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A Value-Neutral Understanding of Capacity

1.1 A Cliff-Edge Approach to Capacity

In law, a bright line is drawn between those who are deemed to have the capacity to make a decision and those who are not. For those found to have capacity (or, more accurately, those not found to lack it, given the law's starting point is that people are presumed to have capacity[1]), that decision is determined by their autonomous choices. Consent must be sought for any treatment or care intervention, and the agent's right to bodily integrity permits them to refuse any treatment, regardless of whether the reasons are 'rational, irrational, unknown or even non-existent',[2] and even where the refusal will result in their death.[3] Treating a capacitous person without their consent will amount to a battery (a form of the tort of trespass to the person, which is committed whenever a person intentionally and directly inflicts force on another[4]), as well as a breach of article 8 of the European Convention on Human Rights (ECHR), which protects the agent's right to 'private and family life' and has been held to encompass both their 'physical' and 'psychological' integrity.[5] Public bodies, including public hospitals and courts, are obliged to act in accordance with this Convention[6] and, while article

[1] Mental Capacity Act 2005, s1(3).
[2] *Re T* (*Adult: Refusal of Medical Treatment*) [1992] 4 All ER 649, 664.
[3] *Re B* (*Adult: Refusal of Medical Treatment*) [2002] 2 All England Reports 449.
[4] A battery has been defined by Clerk and Lindsell on Torts (22nd edition) as 'the direct imposition of any unwanted physical contact on another person' (at 15-09).
[5] *X and Y v. Netherlands* (1986) 8 E.H.R.R. 235, [22]; *Y.F. v. Turkey* (2004) 39 EHRR 34, [33].
[6] Human Rights Act 1998, Section 6.

8 is qualified[7] and subject to restrictions made 'in accordance with law' where 'necessary in a democratic society . . . for the protection of health or morals',[8] in the absence of consent, any interference would not be in accordance with the law, and thus not justified by article 8(2). In extreme cases, treating a person without their consent might even amount to 'inhuman and degrading treatment', protected under article 3 ECHR, which has been held, for example, to apply in the context of forcible feeding.[9] The result is that those who have capacity within the terms of the MCA are accorded extensive powers to govern their lives according to their own values and priorities, with serious ramifications for anyone who seeks to interfere with this without the person's consent.

This is qualified only by the courts' powers under the Inherent Jurisdiction of the High Court, and the Mental Health Act 1983. The former, as Mr Justice Munby has explained, plugs the 'gap' in the MCA's coverage, offering vital protections for vulnerable non-autonomous adults where

> on a strict mental health appraisal, such an individual does not lack capacity in the terms of the MCA 2005 and therefore falls outside the statutory scheme, but other factors, for example coercion and undue influence, may combine with his borderline capacity to remove his autonomy to make an important decision, why, one may ask, should that individual not be able to access the protection now afforded to adults whose mental capacity puts them on the other side of that borderline?[10]

Although he felt it would be 'unwise, and indeed inappropriate'[11] to attempt to define *all* those who might fall under the jurisdiction, he has indicated that it would include a vulnerable adult who,

> even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free

[7] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended (ECHR)), article 8(2).
[8] Ibid.
[9] *A Local Authority v. E* [2012] EWCOP 1639 [126].
[10] *DL v. A Local Authority* [2012] EWCA 253, [65].
[11] *Re SA* (*vulnerable adult with capacity: marriage*) [2006] 1 FLR 867, [77].

> choice, or incapacitated or disabled from giving or expressing a real and genuine consent.[12]

Crucially, as with those found to lack capacity under the MCA, the justification for intervening in such cases is that the agent's capacity for autonomous decision-making has to some extent been undermined by the influence of others, thereby calling into question whether their decision should be upheld.

The same is not necessarily true of those who fall within the remit of the Mental Health Act (MHA), which, justified by reference to risk prevention rather than capacity, covers the detention, care, and treatment of those with a mental disorder. This permits the detention of a person for twenty-eight days for assessment, irrespective of their consent, if it can be shown that they are suffering from a 'mental disorder of a nature or degree' which warrants detention[13] and that detention is necessary for the person's own safety or the safety of others.[14] While detained, the person may be treated for his or her mental disorder, or for any symptom or manifestation of this, and for the first three months, the consent of the patient to this treatment is not required.[15] While a large proportion of people falling within the remit of the MHA will lack the capacity to take treatment decisions, this is not invariably the case. Evidence from Gareth Owen *et al.* suggests that around 86 per cent of people detained under the MHA in general adult acute inpatient units lack capacity to make decisions about their treatment (the figure is around 60 per cent for those on an acute psychiatric ward who are not detained under the MHA).[16] There will be some people detained under the Act then, who do have

[12] Ibid [79]. Subsequently, it has also been held to capture people who lack capacity under the terms of the MCA, providing that they do *not* have a remedy available under the Act: *XCC v. AA & Others* [2012] EWHC 2183 (COP), [54].

[13] MHA, s2(2)(a).

[14] Ibid, s2(2)(b).

