu*) and a person is a person through persons (*umuntu ngumuntu ngabantu*).<sup>13</sup>
- Instead of Descartes' "I think therefore I am", a twenty-first century expression "I am networked therefore I am."<sup>14</sup>

In sum, a relational self emerges from and is continuously shaped by the context of multiple relationships with other individuals and institutions – some of which can promote flourishing and some of which can oppress.

Natalie Stoljar eds., *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (New York: Oxford University Press, 2000) [*Relational Autonomy*]. Also see Lorraine Code, *What Can She Know?: Feminist Theory and the Construction of Knowledge* (Ithica: Cornell University Press, 1991) ch. 2 "Second Persons".

- 10 See Part 4. *a. Competence* below for a discussion of the role of rationality in relational theory.
- 11 This is a play on the metaphor used to describe the relationship between a pregnant woman and fetus in *R. v. Sullivan*, [1991] 1 S.C.R. 489, 63 C.C.C. (3d) 97 [*Sullivan*].
- 12 D.P. McAdams, "What do we know when we know a person" (1995) 63 *J. Personality* 365.
- 13 See Charles Villa-Vicencio, "Identity, Culture, and Belonging: Religious and Cultural Rights" in John Witte Jr. and Johan D. van der Vyver eds., *Religious Human Rights in Global Perspectives: Religious Perspectives* (The Hague: Martinus Nijhoff Publishers, 1996) at 527; Gabriel Setiloane *African Theology: An Introduction* (Johannesburg: Skotaville Publishers, 1996); Valiant A. Clapper "Ubuntu and the Public Official" in *Publico* December 1996 at 27; Lionel Abrahams, "Ubuntu or not to?" in *Sidelines* June 1997 at 1.
- 14 Kenneth J. Gergen, "The Relational Self in Historical Context" (2006) 1 *IJDS* 119 at 122.

### b. Relational autonomy

Flowing from the relational conception of the self, various approaches have been taken to characterizing autonomy as relational.<sup>15</sup> Significant attention has been paid, for example, to what exactly is meant by the claim that the self is social or relational.<sup>16</sup> Feminist scholars have considered the notion of the social self and its implications in a bid to redeem the notion of autonomy from its traditionally individualistic and rationalistic expression.<sup>17</sup> These scholars see the concept of autonomy as worthy of reform because of its usefulness in the struggle to gain equality and respect for women. They have thus resisted the urge to reject the concept of autonomy and instead see it anew through a relational lens. For the purposes of this paper, we offer the following composite characterization:

Autonomy is the capacity for defining, questioning, revising, pursuing one's interests and goals that is exercised, protected, and corroded within relationships and social structures which together shape the individual and determine others' responses to her.<sup>18</sup>

## 4. From relational theory to health law and policy

What might the implications of a relational conception of autonomy be for health law and policy? Consider the core issue of consent to treatment. The traditional approach (grounded in a liberal individualist conception of the self and of autonomy) focuses on the specific encounter between a patient and health care provider and requires that, in order for the health care pro-

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15 See for example the collection of articles on this topic in *Relational Autonomy supra* note 9.

16 See for example Linda Barclay, "Autonomy and the Social Self" in *Relational Autonomy supra* note 9 at 52. Barclay identifies and examines three distinct ways in which the claim for the social self is made through the literature in feminism and communitarianism. Claims are made for the social self as: deterministic, motivational, and constitutive. Each of these claims are seen to have different implications for autonomy.

17 *Relational Autonomy, supra* note 9 at 3-4.

18 This is a definition from Jocelyn Downie & Susan Sherwin, "A Feminist Exploration of Issues around Assisted Death" (1996) XV St. Louis U. Pub. L. Rev. 303 at 327 [*Feminist Exploration*], slightly modified in light of the subsequent literature on relational autonomy.

vider to treat the patient, there must be a consent to treatment made by a competent individual and that consent must be free and informed.<sup>19</sup> To be adequately informed, the disclosure must meet the informational needs of a reasonable person in the circumstances of the patient.<sup>20</sup> If something goes wrong and there is a negligence action, the traditional approach to causation requires that a reasonable and prudent person would not have consented had they been given the information not provided.<sup>21</sup>

An approach grounded in a relational conception of autonomy can expand our gaze quite dramatically. A relational conception of autonomy will call on us to revisit the traditional approaches taken to competence, freedom, disclosure, and reasonableness. It will require us to consider the question of whether the exercise of autonomy is restricted but also whether the capacity for autonomous decision-making itself is corroded and how it might be enhanced.<sup>22</sup> It will also take us outside the specific encounter between individual patient and individual health care provider and into a much broader range of points and types of engagement (for example, who should be involved in discussions and decisions as well as how and what social institutions shape the decision or action contexts in which patients and health care providers are situated).<sup>23</sup>

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19 See, generally, Bernard Dickens, "Medical Negligence" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy* 3<sup>rd</sup> ed. (Markham: LexisNexis Canada Inc., 2007) 101; Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy* 3<sup>rd</sup> ed. (Markham: LexisNexis Canada Inc., 2007) 189 [*Informed Consent*].

