AUTONOMY AND CAPACITY IN HEALTHCARE: WHAT DO THEY MEAN AND TO WHAT EXTENT ARE INTERPRETIVE LIMITATIONS FAILING THOSE WHO LACK THEM?

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ABSTRACT

In 2005, the law regarding mental capacity was established. It pledged to protect and restore power to individuals found to lack the capacity to make decisions for themselves. It stated that all adults should receive the support to make their own decisions where possible and provided a framework to aid those who could not. This dissertation seeks to discover whether the law has complied with these promises or whether it has fallen disastrously short. This will be attained firstly through consideration of the principles of autonomy and capacity and their association. Secondly, analysis of the relevant statute and case law will demonstrate its deplorable interpretive shortcomings with a look to how the law may be reformed to align it with modern understandings and interpretations. It will be argued that the current law on capacity is distorted and provides a disjointed underpinning for autonomy. Subsequently, it will be argued that these contorted interpretations have meant that the law has failed those it vowed to protect. Furthermore, these skewed interpretations have highlighted blemishes in the current safeguards for depriving incapacitated individuals of their liberty which has resulted in a 'theoretical gap' which may have, or indeed already has had, very real consequences. Finally, it will be contended that there are two central adjustments to be made of the law one of which takes inspiration from international interpretations.

Table of Contents

TABLE OF CASES

PC v City of York Council [2013] EWCA Civ 478.

R v Afolabi [2017] EWHC 2960.

Re A [2000] 1 FCR 193.

R v Bournewood Community and Mental Health NHS Trust [1997] EWCA Civ 2879.

R v Bournewood Community and Mental Health NHS Trust [1998] UKHL 24.

Re C (Adult: Refusal of Medical Treatment) [1994] 1 WLR 290 Fam.

R v Cooper [2009] UKHL 42, [2010] Crim LR.

Re T (An Adult: Refusal of Treatment) [1992] EWCA Civ 18, [1993] Fam.

W v M [2011] EWCOP 2443, [2012] 1 WLR 1653.

European Cases

H.L. v. the United Kingdom [2004] 45508/99, ECHR 720.

Herz v Allemagne [2003] application no 44672/98.

Kadusic v Switzerland, [2018] application no.43977/13.

X and Y v Netherlands [1986] 8 EHRR 235.

TABLE OF STATUTES

Assisted Decision-Making (Capacity) Act 2015 (Ireland).

European Convention on Human Rights 1950.

European Convention for the Protection of Human Rights and Fundamental Freedoms 1953 (Cmd, 8969).

Human Rights Act 1998.

Mental Capacity Act 2005.

Mental Capacity (Amendment) Act 2019.

Mental Health Act 1983.

Mental Health Act 2007.

United Nations Convention on the Rights of Persons with Disabilities 2006.

INTRODUCTION

The legal regulation of healthcare has long been a field of discord. There are arguably no more salient issues from a legal and healthcare perspective than those that limit the powers of the autonomous individual. A founding principle of democracies, any infringements are applied reluctantly. Whilst legal concerns cease to be at the forefront of human consideration when making healthcare decisions, the law plays a pivotal role in the decision-making process. Firstly, it dictates when individuals are capable to make their own decisions and when they are deemed incapable to the extent their decisions require intervention. Secondly, it provides a framework to determine what happens when these rights are withdrawn.

The recognition of individual autonomy and the right of the individual to make independent decisions rests on whether they obtain the required mental capacity to do so. This involves an in-depth analysis and assessment of whether the individual's decisions are not clouded by mental defect. Therefore, whilst the law recognises individual autonomy, whether this principle manifests is contingent on whether the standard for capacity is met. This standard is enshrined in the Mental Capacity Act 2005 (MCA).[1] With this in mind, it is necessary to consider the significance and theoretical underpinnings of autonomy and capacity, how they work together and whether the law interprets and applies them correctly. Failing this, it is essential to evaluate the solutions that seek to provide remedy.

To achieve this, an abundance of academic literature and research, as well as legal and medical principles will be analysed. The first chapter will consider theoretical understandings of autonomy and capacity, and their application in healthcare. This will provide a broad understanding of both concepts to allow the second chapter to deconstruct the MCA and how its theoretical and interpretive limitations prevent it from fulfilling its intended purposes. Once this has been substantiated, it is vital to arrive at the most appropriate solutions. To enable such a culmination there must be a combination of theoretical and interpretive improvements made as well as an overhaul of modern perceptions and understandings.