[15] MHA, s63. There are two exceptions to this. Where the treatment is Electric Convulsive Therapy, if the agent has capacity, they must consent to the treatment. If they do not have capacity, a second opinion must be provided by a registered medical practitioner that the treatment is appropriate (s58A). Where the treatment is psychosurgery, the agent must both consent to the treatment, and a second opinion must be provided by a registered medical practitioner that the treatment is appropriate (s57). After the initial three months, the administration of medicine can occur only if either the patient has capacity and consents to it or if they lack capacity but a second opinion confirms that continued treatment is appropriate. Other forms of treatment, including psychotherapy, and even force-feeding, can continue regardless of their consent.

[16] Ibid.

the capacity to consent to treatment – or, of course, to refuse it – yet they may be treated regardless.

While this would seem to be a substantial interference with rights and freedoms of at least some people with capacity, and there is good reason to question its legitimacy,[17] two points must be borne in mind. First, the MHA applies only to those with mental illness, defined as 'any disorder or disability of the mind'.[18] It does not apply to those with alcohol or drug dependency,[19] most learning disabilities (unless associated with abnormally aggressive behaviour),[20] or brain injuries or other cognitive impairments. Secondly, the MHA only permits treatments for the agent's mental disorder, or for symptoms or manifestations of *that* disorder. While this has been broadly interpreted to include treatment for a physical disorder where this might affect the agent's mental health,[21] it will not apply to treatment for a physical illness or condition which is *not* a symptom or manifestation of that mental disorder.[22] The result is that except in two categories of cases (namely, where the agent has a mental disorder and requires treatment for that disorder; and where the agent is deemed especially vulnerable and is subject to the coercion or undue influence of others), an agent's capacitous refusal of treatment will be determinative.

For those who lack capacity, meanwhile, their decisions are not treated as legally authoritative, and a decision must instead be made on the basis of what is in their 'best interests'.[23] Although the term 'best interests' is not defined in the Act, the case law is clear that it captures 'welfare in the widest sense, not just medical but social and psychological'.[24] The Act sets out a number of relevant factors that must (or must not) be taken

[17] It should be noted that there is currently a Draft Mental Health Bill 2022, which would seek to alter the grounds for detention. For a critique of the MHA, see, for example: Department of Health and Social Care, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act 1983* (London: TSO, 2018), see in particular pp. 49–64.

[18] Mental Health Act as amended by Mental Health Act 2007, s1(2).

[19] Ibid, s1(3).

[20] Ibid, s1(2A).

[21] For example, in *Tameside and Glossip Acute Services Trust v. CH* [1996] 1 FLR 762 (QBD), this provision was relied upon to authorise the caesarean section of a pregnant woman suffering from schizophrenia, on the basis that a stillbirth would cause a deterioration in her mental state and interrupt the treatment of her schizophrenia.

[22] For a detailed discussion of this, see *A NHS Trust v. Dr A* [2013] EWHC 2442 (COP).

[23] MCA ss1(5) and (4).

[24] *Aintree University Hospitals NHS Foundation Trust v. James* [2013] UKSC 67, [39] per Lady Hale.

into account by the assessor when making this assessment. The decision cannot be made merely on the basis of the age or appearance of the person;[25] the likelihood of the person regaining capacity must be considered[26] and the assessor is required to 'permit and encourage the person to participate' in the decision.[27] They must take into account, 'if it is practicable and appropriate to consult them', the views of others engaged in the care of the person, or interested in their welfare.[28] Importantly, the assessor must also, 'so far as is reasonably ascertainable', consider

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by [them] when [they] had capacity),
(b) the beliefs and values that would be likely to influence [their] decision if [they] had capacity, and
(c) the other factors that [they] would be likely to consider if [they] were able to do so.[29]

Finally, the assessor must also never be motivated by a desire to bring about death.[30]

Crucially, the framing of section 4 makes clear that none of the factors it outlines is to take priority in the best interests assessment.[31] It is thus left to each individual assessor to decide on the weight to be accorded to each, with the result that an individual's wishes and feelings may frequently be outweighed by other factors, where the perceived need to protect them (or a fear of the legal consequences if the assessors fail to do so) is thought to take precedence over the desire to empower them. While the way in which the provisions are being applied will be considered in Chapter 5, suffice for now to say that the way the provision in section 4 is framed gives doctors very little incentive to make empowering decisions.

The law thus adopts a cliff-edge approach to capacity: for those safely on the clifftop, autonomy and self-determination dominate; but those

[25] MCA s4(1).
[26] Ibid, s4(3).
[27] Ibid, s4(4).
[28] Ibid, s4(7).
[29] Ibid, s4(6).
[30] Ibid, s4(5).
[31] See, for example, *Re M* [2009] EWHC 2525 (Fam), [32] per Mr Justice Munby.

who fall over the edge are powerless – someone else's view of what is 'best' for them is imposed upon them. This approach has been widely criticised in the academic literature,[32] and it is not my intention to rehearse this here.[33] It need only be said that, under the current legal framework, only those deemed to have capacity have the right to decide what will happen to them, both in the treatment and care context (which is the subject of this book), and in a range of other financial and administrative matters.