20 *Reibl v. Hughes*, [1980] S.C.J. No. 105, 2 S.C.R. 880 [*Reibl*].

21 *Arndt v. Smith*, [1997] 2 S.C.R. 539, 148 D.L.R. (4<sup>th</sup>) 48 [*Arndt*].

22 Diana Tietjens Meyers, *Self, Society, and Personal Choice* (New York: Columbia University Press, 1989); Carolyn McLeod & Susan Sherwin, "Relational Autonomy, Self-Trust, and Health Care for Patients Who Are Oppressed" in *Relational Autonomy*, *supra* note 9, 234.

23 See, e.g., Susan Sherwin, "Whither Bioethics? How Feminism Can Help Re-Orient Bioethics" (2008) *International Journal of Feminist Approaches to Bioethics* 7 [*Whither Bioethics*]. There is also an extensive and developing literature on the role of emotion in law and legal decision making that overlaps in significant and helpful ways with the insights gained from relational theory. For a helpful overview of the field see: Terry A. Maroney, "Law and Emotion: A Proposed Taxonomy of an Emerging Field" (2006) 30 *Law and Human Behaviour* 119 [*Law and Emotion*].



### a. Competence

Traditionally, health law has seen competence as linked to rationality and rationality as divorced from what might be characterized as relational decision-making. This has generally disadvantaged women as they have been more likely to be seen as irrational or driven by their emotions or influenced by relationships. They have therefore been found by health care providers and courts to be incompetent and not had their wishes respected.<sup>24</sup>

At least three issues are at play here in what we call relational decision-making.

First, the role of emotion in decision-making.<sup>25</sup> When the self is seen as affective instead of exclusively rational, emotion takes on a legitimate role in decision-making.<sup>26</sup> By way of illustration, think about a decision-making strategy that many readers have likely employed – you have to decide between two options which will have life-changing import (for example, choosing between two job offers, deciding whether to stay with or leave a spouse or whether to have a preventative mastectomy). You imagine yourself as having taken one option and live with that for a day, taking note of how you are feeling. You then imagine yourself as having taken the other option and again live with that for a day, again taking note of how you are feeling about the decision. The decision you actually make is influenced by the emotional reactions you experienced.

Support for the relational claim that there is an affective component to competence can also be found in research involving patients with damage to the part of the brain that processes information about somatic states, conducted by the neurologist Antonio Damasio and considered by legal feminist Jennifer Nedelsky among others. Damasio found that:

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24 Steven H. Miles & Allison August, "Courts, Gender and 'The Right to Die'" (1990) 18 *Law Med. & Health Care* 85.

25 There is also an extensive and developing literature on the role of emotion in law and legal decision making that overlaps in significant and helpful ways with the insights gained from relational theory. For a helpful overview of the field see: Terry A. Maroney, *Law and Emotion*, *supra* note 23.

26 See, Barbara Herman, *The Practice of Moral Judgment* (Cambridge: Harvard University Press, 1993); Susan Sherwin, *Relational Approach*, *supra* note 3; Nedelsky, "Embodied Diversity and the Challenges to Law" (1997) McGill LJ 91 [Embodied Diversity].

what the experience with patients ... suggests is that the cool strategy advocated by Kant, among others, has far more to do with the way patients with prefrontal [brain] damage go about deciding than with how normals usually operate.<sup>27</sup>

Nedelsky summarized Damasio's theory as follows:

effective reasoning requires what he calls "somatic markers". Somatic markers are emotional responses that (for the most part) we have learned, through experience, to associate with certain images. When, in deciding what to do, one imagines a certain action, one associates it with an outcome, which triggers an emotional reaction.<sup>28</sup>

The second aspect of relational decision-making to consider is the practice of attending to the preservation of relationships. Here the work of Carol Gilligan and many of those who followed her in the development of what has come to be known as an ethic of care becomes particularly relevant.<sup>29</sup> Consider the following illustration of two types of reasoning from a psychological study conducted by D. Kay Johnston<sup>30</sup> in which children were asked to respond to the following fable:

It was growing cold, and a porcupine was looking for a home. He found a most desirable cave but saw it was occupied by a family of moles.