[1] Mental Capacity Act [2005].

Despite this, this paper recognises the laws limited ability to provide complete reform and acknowledges there are areas where the law may cease to assist due to potential rigidity.

CHAPTER 1: UNDERSTANDINGS OF AUTONOMY AND CAPACITY

INTRODUCTION

To fulfil the intentions of this paper, it is firstly essential to gain an understanding of what autonomy and capacity mean intrinsically. This chapter will provide understanding of both concepts, their relationship and their legal and medical relevance. This will be followed by demonstration of the inconsistencies present in the case law concerning how they interrelate.

A) CONCEPTIONS OF AUTONOMY

Autonomy, in and of itself, has little to do with healthcare. Originating from Ancient Greece, is merely the idea of self-governance[2] and one's ability to make their own decisions according to their own plan. A contentious topic amongst philosophers, there remains differing interpretations on how autonomy should be understood and exercised. It is not the intention of this paper to reach a complete and faultless interpretation of how autonomy should be interpreted and applied. Such a feat would be impossible and discourteous of all the innovative contributions made by various thinkers throughout the centuries. To land on an absolute understanding would be unachievable, as Gerald Dworkin noted, the only two undisputed aspects of autonomy are that it is an element of all persons, and that it is a 'desirable quality to have'.[3] However, it is important gain a sufficient understanding of its components to provide context to the present topic.

Whilst there is somewhat consensus on what autonomy is, enabled by stripping it of its philosophical interpretations and reverting it back to its Ancient Greek, *auto* meaning 'self'

[2] https://www.oxfordlearnersdictionaries.com/definition/american_english/autonomy#:~:text=the%20ability%20to%20act%20and,autonomy%20in%20their%20own%20lives Accessed April 2024.
[3] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1988) page 22-23.

and *nomos* meaning 'law'[4], its philosophical underpinnings provide insight into how it should be applied in practice which prove useful for this essay. Two central contributors to contemporary interpretations of autonomy and its application are Kant and Mill. Kant referred to rationality when he spoke of individual autonomy. This was achieved through the following of objective principles such as the universalizability principle which states one's actions should be permissible for others to imitate[5].

On the other hand, using the Utilitarian approach birthed by Bentham, Mill introduced the harm principle[6]. This maintains that one's autonomous actions should only be restricted if they cause harm to others. Mill's interpretation is functional for this paper as it emphasises the limits that should be placed on autonomy based on the consequences one's actions may produce. Furthermore, an issue arises when the harm principle is applied to the individual themselves. It is rational to argue that one's autonomy be limited to prevent harm to others but what if one's actions cause harm to themselves, and they are capably aware of this? For example, a Jehovah Witness' refusal to undergo a blood transfusion may be detrimental to themselves but does not directly affect anyone else, other than perhaps loved ones. This begs the question on where the line is drawn when a capable individual openly puts themselves at risk through their actions. Is forcing upon individuals what is objectively right for them ethical? There is certainly an argument to say that it is, and blood transfusions provide a good example. However, less sinister examples provide argument to the contrary. Gillon's use of unhealthy food provides an useful illustration[7]. The choice to eat healthy food is in the long-term interests of all individuals yet many succumb to unhealthy food with the full knowledge it is not in their long-term interests. Therefore, should individuals be prevented from eating unhealthy foods just because it is better for them? To take it upon oneself to restrict the food choices of others in advocacy of their long-term benefit seems excessive. Consequently, whether it is permissible to limit one's autonomous choices is dependent on the effects of

[4] https://www.vocabulary.com/dictionary/autonomy Accessed April 2024.
[5] Immanuel Kant, *Groundwork on the Metaphysics of Morals* [1785] (J.W. Ellington Translation, Hackett Publishing 1993).
[6] John Stuart Mill, *On Liberty* [1859] (J.Grey ed) *On Liberty and Other Essays* (Oxford University Press, 1991) page 14.
[7] Raanan Gillon, 'Ethics need principles – four can encompass the rest – and respect for autonomy should be "first among equals"', Journal of Medical Ethics Vol 29 [2003] page 310.

the decision being made and so there must be a line where something becomes potentially too disastrous to allow the individual act on, but whether this is right or wrong which is the ultimate question.