1.2 The Role of the Capacity Threshold in Defining the Limits of Legitimate State Authority

This approach to capacity reflects Enlightenment ideas about the limits of legitimate state authority, as encapsulated in John Stuart Mill's conception of liberty.[34] According to this, considerable justification is required before the state may interfere with the autonomous choices of its citizens;[35] justification, in his view, is found only where the actions of an individual will cause harm to another person.[36] To understand how Mill's conception of liberty operates, it is necessary to put it in the context of his wider philosophy. In his view, 'happiness is desirable, and the only thing desirable, as an end, all other things being desired as a means to an end.'[37] As a proponent of utilitarianism, Mill argued that actions are right if they result in producing the greatest sum of human happiness. It is not therefore that people have a 'right' to liberty, but rather that respecting it will result in the best outcome for society and

[32] See, for example, Clough, *The Spaces of Mental Capacity Law*; Martin *et al.*, *Achieving CRPD Compliance*; Richardson, 'Mental Disabilities and the Law'.

[33] See Conclusion for more discussion of this.

[34] J. S. Mill, *On Liberty* (Cosimo Classicz, 2005 [1859]); for a more detailed discussion of this, see J. Feinberg, *Harm to Self* (Oxford: Oxford University Press, 1986).

[35] As J. Coggon and J. Miola 'Autonomy, liberty, and medical decision-making' (2011) 70(3) *Cambridge Law Journal* 523–543, there are many other theories in political philosophy which state that a person should be free to act autonomously, 'provided they do not breach well-grounded external laws which legitimately limit their actions' (p. 528). While Mill's harm principle represents the simplest and most widely accepted basis for these laws, other examples cited by them include 'positive obligations derived directly from the receipt of benefits inherent in membership of a stable political system, and in being part of a system of civic republicanism' (p. 528).

[36] Mill, *On Liberty*, 68.

[37] J. S. Mill, *Utilitarianism* (Oxford Philosophical Text Series edn, Oxford: Oxford University Press 1998), 81.

its citizens, 'utility in the largest sense, grounded on the permanent interests of man as a progressive being'.[38] Achieving happiness demands that a person be free to pursue '[their] own good in [their] own way',[39] providing this does not interfere with the interests of others. As Mill asserts:

> In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[40]

For Mill, a sphere of independence from state intervention was essential for human individuality to develop. It was also necessary if people were to have the freedom to pursue those things which they enjoyed, or deemed morally appropriate, and thus was an essential part of ensuring the happiness and morality of individuals.[41] Other commentators have similarly seen respect for autonomy as important because it leads to greater well-being – although often this is intended to apply to individual 'welfare' rather than collective 'happiness' in the Millian sense. As David Molyneux observes, this might occur instrumentally and intrinsically.[42] Regarding the former, it is argued that respecting autonomous choice is the best way of determining what is best for the individual: as Mill explains it, individuals are best placed to make choices that are good for them.[43] Others, by contrast, are often not very good at assessing what may be in someone else's interests,[44] inevitably facing limitations in their attempts to do so. As Kim Atkins observes, respect for autonomy is therefore

> an acknowledgment of the limitations of our knowledge of other people and a willingness to incorporate that understanding into our world-views. When we respect autonomy we do not simply observe another's freedom from a distance, as it were; we accede to our fundamental fallibility and epistemological humility. It is in recognition of the fact that we cannot

[38] Mill, *On Liberty*, 70.
[39] Mill, *Utilitarianism*, 56, 142.
[40] Mill, *On Liberty*, 14.
[41] Ibid, 75–76.
[42] D. Molyneux, 'Should Healthcare Professionals Respect Autonomy Just Because It Promotes Welfare?' (2009) 35 *Journal of Medical Ethics* 245.
[43] Mill, *On Liberty*.
[44] For a discussion of this, see Herring and Wall, 'Autonomy, Capacity and Vulnerable Adults', 698, 702.

> experience from another's perspective that we normally refrain from judging what will make another's life good for them.[45]

But it may also be the case that autonomy is a fundamental (or intrinsic) part of well-being. As Ronald Dworkin explains, it is essential for our fulfilment that we lead our life by our own beliefs:

> Autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction, and interest. It allows us to lead our own lives rather than be led along by them, so that each of us can be, to the extent such a scheme of rights can make this possible, what he has made himself.[46]

In a similar vein, Will Kymlicka argues that an authentic life is one that is lived from the inside, pursuing values and objectives that the *individual* considers important;[47] while Joseph Raz notes that an autonomous person's well-being consists in 'the successful pursuit of *self-chosen* goals and relationships'.[48] John Stuart Mill further observes that the capacity to choose, and the exercise of this choice, is in itself fulfilling, enabling us to use our 'human faculties of perception, judgement, discriminative feeling, mental activity, and even moral preference' to come to a reasoned decision.[49] James Griffin captures this inherent value of autonomy when he makes the point that 'even if you convince me that, as my personal despot, you would produce more desirable consciousness for me than I do myself, I shall want to go on being my own master'.[50] This intuition, as Jonathan Pugh observes, suggests that 'we value autonomy for its own sake, and not just because we believe that being autonomous will lead to our attaining other prudentially valuable ends'.[51] Autonomy is thus 'partly *constitutive* of (rather than merely instrumental to) well-being'.[52]Accordingly,

[45] Atkins, 'Autonomy and the Subjective Character of Experience' (2000) 17 *Journal of Applied Philosophy* 71, 75.
[46] R. Dworkin, 'Autonomy and the Demented Self' (1986) *The Millbank Quarterly* 4, 5.
[47] W. Kymlicka, *Liberalism, Community, and Culture* (USA: Clarendon Press, 1991), 12.
[48] J. Raz, *The Morality of Freedom* (Oxford: Clarendon Paperbacks, Oxford University Press, 1988).
[49] Mill, *On Liberty*, 122.
[50] J. Griffin, *Well-Being: Its Meaning, Measurement and Moral Importance* (USA: Oxford University Press, 1988), 9.
[51] J. Pugh, *Autonomy, Rationality, and Contemporary Bioethics* (Oxford: Oxford University Press, 2020), 237–238.
[52] Ibid.