"Would you mind if I shared your home for the winter?" the porcupine asked the moles.

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27 Antonio R. Damasio, *Descartes' Error: Emotion, Reason and the Human Brain* (New York: Grosset/Putnam, 1994) at 172.

28 Nedelsky, *Embodied Diversity*, *supra* note 26 at 102.

29 Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982); Joan C. Tronto, "Beyond Gender Difference to a Theory of Care" (1987) 12:4 *Signs: Journal of Women in Culture and Society* 644.

30 D. Kay Johnston, "Adolescents' solutions to dilemmas in fables: Two moral orientations – Two problem solving strategies" in Carol Gilligan, et al., eds. *Mapping the moral domain: A contribution of women's thinking to psychological theory and education* (Cambridge: Harvard University Press, 1988) 49.

The generous moles consented and the porcupine moved in. But the cave was small and every time the moles moved around they were scratched by the porcupine's sharp quills. The moles endured this discomfort as long as they could. Then at last they gathered courage to approach their visitor.

"Pray leave," they said, "and let us have our cave to ourselves once again."

"Oh no!" said the porcupine. "This place suits me very well"<sup>31</sup>

Ethic of justice responses included – "The porcupine has to go definitely. It's the mole's house," "It's their ownership and nobody else has the right to it" or "Send the porcupine out since he was the last one there." Ethic of care responses, in contrast, included – "The both of them should try to get together and make the hole bigger" and "Wrap the porcupine in a towel."<sup>32</sup> Contemporary relational theory has distanced itself from various aspects of the ethics of care (e.g., the failure to acknowledge the oppressive nature of some relationships, the stark juxtaposition of care and justice, and the extent of gender difference claimed). However, it retains a modulated belief in the legitimacy of attending to the preservation of relationships in competent decision-making.

A third aspect of relational decision-making is the inclusion of intimates in the process of decision-making. While having family present during a consent process is certainly common in contemporary health care, when family members exert what is characterized as too much influence in the process, questions of competence and voluntariness may be raised. The liberal individualist model cannot comprehend a competent individual believing that another person should have decision-making authority for their treatment decisions. A relational model can entertain a wider range of possible levels and kinds of decisional authority-shifting without concluding that the individual is incompetent and the consent therefore invalid.

A relational conception of autonomy allows us to see emotion and relational reasoning as legitimate aspects of competence. It suggests that that health law, policy, and practice should see and treat as competent a wider range of decision-makers and decision-making than they do at present.

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31 *Ibid.* at 71.

32 *Supra* note 30 at 53.

## b. Freedom

Autonomy and consent take us not just to the issue of competency but also to the issue of freedom. Traditionally, health law has considered a decision to be free if it is made without external forces directly interfering with a choice between the options in front of the individual; no arm twisting, no guns to heads, no vast sums of money dangled in front of the person. Unfortunately, this approach loses sight of other important barriers to freedom as well as the conditions necessary to support freedom.

A relational approach surfaces the fact that there are not just external direct forces but also internal and indirect forces that must be attended to and resisted where restrictive or corrosive and promoted where enhancing.

By forces indirectly interfering with choice we mean “forces that limit the set of options and thereby interfere with choice.”<sup>33</sup>

By internal forces interfering with choice we mean “a person’s own desires that are grounded in the perceptions of herself and her options that have been oppressively constructed through socialization in such a way that the person does not accurately perceive herself or her options.”<sup>34</sup>

Consider some concrete health law examples:

External direct forces – a twenty-three-year-old man is physically forced into a psychiatric facility for treatment of his schizophrenia.

External indirect forces – a pregnant teenager has recently moved from Quebec to Nova Scotia. She can only get an abortion if she pays up front and claims the funds back from Quebec.<sup>35</sup> Abortion is not illegal so there are no external direct forces preventing her from having an abortion but she does not have the necessary funds.<sup>36</sup>

Internal direct forces – a 5’6” 140 pound woman appears at the surgeon’s office seeking gastric bypass surgery citing the same reasons that she used previously for breast implants, cheek implants, botox treatments, rhinoplasty, calf implants, and liposuction.<sup>37</sup>

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33 See, e.g., Jocelyn Downie & Susan Sherwin, *Feminist Exploration*, *supra* note 18; Susan Sherwin, *Relational Approach*, *supra* note 3.