Which of these interpretations is ethically 'correct' merits boundless discussion but for the purposes of this paper it is Mills that provides the most practical interpretation to adopt as opposed to using autonomy in a Kantian sense.

i) In Bioethics

Developments in individual autonomy has inevitably translated into other areas and is not exclusive to philosophical discussion. One place it has gained a notable increase in recognition is in healthcare with the paternalism previously inherent in the medical profession yielding to patient autonomy.

The previous ethical and legal models of healthcare focussed on prevention of physician malpractice and their obligation to provide appropriate treatment. However, the current autonomy model ensures medical professions are more attentive to the patient's wishes. There has been a shift from the physician being responsible for determining what is objectively best for the individual, to the physician's responsibility to fulfil the patient's wishes.[8] Autonomy holds a contentious place in healthcare due to its conflict with other principles of medical ethics. The healthcare industry is founded on the assumption that those with medical expertise are best placed to decide solutions for how to improve one's health. However, in recent times the conclusions drawn by physicians have been abdicated in support of individual autonomy. For example, *Airedale NHS Trust v Bland*[9] highlighted the right of the autonomous patient to decline medical intervention even if resulting in their death. Moreover, Lord Goff explicitly stated that the sanctity of life has surrendered to the autonomy

[8] Charles W. Lidz, Lynn Fischer, Robert M. Arnold, 'The Meaning of Autonomy in Long Term Care', *The Erosion of Autonomy in Long-Term Care* (Oxford University Press New York, 1992) page 604 https://repository.law.miami.edu/cgi/viewcontent.cgi?article=1883&context=umlr Accessed April 2024.

[9] *Airedale NHS Trust v Bland* [1993] AC 789.

principle.[10] More recently, *Montgomery v Lanarkshire Health Board*[11] presented a clash between patient autonomy and medical expertise in which the former reigned supreme.

The increased recognition of patient autonomy is fundamentally constructive and commendable. However, whether it should override auxiliary medical principles is disputable. The previous model of physicians making patient decisions has been compared to the paternalism seen in a 'condescending gentleman'[12] and subsequently obtains authoritarian elements, particularly true at its inception in the eighteenth century. A move toward a more inclusive decision-making process was appropriate, however, it has ultimately been at the expense of another medical principle. The principle of beneficence places a duty on physicians to act to the benefit of the patient. How this is to be interpreted is contentious, but it stands to reason that in healthcare it means to improve the patient's health or to reduce the harm or pain suffered. Consequently, these can sometimes conflict with what the patient wishes as considered above. Whilst they will almost certainly want to reduce their pain or suffering, the viable methods to do so may differ between patient and physician. Beneficence is a cornerstone of medical ethics and has been described as a moral obligation of physicians[13] and so acknowledge of it is important to the issue of limiting patient autonomy.

B) WHERE DOES CAPACITY FIT IN?

A plausible prerequisite to exercise one's autonomy is the need to obtain the capacity to do so. Capacity has different definitions dependent on context, however, the relevant definition for the purposes of this paper is 'the ability to understand or to do something'.[14] Much like autonomy, there ceases to be an absolute definition, understanding or interpretation but it

[10] *Ibid* page 867.
[11] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[12] Edmund Pellegrino and David Thomasma, 'The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution', Journal of Contemporary Health Law and Policy Vol 3 1 [1987] page 25. https://scholarship.law.edu/cgi/viewcontent.cgi?article=1689&context=jchlp
[13] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (Oxford University Press 2001).
[14] https://www.oxfordlearnersdictionaries.com/definition/american_english/capacity#:~:text=%5Bcountable%2C%20usually%20singular%2C%20uncountable,capacity%20for%20developing%20new%20products Accessed April 2024.

is accurate to state that it is often synonymous with ability. The differing interpretations surrounding capacity are beyond the realms of this paper as the primary concern here is to provide knowledge of how it can be broadly understood and its legal relation to autonomy. The declaration by George Box that "All models are wrong, but some are useful"[15] has never been more so accurate than when dealing with capacity. This said, there are different interpretations that provide functional.