> as long as an individual's choice is autonomous, that should give us at least a *pro tanto* reason to believe that respecting that choice will benefit that person, not because the choice is likely to lead to greater happiness (as the explanatory hedonist might claim), but rather because on this view there is prudential value to directing the course of one's life in accordance with one's own beliefs about what is of value, and with one's own beliefs about which values should take precedence.[53]

While the role of autonomy in promoting individual well-being is the most convincing rationale for why it should be respected, it should be noted that not all philosophers who advocate the importance of it regard its value as deriving from its contribution to (and constituent importance of) well-being.[54] Molyneux draws on Darwall's theory of demand autonomy, for example, which involves an essentially Kantian argument that there is something fundamentally important about being a person that demands our respect for the person's autonomous choices,[55] 'not because the choices are respect-inducing in themselves, but because respect for choices is what one person can reasonably demand of another person'.[56] In other words, respect for a person and their capacity for self-rule demands that we respect their autonomy, even when to do so would not promote their individual (or collective) welfare.

This, for reasons aptly explained by Jennifer Hawkins, is less compelling than explanations tied to well-being:

> [I]t is an argument that makes *no appeal whatsoever* to what it might be like for the subject to be interfered with. It does not appeal to the *value* of free choice for the person who has it. It ultimately locates the wrongness of paternalism in a kind of irrationality on the part of the would-be paternalist.[57]

[53] Ibid, 256.

[54] It is important to be clear at the outset that for the present discussion, I am concerned with autonomy only in the sense of a quality, trait, or characteristic that individuals can exhibit throughout their lives, not in a Kantian sense, which concerns the person's capacity to impose moral law on themselves (E. Kant, *Groundwork of the Metaphysics of Morals* (Cambridge Texts in the History of Philosophy ed, 2nd edn, Cambridge University Press 2012)), or as a source of political legitimacy, according to which political power and authority can be justified only if it is acceptable to all the citizens who are bound by it (see, for example, J. Rawls, *Political Liberalism* (New York: Columbia University Press, 1993), 144–150).

[55] S. Darwall, 'The Value of Autonomy and Autonomy of the Will' (2006) 116(2) *Ethics* 263.

[56] Molyneux (n61), 248.

[57] J. Hawkins, 'Why Even a Liberal Can Justify Limited Paternalistic Intervention in Anorexia Nervosa' (2021) 28(2) *Philosophy, Psychiatry & Psychology* 155–158.

Hawkins is therefore right to suggest that 'if paternalism is wrong, it must be because of how it affects those who are treated paternalistically'[58]: it imposes something onto them which does not contribute to their well-being, in the way that respect for autonomy would. But whatever one's reasons for respecting autonomy, given the normative importance that is attached to people being free to make autonomous choices, it is widely accepted that this sphere of independence should not be too readily interfered with by the state.

One circumstance in which most accept that the state has jurisdiction to intervene, is where in exercising their autonomy, a person causes (or is likely to cause) harm to another, thereby interfering with that person's autonomy. Mill captured it thus: 'the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is *to prevent harm to others*.'[59] Of course this must be subject to qualifications. Mill himself set out a number: he differentiated harm (an action that was injurious or set back important interests of others) from 'mere offence' (which did not warrant protection),[60] excluded consensual harms,[61] and reiterated that harm prevention should be seen as a necessary, but not a sufficient condition for restricting individual liberties (which will depend on a utilitarian calculation of whether the benefits of regulation outweigh its disadvantages[62]). While it is not necessary to examine these in detail for the purposes of this discussion, it is clear that the law has a legitimate utilitarian goal of promoting the welfare of its citizens, such that when a person's welfare is infringed by another, the law is sometimes justified in encroaching on the liberty of the infringer in order to prevent this from occurring.

Much more contentious, however, is the role of the state in protecting its citizens from *themselves*. Mill's stance on this issue was clear: paternalistic interference of the state is not deemed acceptable where a person understands the decision they are making and is capable of freely

[58] Ibid.
[59] Mill, *On Liberty*, 68.
[60] Mill, *Utilitarianism*, 141. This distinction was reiterated by Joseph Feinberg, who likewise distinguishes hurt and offence – which, while undesirable, does not thwart our interests – from harm, which he defines as a setback to interests (see J. Feinberg, *Harm to Others: The Moral Limits of the Criminal Law* Volume 1 (Oxford Scholarship Online, November 2003), 45–51). For a more in-depth discussion of the nature of 'harm', see Chapter 6 (Section 6.2) of this book.
[61] Ibid, 142.
[62] Mill, *Utilitarianism*, 70.

exercising their autonomy. However, even for later liberal philosophers who have been vociferous in their objections to paternalism, intervention in self-regarding decisions is acceptable only in very limited cases, and certainly would not be accepted in the kinds of treatment and care decisions being contemplated in this book. Joseph Raz, for example, contemplates some intervention where it is necessary to protect the person from making decisions which will severely limit their future autonomy.[63] While he does not set out in detail when these circumstances will arise, he notes in particular that