34 Jocelyn Downie & Susan Sherwin, *Feminist Exploration*, *supra* note 18.

35 Jocelyn Downie & Carla Nassar, “Barriers to Access to Abortion Through a Legal Lens” (2007) 15 *Health Law Journal* 143 [*Barriers*].

36 *Ibid.*

37 For more on this, see, Carolyn McLeod & Susan Sherwin, *Relational Autonomy*, *supra* note 9.

Internal indirect forces – a woman appears in her family physician’s office. She was sexually abused as a child and is now in an abusive marriage. She has internalized her father’s and partner’s denigration of her and cannot see leaving him as an option open to her.<sup>38</sup>

Within a traditional liberal individualist framework, the first set of forces would be acknowledged as a threat to autonomy but the latter three would not.

To ensure that all decisions in the health arena are free, we must attend to a wider variety of forces shaped by personal and social relationships than we have traditionally. Law and policy should require this broader gaze when assessing the validity of consents in specific cases. It should also consider the implications for the possibility of voluntary decisions when making policy that can generate external and internal, direct and indirect forces that limit or enhance the exercise of autonomy.

### c. Disclosure

We turn now to a discussion of the rules with respect to the disclosure required for a valid consent in light of the relational conception of autonomy. There is a variety of ways in which, on a relational account, the health care provider may fail to meet adequate disclosure.

First, the discloser may be insufficiently informed because, given the inequality in the relationship, the patient does not feel empowered to ask questions of, or provide information to, the physician and so the physician cannot know what the patient wants to know.

Second, the discloser may be insufficiently informed because he does not know what he does not know about the patient’s relevant circumstances and so cannot perform his role as discloser sufficiently well. To borrow a phrase from the “poetry” of Donald Rumsfeld, there are so many “unknown unknowns”<sup>39</sup> lying between many physicians and patients as well as between health lawyers and the people most affected by health law and policy we help to shape. Many of these unknowns relate to our lack of understanding of the social contexts of others.

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38 See, Carolyn McLeod, *Self-trust and Reproduction* (Cambridge: MIT Press, 2002) [Self-trust].

39 Hart Seely, ed., *Pieces of Intelligence: The Existential Poetry of Donald H. Rumsfeld* (New York: FREE PRESS, A Division of Simon & Schuster, Inc., 2003) at 2.

A thought experiment involving risk may illuminate this issue. Think about the issue of disclosure of risk in the context of genetic counselling. Think about the risk of one-in-180 chance of having a child with a chromosome abnormality at age 35. Picture a patient in front of you to whom you are about to disclose this risk and imagine the conversation you will have about risk.

Now consider the following description of a real patient:

a low-income pregnant Afro-Puerto Rican woman in Los Angeles. She has a 100 percent chance of running out of food stamps this month, a 25 percent risk of having one son or brother die in street violence, and an 80 percent chance of getting evicted by the end of the year.<sup>40</sup>

Now think back to your previously imagined risk disclosure conversation. Would it still be appropriate for this patient? Of course this is an extreme and non-local example – deliberately so. The point is that we need to be forced outside ourselves in thinking about disclosure.

We can fairly easily put ourselves in the shoes of the patient and think (using the facts from *Reibl v. Hughes* which will be more familiar to most readers than the facts in our thought experiment) “oh, I should ask whether he has plans to retire in a few months such that he could wait for the surgery and not risk his pension.”<sup>41</sup> But, in doing so, we are putting ourselves

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40 This example is taken from Angela Thachuk, “Midwifery, Informed Choice, and Reproductive Autonomy: A Relational Approach” (2007) 17 *Feminism & Psychology* 39.

41 In *Reibl v. Hughes*, a 44-year old Hungarian immigrant, Mr. Reibl, elected to undergo a surgical procedure to remove an occlusion in an artery near his brain that was preventing blood flow through the artery. Dr. Hughes, a competent neurosurgeon, performed the surgery successfully. Shortly thereafter, Mr Reibl suffered a massive stroke resulting in the paralysis of his entire right side. In the absence of the surgery, the risk of stroke had not been imminent, however Dr. Hughes did believe that Mr. Reibl’s chances of suffering a stroke would be greater if he did not undergo the procedure. Prior to the surgery, Dr. Hughes explained the risks of the procedure to Mr. Reibl including the risk of death or stroke, but Mr. Reibl did not understand those risks, and claimed that he would not have gone ahead with the surgery if he understood them, especially because he was only one and a half years away from being eligible to receive his pension. The issue for the Supreme Court of Canada concerned Dr. Hughes’ liability

(with all our privilege as we have jobs to retire from and we have pensions ahead of us) in the shoes of the patient. Instead, we must see the patients in their own shoes. Most importantly, we must not fail to appreciate the aspects of their lives that relate most oppressively to their social situatedness (e.g., class, race, gender, disability).