A distinction must firstly be made between mental and legal capacity. Legal capacity refers to the formal ability to hold and exercise legal rights and duties.[16] Therefore, theoretically and according to human right principles, everyone has or should have legal capacity. This right is inferred by legislation such as the Human Rights Act[17] and conventions such as the European Convention on Human Rights (ECHR)[18]. Legal capacity is often brought to the forefront when impaired individuals find that their legal capacity only exists in theory. On the other hand, mental capacity, which is the one of relevance in this essay although legal capacity will be referred to again, regards one's decision-making skills on certain decisions. The substantive law on mental capacity will be analysed in the next chapter, but at this stage it can be understood as one's ability to understand information and use it to form decisions. Whilst legal capacity applies to all and is objective, mental capacity does not and is not. One's mental capacity is subject to scrutiny and is medically assessed to determine whether they can comprehend information given and make informed choices accordingly. Consequently, mental capacity ranges from person to person for reasons such as mental impairment, age or brain injury.

It is also important to consider the legal relationship between mental capacity and autonomy. Paul Skowron posits three contradictory accounts in the case law regarding the relationship.[19] The first to consider is capacity as autonomy's gatekeeper. This is the most dominant

[15] George E.P. Box, 'Science and Statistics', Journal of the American Statistical Association [1976] Vol 71 [356] 791-799.
[16] https://legalcapacity.org.uk/everyday-decisions/what-is-legal-capacity/ Accessed April 2024.
[17] Human Rights Act 1998.
[18] European Convention on Human Rights 1950.
[19] Paul Skowron, 'The Relationship between Autonomy and Adult Mental Capacity in the Law of England and Wales', Medical Law Review Vol 27 1 [2018] pages 32-58.

interpretation. This account maintains that if someone has the mental capacity to make a decision then they are autonomous in that decision and so there should cease to be state interference. On the other hand, if they do not have mental capacity, they are not autonomous and so state interference may be permitted. However, this account does recognise that those who lack capacity still have an ability to self-govern. *Re C*[20] provides a good example of the gatekeeper account in which Thorpe J summarised it as if an individual's capacity to decide is not impaired then autonomy holds more weight, however, 'the further capacity is reduced, the lighter autonomy weighs'.[21] Subsequently, capacity acts as a gatekeeper since is the tool one can use to access their autonomy in a legal sense.

The second account is the insufficiency account. Like the gatekeeper account, it acknowledges that incapacitated individuals do not obtain an overriding right to respect for autonomy however it also does not recognise that those with mental capacity do necessarily obtain this right. For instance, there are other criteria that need satisfing for even capable individuals to gain respect for their autonomy. Consequently, having mental capacity does not equate to autonomous recognition. In *R v Cooper* Lady Hale maintained that autonomy includes the 'freedom and the capacity to make a choice'[22]. Therefore, capacity is only one element of autonomy. The other is 'freedom'. This freedom can be understood as freedom from external forces. In *Re T* Lord Donaldson held it was not only necessary for doctors to consider a patient's capacity but also whether they were under significant influence from others.[23] If this 'undue influence'[24] is present, even on capable individuals, the court considers this to 'destroy her volition'[25]and so will cease to recognise them as autonomous when determining whether their wishes ought to be recognised as autonomous.

Finally, Skowron notes the survival account[26]. This contends that respect for an incapable individual's autonomy can still withstand state intervention. In *WvM,* Mr Justice Baker

[20] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290 Fam.
[21] *Ibid* [292] (Thorpe J).
[22] *R v Cooper* [2009] UKHL 42, [2010] Crim LR [75].
[23] *Re T (An Adult: Refusal of Treatment)* [1992] EWCA Civ 18, [1993] Fam 95 [37].
[24] *Ibid* [41] (Butler-Sloss LJ).
[25] *Ibid.*
[26] Skowron [2019].

confirmed that 'person autonomy survives the onset of incapacity'.[27] Whilst this seems certain, as Skowron highlights, the position this takes up is not straightforward. This account of the relationship between autonomy and capacity falls somewhere between the following extremes. At one end is the notion that all individuals, capable or not, be free from state intervention because they are humans are autonomous. At the opposing end is the argument that incapable individuals, whilst retaining some capacity to self-determine, should not be recognised as autonomous. The survival account maintains that the autonomy right can still be upheld despite incapacity, yet, it does not have to. For instance, Mr Justice Baker further contended that a court decision that sufficiently regards the patient's autonomy and wishes of them and their family and withholds treatment in the patient's best interests[28] does not breach autonomy under Article 8[29]. Therefore, this is suggestive that respect for autonomy can still be maintained despite incapacity. Put differently, respect for autonomy can limit decisions made on behalf of incapable individuals.