> paternalism affecting matters which are regarded by all as of merely instrumental value does not interfere with autonomy if its effect is to improve safety, thus making the activities affected more likely to realize their aim.[64]

Regulations directed at the safety and efficacy of products or mandating the use of seat belts in cars may therefore be justifiable: they do not greatly violate the person's autonomy, since the behaviour which they constrain is not a central purpose of the person's reason for acting. However, a distinction can be drawn between this and, for example, a risky sport, 'where the risk is part of the point of the activity or an inevitable by-product of its point and purpose'.[65]

It is the latter kind of choice which aligns more closely with the sorts of treatment and care decisions which are being contemplated in this book. Where an agent makes a decision to either have or to refuse treatment or care, they are usually deliberately seeking a certain outcome or, at the very least, are aware of (and accept) the risks inherent in making the choice that they do. The risks are therefore rarely unforeseeable or inadvertently taken; rather, the agent has weighed up the advantages and disadvantages of different courses of action and formed a judgement about which they would rather pursue, based on their values and

[63] Central to his theory is the idea that the government has a positive duty to protect and promote the autonomy of its citizens. The use of coercion thus violates their autonomy in two ways: 'it violates the condition of independence and expresses a relationship of domination and an attitude of disrespect for the coerced individual', and it 'is a global and indiscriminate invasion of autonomy': Raz, *The Morality of Freedom*, 418. Its use is therefore a way of causing harm to the person, depriving them of opportunities which they would otherwise have. However, it may be justified where it is necessary to prevent one's actions diminishing the autonomy of others, 'even of that person himself in the future' (Ibid, 413).

[64] Ibid, 422.

[65] Ibid.

priorities. To interfere with this decision would thus constitute a very large invasion of their autonomy, even more so given that imposing treatment or protective care measures on an agent will likely necessitate the infringement of either their bodily integrity or their liberty, causing potentially substantial psychological or emotional harm.[66] Therefore, while Raz and others have taken a less robust stance against paternalism than Mill, their views do not undermine the importance attached to people being able to exercise their autonomy in decisions about their treatment and care. Indeed, elsewhere Raz explicitly distinguishes 'decisions about the safety of pharmaceutical products' (which are *not* the sort of decisions which a person ought to decide for themselves, rather than following authority), from 'decisions about undergoing a course of medication or treatment where we may well feel that I should decide for myself, rather than be dictated to by authority'.[67] This may be especially important when seen in the context of medical practice, where widespread paternalism provoked a powerful movement in favour of greater protections for patient autonomy in the latter part of the twentieth century.[68] As Jos and Sander Welie explain:

> The history of medicine, health care and biomedical research is marked by silence, disregard of patients' wishes, and at times coercion. In order to protect patients against medical paternalism, patients have been granted the right to respect of their autonomy. First explored in the late 19th and early 20th century, by the end of the second millennium patient autonomy had become an undisputed staple of all codes of ethics in health care and a legally protected and enforceable right. This right is operationalized first and foremost through the phenomenon of informed consent. If the patient withholds consent, medical treatment, including life-saving treatment, may not be provided.[69]

Yet, crucially, this proscription against interfering with an individual's choices does not extend to those who are incapable of autonomous

[66] This is especially so given that, unlike for health and safety regulations or the mandatory wearing of seat belts, such interventions do not entail the removal of 'bad' options at a legislative level, but rather involve an individual doctor or carer taking a view of what is best for the specific person in the future and overriding individual choices accordingly.

[67] J. Raz, 'The Problem of Authority: Revisiting the Service Conception' (2005) 90 *Minnesota Law Review*1003.

[68] Beverley Clough identifies a similar trajectory in the social care context, where increasing importance has been attached to choice and independence: see Clough, *The Spaces of Mental Capacity Law*, 46–49.

[69] J. V. M. Welie and S. P. K. Welie, 'Patient Decision-Making Competence: Outlines of a Conceptual Analysis' (2001) 4(2) *Medicine, Healthcare and Philosophy* 127–138.

decision-making. Immediately following the harm principle, Mill notes that 'it is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings *in the maturity of their faculties* . . . Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury'.[70] Later this is made even more explicit: the principle of liberty has no application to people incapable of 'free and equal discussion',[71] those without an 'ordinary amount of understanding',[72] or to someone who is 'a child, or delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty'.[73] Mill also gives an example of someone about to cross a bridge that is unsafe. If there is no time to warn him, then it is acceptable to grab him and pull him back, as this does not interfere with his liberty, as liberty is only the freedom to do what one voluntarily desires, and in this instance, he does not desire to fall into the river below. If, however, he determines, with knowledge of the risk, to proceed over the bridge, we must accept his autonomous choice.[74] While in this instance the lack of autonomy is attributable to a lack of information rather than an inherent vulnerability caused by an impairment or illness, it is demonstrative of the fact that Mill permits a degree of paternalistic interference where it does not interfere with the *autonomous* choices of people. Similarly, H. L. A. Hart argues that paternalism can be justified if a person's capacity to make free and informed choices is diminished by factors such as 'inner psychological compulsion' or 'pressure from others', or where they have an inadequate appreciation of the consequences of their choices.[75]