We need to explore the “unknown unknowns.” We need to build much greater awareness into our disclosure rules and practices. We need to explore different and greater obligations for health care providers to inquire prior to the disclosure. This may, for example, shift the power imbalance (as the physician seeks information that the patient has and therefore indirectly gives the patient more power). This may increase the chances that the health care provider will understand what patients actually need to know. Finally, if it results in broadening what health care providers typically ask about, it may avoid stereotypes resulting in missed information (e.g., the physician assuming that a pregnant, wealthy, white woman is not abusing drugs or subject to violence in her home).

Third, there are also times when a health care provider knows what is relevant to the patient and is prepared to disclose all the relevant information that she has to the patient but is lacking information as a result of health law, policy, and practice. For example, it is well documented that there are gaps in knowledge about the safety and efficacy of cardiac care for women and the use of antidepressants in African Canadians.<sup>42</sup> Even in the recent past, health care professionals did not have the relevant information because the research wasn't done to determine subgroup differences. Treatments shown to work and be safe for white males were applied (sometimes detrimentally) to women, visible minorities, etc. On an ongoing basis, those setting much of the research agenda are focusing on the market and therefore on issues for wealthy white men. Those in charge of the policies that impact on the setting of the research agenda appear to be unaware of, or insensitive to, the ways in which the setting of the research agenda is leading to significant gaps in knowledge and thereby resulting in insufficiently informed disclosures (and thereby compromising consent). Clearly, consid-

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for failure to meet the requisite standard of disclosure for informed consent. *Reibl, supra* note 20.

42 Françoise Baylis, Jocelyn Downie, & Susan Sherwin, “Reframing Research Involving Humans” in *The Politics of Women's Health: Exploring Agency and Autonomy*, The Feminist Health Care Ethics Research Network, Susan Sherwin, coordinator, (Philadelphia: Temple University Press, 1992) 234.

ering disclosure through a relational lens, we must assess law and policy for its impact on what health care providers will have available to them to disclose in encounters with patients (particularly where the lack of knowledge disproportionately affects those in society who are already disadvantaged by social structures and institutions).

#### d. Reasonable person in the circumstances of the patient

In traditional consent law, we look at what the reasonable person in the circumstances of the patient would want to know and what the reasonable person in the circumstances of the patient would have decided had she been given a particular piece of information before consenting to what ended up being a harmful treatment.<sup>43</sup>

Much criticism has been levied against the modified objective test and the reasonable person standard.<sup>44</sup> We will not rehearse those criticisms here. What we will do, however, is simply point out that the preceding discussion of the role of rationality vs. emotion in decision-making and the role of relational reasoning will apply here too. For example, it seems misguided to allow for rational fears but never irrational (and yet authentic) fears.<sup>45</sup>

We also want to explore briefly another feature of decision-making that can arise from the relational conception of the self and can challenge/enrich our approach to causation analysis. That is, the role of the interests of others in our decision-making. A traditional approach takes self interest and the interests of others as being entirely distinct. One might choose to privilege the interests of others (particularly those close to us) over oneself but it is a form of self-sacrifice (and cannot, “reasonably”, be taken too far).

However, a relational approach could posit that the interests of others (at least some others) are inextricably linked up with our interests.<sup>46</sup> That is, there is no stark self/other interest distinction. Rather, the interests of some others are included in/constitutive of my own interests – self-other interest.

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43 *Hopp v. Lepp*, [1980] S.C.J. No. 57, 2 S.C.R. 192; *Reibl*, *supra* note 20; *Arndt*, *supra* note 21.

44 See, e.g. Patricia Peppin, *Informed Consent*, *supra* note 19; Vaughan Black & Elaine Gibson, The Temporal Element of Informed Consent *Afshar v. Chester* (2004)13 Health L. Rev. 36.

45 *Arndt*, *supra* note 21.