CONCLUSION

It can be summarised that these interpretations provide differing considerations of how the legal relationship between autonomy and capacity should be understood. Though, it is often a matter of judicial interpretation and capacity's influence on autonomy is only as prevalent as judges allow it to be. The next chapter will consider the current law on capacity beginning with its provisions, principles and assessment. Subsequently, its limitations will be illustrated with the focus being on its interpretative and theoretical misapprehensions as opposed to its practical limitations such as the burden placed on healthcare workers.

[27] *W v M* [2011] EWCOP 2443, [2012] 1 WLR 1653 [95].
[28] *Ibid* [95].
[29] Article 8 European Convention on Human Rights [1950]. Right to Respect for Private and Family Life, Home and Correspondence.

CHAPTER TWO: A JUSTIFIABLE INFRINGEMENT OR UNFIT FOR PURPOSE?

INTRODUCTION

A more comprehensive understanding of autonomy and capacity allows analysis of the current law. Assessments of capacity are consequential to an individual's ability to self-govern. The MCA was contended to be a 'visionary piece of legislation'[30] and a triumphant achievement for autonomy, however, this rhetoric has proved far from accurate. Its inadequacy has been demonstrated by a plethora of academics, legal experts and physicians. This chapter will cease to be an exhaustive list of the many deficiencies of the MCA, these are widely recorded, by government departments[31], academics[32] and legal specialists[33]. This chapter is more concerned with the ways in which the MCA firstly; has a narrow and limited interpretation of autonomy; a misguided and archaic perspective on capacity, and lastly, how its current framework for liberty deprivation is broken.

A) Historical Context

Roots of the MCA are found in *F v West Berkshire HA*[34]. Here, the House of Lords concluded a sterilisation operation could be performed on an impaired adult woman without her consent if it was in her best interests. *Berkshire* is notorious for the attention it gave to patient's best interests. This defence of acting in the patient's best interests is now enshrined in Section 5

[30] Select Committee on the Mental Capacity Act 2005, 'Mental Capacity Act 2005: Post-Legislative Scrutiny' (2014) HL Paper 139.
http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf
Accessed February 2024.
[31] *Ibid.*
[32] Sam Wilson, 'Mental Capacity Legislation in the UK: Systemic Review of the Experiences of Adults Lacking Capacity and Their Carers', BJPSych Bulletin [2017] Vol 41 [5] 260-266.
[33] Law Commission, Mental Capacity and Deprivation of Liberty Law Com No 372.
[34] *F v West Berkshire Health Authority* [1990] 2 AC 1.

of the MCA[35]. Following *Berkshire,* the Law Commission concluded[36] that the Mental Health Act[37] responsible for capacity matters was unsystematic and heedless of modern values. Consequently, reform necessitated consideration of wider legal and social issues than previously addressed.

i) Provisions and Principles

The MCA provided a legal framework by which to determine one's mental capabilities. It additionally provides those responsible for care with the right to make decisions on their behalf. The principles of the MCA can be found in Section 1 (1-6)[38]. The first, maintains the assumption of capacity unless there is well-founded evidence to the contrary. Secondly, everything must be done to enhance the decision-making capabilities of the individual. Subsequently, a mere irrational decision is not indicative of incapacity. The fourth and fifth principles assure the best interests of the individual are met and that the least restrictive treatment option is used.

It is a subjective, situation-specific framework. Matthew Hotopf demonstrates this with the example of dementia patients[39]. The Act does not render all dementia patient's incapable. Rather, the Act assumes their capacity unless demonstrated that their dementia restricts their capabilities. Additionally, incapacity on one decision does not mean incapacity on *all* decisions. The capacity assessment itself is two-fold. The first element requires impairment of mind, usually mental illness but also encompasses mind-altering drugs. Secondly, the impairment must *cause* the individual to be incapable of making decisions when required. This speaks to the fluctuation often present with capacity. Patients often lack capacity on one decision but not others and it is certainly possible for one to regain capacity.