Although neither Mill nor Hart engaged in detail with why the principle of non-interference ought not to apply to people incapable of making autonomous choices, the justification for this differential treatment lies in the reasons we have for respecting autonomy in the first place. Generally the decisions people make will reflect their values and desires, enabling them to live according to their own conception of the 'good life'. Respecting a person's autonomous choices is therefore most likely to maximize their welfare, both because people are best placed to

[70] Ibid, 69.
[71] Ibid.
[72] Ibid, 142.
[73] Ibid, 166.
[74] Mill, *On Liberty*, Ch 5.
[75] H. L. A. Hart, *Law, Liberty and Morality* (Stanford, CA: Stanford University Press, 1963), 32–33.

determine what is good for them and because there is value in itself to governing one's life. There will be some people, however, who are incapable of making autonomous decisions which reflect and further their priorities and goals and whose decisions may therefore not be welfare-enhancing, even according to their own subjective standards. In these cases, the law is justified in intervening to ensure that the decision that is made is one which promotes the person's interests, and to prevent them from harming themselves through making decisions, the consequences of which they do not fully appreciate. As Jonathan Herring observes, enabling people to flourish 'may be possible with little intervention by the state' for some people, but for others, some degree of intervention may be necessary 'to enable a person (or a group of people) to live their lives fully'.[76] This 'right and duty to care for those not able to care for themselves'[77] has been recognised in England since feudal times, with the *parens patriae* doctrine originally bestowing the power to do so on the monarch, before this was transferred to the courts in the sixteenth century.[78]

For those who regard autonomy as having independent normative importance beyond its connection to welfare, it may also be said that decisions made by people incapable of autonomy do not warrant the same respect. According to Kant, it is their capacity for rational action that distinguishes humans from other animals, and makes them worthy of respect.[79] As Simon Lee suggests, respect for autonomy thus rests on an assumption: that people are rational beings, capable of assessing the information and weighing the options available to them.[80] The value in recognising people as rational agents capable of making choices may therefore be deemed less pertinent for people who lack that decision-making ability.

According to the liberal framework which underpins the MCA, therefore, while people capable of autonomy ought to have the liberty to make decisions free from state interference, for those who are incapable, the law has a legitimate role in intervening to ensure that the decision made best reflects the agent's values and beliefs and protects their interests. As

[76] J. Herring, *Caring and the Law* (Oxford: Hart Publishing 2013), (n74), 304.
[77] G. Laurie, 'Parens Patriae Jurisdiction in the Medico-Legal Context: The Vagaries of Judicial Activism' (1999) 3 *Edinburgh Law Review* 95, 95.
[78] Ibid.
[79] Kant, *Groundwork of the Metaphysics of Morals*.
[80] S. Lee, *Law and Morals: Warnock, Gillick, and Beyond* (Oxford: Oxford University Press, 1986), 64.

Beverley Clough observes, 'this distinction between the public sphere of interference and the private sphere of non-interference has been challenged by many feministic legal theorists', as has the Enlightenment 'ideal of an individualistic, rationalistic, and masculine legal subject' on which such legal frameworks are built.[81] It is not my intention to rehearse such criticisms here (though they will be picked up on again in the Conclusion).[82] Rather, I aim simply to acknowledge the political and jurisprudential framework which underpins the current law with a view to analysing the extent to which it does – and indeed can – live up to the liberal ideals it seeks to promulgate. According to this framework, it is essential that the law can reliably distinguish those who are capable of making autonomous choices from those who are not. This is the role of capacity in law, which, as Jonathan Herring and Jesse Wall note, seeks to determine 'the minimum necessary for autonomy and treats the person as autonomous once they cross that threshold'.[83] Capacity is thus generally understood as a condition for the exercise of autonomy: if a person has capacity, then absent other ways in which their autonomy may be being undermined (such as the coercion or undue influence of others), they are deemed to be capable of acting autonomously. If they do not, they are thought not to be able to take autonomous decisions. The test for capacity contained in the MCA thus plays a crucial role in determining when the state will defer to the 'individual's subjective choices, protecting individual's autonomy from outside intrusion',[84] and when it will not.

1.3 The Test for Capacity

Given its role in determining the limits of legitimate state authority, it is generally assumed that the test for capacity must be neutral as to the

[81] Clough, *The Spaces of Mental Capacity Law*, 45. See, for example, Mackenzie and Stoljar, *Relational Autonomy: Feminist Essays on Autonomy, Agency and Social Self*, 2000; MacKinnon, *Toward a Feminist Theory of the State*; Sandel, *Liberalism and the Limits of Justice*; Wolpe, 'The Triumph of Autonomy in American Bioethics'; Mackenzie, 'Relational Autonomy, Normative Authority and Perfectionism', 512, 51; Christman, 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves', 143–164; Kong, *Mental Capacity in Relationship*.

[82] For a good discussion of deconstructing the normative assumptions on which our legal framework is based, see Clough, *The Spaces of Mental Capacity Law*.

[83] Herring and Wall, 'Autonomy, Capacity and Vulnerable Adults', 698, 703.