46 Françoise Baylis & Jocelyn Downie, “An Ethical and Criminal Law Framework for Research Involving Children in Canada” (1993) 1 Health L. J. 39.



A person's interests are in part constituted by the interests of others. This transforms what could be seen as self-sacrifice to self-interest. This approach could lead one to accept the claim that someone would have reasonably made a decision that would be seen as unreasonable or imprudent on a more traditional dichotomous view of self/other interests.

e. Corrosion of capacities essential to autonomy

Of course, we need to ask whether law, policy, or practice are placing limits on the exercise of autonomy in any particular situation. We tend to do that, to a limited extent, quite well. However, we also need to ask whether law, policy, or practice are corroding the capacity for autonomous decision-making. Consider, for example, the issue of forced treatment of women with addictions and histories of abuse. This issue is frequently pitched as a conflict between restricting the exercise of choice of a woman and protecting her health. But it should also be analyzed in terms of the effect of such mandatory treatment on the woman's capacity for autonomy. As noted by Sue Sherwin and Carolyn Macleod:

Forcing them into treatment that will probably be ineffective (since coerced treatment typically is ineffective) will have the likely consequence of further undermining their already limited autonomy. Imposing treatment will increase the powerlessness of these addicts because all that it achieves is a further reduction in their decision-making power. Taking this power away from them in the context of treatment for their addictions could only be justified if the intent and the most probable consequence of doing so would be to improve their level of autonomy in the long run. Ineffective treatment would not have this consequence, and thus, for addicts with low self-trust, it is especially urgent that means other than coercion be sought to encourage them to escape from the compulsive nature of their addictions.<sup>47</sup>

Because they are alienating or blind to the relational nature of the self, particular practices can rob individuals of traits that relational theorists such as Diana Meyers have argued are necessary for autonomy – self-knowledge,

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47 Carolyn McLeod & Susan Sherwin, *Relational Autonomy*, *supra* note 9.

self-definition, self-direction,<sup>48</sup> and the additional trait added by Carolyn MacLeod – self-trust.<sup>49</sup> Health law and policy needs to be alert to such practices and respond to them with appropriate instruments designed to enhance rather than allow the corrosion of relational autonomy. This, of course, would take us well into the arena of law and policy relating to education, violence, poverty, and the many other social determinants of health.<sup>50</sup>

## Conclusion

We hope that we have described a new paradigm and given the reader some concrete illustrations of how embracing that new paradigm might play out in relation to a specific health law and policy context. More globally, we hope that we have illustrated that embracing relational theory will take us to new questions, new answers to old questions, and new priorities for our work. In sum, that it can enrich and transform health law and policy.

If we have piqued your interest (and to take you beyond the narrow confines of autonomy), we would point you to: Sue Campbell's work on memory and its implications for the use of false memory syndrome evidence in sexual abuse cases as well as her work on privacy and its implications for the disclosure of medical records in sexual assault cases<sup>51</sup>; Christine Koggel's work on equality<sup>52</sup> and its implications for, for example, the dignity step in s.15 analysis for an equality claim regarding abortion access; and Jennifer Llewellyn's work taking a relational lens on equality in the context of allocation of health resources.<sup>53</sup> We would also encourage you

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48 Diana Tietjens Meyers, "Intersectional Identity and the Authentic Self? Opposites Attract!" in *Relational Autonomy*, *supra* note 9, 151.

49 Carolyn McLeod, *Self-trust*, *supra* note 38.

50 Susan Sherwin, *Whither Bioethics*, *supra* note 23.

51 See, e.g. Sue Campbell, "Relational Remembering: Suggestibility and Women's Confidential Records" in Christine M. Koggel, Allannah Furlong & Charles Levin *Confidential Relationships: Psychoanalytical, Ethical & Legal Contexts* (Amsterdam/New York: Rodopi, 2003) 151.

52 Christine M. Koggel, "Confidentiality in the Liberal Tradition: A Relational Critique" in Christine M. Koggel, Allannah Furlong & Charles Levin *Confidential Relationships: Psychoanalytical, Ethical & Legal Contexts* (Amsterdam/New York: Rodopi, 2003) 113.

53 Jennifer Llewellyn, "A Healthy Conception of Rights? – Thinking Relationally About Rights in a Health Care Context" in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court* (Toronto: Irwin Law Inc., 2007) 57.

to take up this challenge – take the relational conception of self, reflect on its implications for the core value of autonomy as well as other core values such as equality and justice, go to your own areas of expertise in health law and policy, and reflect on and write about the implications and power of relational theory.