[35] Mental Capacity Act 2005 Section 5.
[36] House of Commons: Law Commission Mental Incapacity, Law Com No 231 1995. https://cloud-platforme218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/30/2015/04/lc231.pdf Accessed April 2024.
[37] Mental Health Act 1983.
[38] Mental Capacity Act 2005 s1 [1-6].
[39] Matthew Hotopf, 'The Assessment of Mental Capacity', Clinical Medicine [2005] Vol 5 6 page 580.

B) Operating on a Cliff-Edge: A Narrow Interpretation of Autonomy

One argument that has been accurately accentuated is the MCA's cliff-edge approach to capacity.[40] Those found capable obtain the legal privileges that accompany this. Their consent must be given before treatment, and they may reject life-saving treatment if they wish[41]. Consequently, legal repercussions are sanctioned should a capable individual have treatment enforced upon them without consent, with physicians potentially guilty of battery due to unlawful force[42] and a breach of Article 8 concerning the right to private and family life which now accounts for physical and mental integrity[43] illustrated in *X and Y v Netherlands*[44]. It may also amount to a breach of Article 3[45] if it is to be considered degrading.

However, those found incapable are not afforded the same legal advantages. Their decisions are not considered to hold any real authority or validity. Therefore, decisions must be made in their best interests[46]. However, lack of clarity on what constitutes 'best interests' means discretion is left to the decision-maker. There are various guidelines such as the likelihood of the individual regaining their capacity and encouraging their participation.[47] It is also necessary for decision-makers to consider any wishes or beliefs that likely would have impacted their decision were they capable and any advance directive provided when they had capacity[48]. However, no factor obtains priority and therefore it is down to the decision-maker

[40] Cressida Auckland, 'The Cusp of Capacity: Empowering and Protecting People in Decisions About Treatment and Care', [2019] University of Oxford page 27. https://ora.ox.ac.uk/objects/uuid:ae83cf82-86b3-4816-a4eaaf59c67990c5/files/m1467fc566f6d76a653d3754ec1578a09 accessed February 2024.
[41] *Ibid.*
[42] *R v Afolabi* [2017] EWHC 2960.
[43] Auckland [2019] page 28.
[44] *X and Y v Netherlands* [1986] 8 EHRR 235 [22].
[45] Article 3 European Convention on Human Rights 1950 Prohibition of Torture Including Inhuman or Degrading Treatment.
[46] Mental Capacity Act 2005 s1[5].
[47] *Ibid* s4 [7].
[48] *Ibid* s4 [6].

how much weight is given to each factor and so it is not uncommon for the patient's wishes to be sabotaged by external forces.

The law operates on a cliff-edge because too much emphasis is afforded to the capacity threshold when determining the extent of one's autonomous capabilities. As Auckland accurately alludes to, this means is that those safely on the cliff are afforded the legal prerogative but those who find themselves over the cliff (not meeting the capacity threshold) find themselves without legal validity. This has promoted the belief that the law adopts a narrow interpretation of autonomy[49]. John Coggon's three-dimensional classification of autonomy proves useful to demonstrate this.[50] Coggon's first classification is *ideal desire* autonomy. By applying objective universally accepted values, this reflects what a person *should* want. Secondly, there is *best desire* autonomy. This reflects the individuals' underlying beliefs and values, even if conflicting with their immediate wants. Finally, is *current desire* autonomy, reflecting a decision based on immediate inclinations.[51] It appears the MCA adopts this third interpretation. Section 3 stresses the importance of the patient's decision-making process and ability to retain information to draw conclusions. Little consideration is given to whether the decision reflects the individual's values or beliefs. This has led to what Coggon and Miola term 'value-agnosticism'[52]. This is the laws willingness to consider the patient's rational process whilst classifying their values and beliefs as redundant because they cannot be known due to their incapacitation. There is a circularity to this argument and whilst this presents the law as value-neutral, scrutiny of a patient's underlying beliefs is necessary to prevent them acting on ill-founded, harmful beliefs.