[84] Kong, 'Mental Capacity in Relationship'.

substance of the values, beliefs, or reasons underpinning any given decision. After all, to place any substantive limits on the types of decision that a person can capacitously take, or the reasons or values that a person may choose to act upon, would seem to directly contradict the objective of creating a protected space for individual autonomy. As a result, the Mental Capacity Act 2005 adopts a process-orientated account of capacity, which focuses on whether certain of the agent's cognitive capacities are intact, and not on the outcome of the decision, or on the substance or origins of values or beliefs which underpin it.

Although the MCA imposes a presumption in favour of an agent having capacity,[85] whether they are deemed capable of making a decision depends on whether they meet the test for capacity set out in sections 2 and 3 of the MCA. Under section 2(1) of the MCA, an agent 'lacks capacity in relation to a matter if at the material time [they are] unable to make a decision for [themselves] in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. Section 3(1) further explains that 'for the purposes of section 2', an agent is 'unable to make a decision' if they are unable'

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate [their] decision (whether by talking, using sign language, or any other means).

Further guidance on these limbs of the test for capacity can be found in the Code of Practice accompanying the MCA.[86] This makes clear that the information 'relevant' to the decision includes 'the nature of the decision, the reasons why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all',[87] while the agent must only retain the information 'long enough to use it to make an effective

[85] MCA, s1(2).
[86] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London: TSO, 2007). NB: there has recently been a consultation on a new Code of Practice, with the final version expected soon. See www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps. Accessed 21 September 2022.
[87] Ibid, 4.16.

decision'.[88] It also elaborates on what is meant by the ambiguous 'use or weigh' limb of the test (explored in more detail in Chapter 2), explaining that

> sometimes people can understand information but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given.[89]

The MCA thus proceeds on the assumption that an agent either possesses the capacity to make decisions or they do not, and that this can be objectively determined through a test for capacity which assesses various cognitive capacities an agent may have (understanding, retention, weighting of information). As Natalie Banner explains, according to this approach,

> capacity can be operationalized through measuring its constituent psychological processes, which are taken to be, in principle, amenable to observation and measurement via the construction of behavioural indices.[90]

That the MCA focuses on *cognitive* processes is perhaps unsurprising given its conceptual origins in liberal thinking. As Robin Mackenzie and John Watts have observed, the criteria for capacity have inevitably been shaped 'by liberal views of the person who expresses free will and agency in rational, self-determining decisions' which makes 'it is logical enough that competence tests would center upon measuring cognitive abilities'.[91]

However, defining competence in these 'exclusively cognitive terms' is, as Louis Charland observes, also essential to maintaining an air of objectivity in the test: 'so defined, competence has little or nothing to do with value … [making] it easier to view it as an objective commodity'.[92] Given the role played by the test for capacity in defining when an agent may make decisions for themselves, this objectivity is perceived as crucial. Whether or not an agent is able to decide for themselves ought to

[88] Ibid, 4.20.
[89] Ibid, 4.21.
[90] N. Banner, 'Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity' (2012) 18(5) *Journal of Evaluation in Clinical Practice* 1038–1044, 1039.
[91] R. Mackenzie and J. Watts, 'Including Emotionality in Tests of Competence: How Does Neurodiversity Affect Measures of Free Will and Agency in Medical Decision Making?' (2011) 2(3) *AJOB Neuroscience* 27–36, 28.
[92] L. Charland, 'Mental Competence and Value: The Problem of Normativity in the Assessment of Decision-Making Capacity' (2001) 8(2) *Psychology and Law* 135–145, 136.

hinge on whether they have, or do not have, certain cognitive capacities, and should not depend on the idiosyncrasies of either the assessor or the agent themselves. As Charland observes:

> Similar tests should yield similar judgements in like cases. The standards employed should be sufficiently objective to be replicable in a manner that yields consistent results across like cases. Anything less would be unjust to those whose competence is at issue.[93]

Since a person's values and beliefs are inherently subjective and idiosyncratic, any reliance on them when assessing capacity may risk introducing subjectivity into the test. It was for this reason that the Law Commission cautioned against any approach which focused on the *content* of a person's decision, given the risk inherent in it, that 'any decision which is inconsistent with conventional values, or with which the assessor disagrees, may be classified as incompetent', which 'penalises individuality and demands conformity at the expense of personal autonomy'.[94] In a similar vein, the Law Commission recommended including a further provision in the Mental Capacity Draft Bill to reiterate that 'a person is not to be treated as unable to make a decision merely because he or she makes a decision which would not be made by a person of ordinary prudence'.[95] This now embodies one of the key statutory principles underpinning the Act, contained in section 1(4) of the MCA (albeit the notion that a person of 'ordinary prudence' has been replaced with simply 'an unwise decision'[96]), and the accompanying Code of Practice further emphasises that when testing for capacity, 'what matters is [the agent's] ability to carry out the processes involved in making the decision – and not the outcome'.[97]

The test for capacity thus adheres to a form of 'value-agnosticism'.[98] As Richard Huxtable explains, the test 'purports to focus upon functioning (and thus process and rationality) rather than on the substance of, or the reasons (and values) underpinning, the decision'.[99] Indeed, as Lord

[93] Ibid.
[94] Law Commission Consultation Paper, *Mental Incapacity*, Law Com No 231 (HMSO, 1995), 3.4.
[95] Ibid, 3.19.
[96] MCA 2005, s1(4).
[97] Department for Constitutional Affairs, 4.2.
[98] Coggon and Miola, 'Autonomy, Liberty, and Medical Decision-Making', 523–543.
[99] R. Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, Non-Treatment and the Values of Medical Law' (2014) 22(4) *Medical Law Review* 459–493, 463.

Donaldson set out in *Re T*, a person who has capacity is entitled to refuse treatment or care interventions whether the reasons are 'rational, irrational, unknown or even non-existent'.[100] This, as John Coggon observes, would seem to suggest that 'as long as the patient's thought processes are not in doubt, his underlying reasons are not open to question',[101] a view reinforced by Lady Justice Butler-Sloss's powerful assertion in *Re MB* that even a decision 'which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'[102] should not be taken to be illustrative of incapacity.

At first sight, this approach has much to commend it. It helps to ensure certainty and consistency in the application of the law, which is essential if people are to be able to plan their lives accordingly and not have their freedom arbitrarily interfered with. More importantly, it is essential to protecting a sphere of independence for people to pursue their own values, in accordance with the principles of a liberal society set out earlier. As Charland explains, 'the right of an individual to make his or her own medical treatment decisions goes to the heart of what it means to be an autonomous individual'.[103] The decision of whether to accept treatment or care is not merely a medical question – it engages the agent's priorities and aims in life, their familial and relational circumstances, and sometimes even their belief system. The agent must balance a number of different factors and interests against one another to determine what course of action will be best for them, the weight or importance being attached to each inevitably depending on how they value and prioritise different aspects of their life, or death. Given this, there is no one objectively verifiable answer to the question of what is best for a person in any given treatment and care decision: people may legitimately reach different conclusions, as perspectives diverge on the sanctity of human life, on what chances are worth taking at what cost, on what

[100] *Re T* (*Adult: Refusal of Medical Treatment*) [1992] 4 All ER 649, 664. See also Lady Justice Butler-Sloss in *Re MB* (*Medical Treatment*) [1997] EWCA Civ 3093: 'A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.' [17].

[101] J. Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) *15 Health Care Analysis* 235, 239.

[102] *Re MB* (*Medical Treatment*) [1997] EWCA Civ 3093, [30].

[103] Charland, 'Mental Competence and Value', 135–145.

makes for a 'good' life and a 'good' death. Nowhere is this more true than in decisions at the end of life. As Alexander Kon observes, 'deciding when the outcome of care will be a fate worse than death' is a deeply personal matter: 'there is no right or wrong answer'.[104] A finding that someone lacks capacity in this context, denying them the right to make decisions according to their own values and beliefs merely because these contravene 'conventional values',[105] would seem wrong: it would be to force objective conceptions of what is valuable on a person, denying them the opportunity to pursue values and commitments that *they* consider important. This, as Kymlicka explained, does not benefit a person,[106] and it might even harm them. In Ronald Dworkin's powerful words, 'making someone die in a way that others approve, but he believes a horrifying contradiction to his life, is a devastating, odious form of tyranny'.[107]

Maintaining value neutrality and objectivity in the test for capacity is thus considered essential for it to perform its role in demarcating the appropriate boundaries of state interference. In a liberal democracy committed to value pluralism and tolerance of different beliefs and perspectives, a person ought, in principle, to be able to live – or die – according to their own values, beliefs, and commitments, providing that in doing so, they do not cause harm to others. And as Rob Heywood notes,

> if the law is to take seriously views about freedom of religion, expression, and the right to respect for private and family life, it must attach genuine significance to medical decisions which are underpinned by those values.[108]

Yet, as Chapter 2 will make clear, the picture is, in reality, far more complex. Given the way the current test for capacity is framed, it cannot be applied in practice without reference to the values that underpin the decision. This is not merely a problem with its current framing in the MCA; rather, as Charland captures, 'there is no such thing as mental

[104] A. Kon, 'When Parents Refuse Treatment for Their Child' (2006) 8(1) *JONA'S Healthcare Law, Ethics, and Regulation* 5–9.
[105] Law Commission Consultation Paper, 3.4.
[106] Kymlicka, *Liberalism, Community, and Culture*, 12.
[107] R. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Alfred A Knopf, 1993), 217.
[108] R. Heywood, 'Parents and Medical Professionals: Conflict, Cooperation, and Best Interests' (2012) 20(1) *Medical Law Review* 29, 33.

competence without value, and normative considerations associated with value cannot be eliminated from the assessment of decision-making capacity'.[109] An agent's decision-making processes cannot be assessed in isolation from the substance of the values, priorities, or beliefs driving that decision. In practice, the current approach, with its ostensible value agnosticism, gives assessors considerable latitude to determine how they wish to use values in their assessments and whose values they wish to use. The result is not only subjectivity and inconsistency in the application of the test for capacity but also the obscuring of heavily value-laden judgements, which are insulated from scrutiny and challenge, allowing potentially unwarranted paternalism to go unchecked.

In Chapters 2–6, changes to the test for capacity will therefore be suggested, which articulate a more explicit role for values. In doing so, they will be required to engage head-on with the tension this raises between the liberal ideals espoused in this chapter, and the complex realities of decision-making on the ground, where, especially in the psychiatry context, too puritanical a commitment to value neutrality may result in a failure to protect highly vulnerable and non-autonomous individuals.

[109] Charland, 'Mental Competence and Value', 135–145.