NHS Trust v Mrs T[53] provides a noteworthy example. Mrs T suffered borderline personality disorder and had self-harmed to the extent her haemoglobin level was so low she required a blood transfusion. Mrs T was astutely aware that without treatment she would die yet

[49] Auckland [2019] page 58.
[50] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' [2007] Healthcare Analysis 15 235,240.
[51] *Ibid.*
[52] John Coggon and Jose Miola, 'Autonomy, Liberty and Medical Decision-Making', Cambridge Law Journal 70 [3] 523-543,528 [2011].
[53] *NHS Trust v T* [2004] EWHC 1279 Fam.

remained uncooperative. Her reasoning was her belief that her blood was evil and was transporting evil around her body. Whilst she believed blood used in transfusions was "clean" she contended that once it mixed with her own it would be contaminated and would therefore not prevent her evil acts. The issue here was not Mrs T decision-making process nor was it her ability to reach reasoned conclusions. She not only understood the consequences but provided thorough reasoning as to why she had reached such conclusion, demonstrated in her advance directive. The problem was her starting point that her blood was evil. If her belief was correct, then her reasoning was not only legitimate but courageous. Consequently, an interpretation of autonomy concentrated on the decision-making process only accounts for the effect of mental illness on that process, not the effect mental illness has on underlying beliefs. Therefore, there is a need to put underlying beliefs under scrutiny and the risk of losing value-agnosticism is a price worth paying to prevent harmful actions based on them.

C) A Misinterpretation of Incapacity?

Adding to this narrow interpretation of autonomy is a misconstrued interpretation of capacity. Capacity was previously noted to encompass those who could understand and retain information. Therefore, incapacity must include those incapable of this. However, this should not be assumed to be a complete understanding. Understandings in the way humans engage in decision-making has evolved continued to do so. One points to the emergence of emotions[54] and cognitive biases[55] and their increased recognition in decision-making. If decision-making is dependent on an ability to demonstrate capacity, why is this assessment founded on a criterion that does not reflect the multifaceted decision-making process all individuals engage with?

Prior to the MCA, to have had capacity one must have 'believed' the information given to them[56].This was arguably translated into the MCA although not explicitly, however, the

[54] Antonio Damasio, *Descartes' Error: Emotion, Reason and the Human Brain* (Random House 2008).
[55] Martie G. Haselton, Daniel Nettle and Paul W. Andrews, 'The Evolution of Cognitive Bias' [2005] in The Handbook of Evolutionary Psychology Interfaces with Traditional Psychology Disciplines (John Wiley & Sons 2nd Edition 2015) pages 724-746.
[56] *Re C (Adult:Refusal of Medical Treatment)* [1994] 1 WLR 290.

requirement to understand 'the reasonably foreseeable consequences of deciding one way or another' bares resemblance[57]. Following the MCA, the courts again adopted this necessity of belief[58]. This is unsurprising since the starting point of court proceedings is to establish the facts which stalls if the individual does not agree on such facts.

What it means to 'believe' is contentious. For instance, is it merely to agree with the advice one is given? Bartlett uses the example of a clinician changing a diagnosis to demonstrate the insufficiency of this interpretation. If a patient considers a previous diagnosis more persuasive, whilst they may be factually incorrect but surely this cannot be indication of their incapacity[59]. Moreover, what about incorrect beliefs held by a significant amount of people? If one rejects a Covid-19 vaccination because it does not exist, do they lack capacity even though there are a wide-range of people that would agree with them? The answer is of course, no. Therefore, 'belief' being a requirement for capacity does not provide a sufficient interpretation of what capacity is.

The courts answer to this is causation. If a false belief is the direct result of impairment, then the patient lacks capacity[60]. However, as Bartlett rightly analyses this creates problems of its own. The first is, whilst theoretically convenient, how to determine whether a false belief is a product of disorder is ambiguous.[61] There is almost always an interlocking of factors that play into an incorrect belief and so how much of an influence does disorder have to contribute and how can this be measured? This remains unclear. Secondly, there is inconsistency in how different unjustifiable reasons for a belief are considered. For instance, mental disorder is considered an indefensible reason to obtain a specific belief yet gaining one's belief from the internet, although not sufficient reason to have such belief, does not render one incapable. This fixation on belief and weight given to it has led to what Williams terms the 'concertina

[57] Mental Capacity Act 2005 s 3 [4].
[58] *A Local Authority v MM* [2007] EWHC 2003.
[59] Peter Bartlett 'Re-thinking the Mental Capacity Act 2005: Towards the Next Generation of Law' [2022] Modern Law Review Vol 86 3 page 686.
[60] *PC v City of York Council* [2013] EWCA Civ 478.
[61] Bartlett [2022] page 686.

effect'. [62] This states that the capacity assessment is fundamentally dependent on the assessor's view of the outcome of the decision being made. Instead of allowing an unwise decision to unravel, assessors consider a poor decision to be a symptom of disorder and therefore evidence of incapacity[63], a direct infringement on the central principles of the MCA[64]. The Act makes clear that unwise decisions outside of social norms are not evidence of incapacity as autonomy requires that individuals can draw conclusions that the rest of society deem irrational.[65] One group to consider here is anorexic patients. *A Local Authority v E*[66] demonstrated that the decision of anorexic patient's not to eat is often considered evidence of incapability to decide anything. Consequently, people with anorexia are deemed to be incapable of making decisions regarding treatment such as force-feeding even if this decisions on rests on other views they may have. Concludingly, the MCA must adopt more contemporary understandings of factors that influence decision-making and resist the temptation to consider disorder an absolute hinderance to drawing reasonable conclusions.

D) The Deprivation of Liberty Safeguards

The misinterpretations of autonomy and capacity negate the purpose of the liberty deprivation framework. This is because they are intended to deprive incapable individuals of liberty to ensure the safety of them and those around them. Yet, as shown above, the flawed understanding of capacity means some are found incapable when they are not and restricted of their autonomy when they should not. Consequently, it is important to analyse how these skewed interpretations have led to the violation of fundamental rights in the liberty deprivation safeguards with many being deprived of their liberty, capable or incapable, when they should not be.

[62] Val Williams, Geraldine Boyle, Marcus Jepson, Paul Swift, Toby Williamson and Pauline Heslop, 'Best Interests Decisions: Professional Practices in Health and Social Care', Health & Social Care in the Community Vol 22 1 [2013] pages 78-86.
[63] *Ibid* page 82.
[64] Mental Capacity Act 2005 s 1[4].
[65] *Ibid.*
[66] *A Local Authority v E* [2012] EWHC 1639 COP.

The Mental Health Act 2007[67] incorporated the Deprivation of Liberty Safeguards (DoLS) into the MCA. They permit the restriction of individuals in a hospital or care home if in the patient's best interests. The safeguards provide a legal framework through which individuals may be deprived of their liberty on the grounds of necessity and best interest. The DoLS were required following the final decision in *Bournewood*[68] in which, after a series of judgements, the ECtHR held that an autistic man had been unlawfully deprived of his liberty and his rights violated under Articles 5 (1) and 5 (4) ECHR[69]. Parliament was therefore required to introduce its own legislation compatible with international human rights law.

The DoLS advocate a six-step assessment to determine whether an individual can legally be deprived of their liberty, the individual being at least eighteen being the first one. The second requires disability of the mind subject to the Mental Health Acts. Thirdly, the individual must be incapable. Next, it must be in the individual's best interests to be deprived of their liberty. The individual must be eligible to be deprived of their liberty under the DoLS, completed by a mental health practitioner to determine whether the individual is under the jurisdiction of Mental Health Acts or if other legislation is more suitable. Finally, liberty deprivation of the individual must not conflict with a justifiable refusal they have to object to any proposed treatment[70].

i) Destined to Fail?

The potential severity of the DoLS warrants a cautious and clear framework in which legal and medical professionals can operate yet lack of a definition of what deprivation of liberty consists of, not only in the legislation but also the code of practice, means this has not come

[67] Mental Health Act 2007.
[68] *R v Bournewood Community and Mental Health NHS Trust* [1997] EWCA Civ 2879. *R v Bournewood Community and Mental Health NHS Trust* [1998] UKHL 24.
[69] *HL v. UK* [2004] European Court of Human Rights (application no. 45508/99)
[70] 'The Six Key Assessments for DoLS', Mental Capacity in Practice 2023 https://mental-capacity.co.uk/six-assessments-dols-application/ accessed March 2024.

to pass[71]. There also ceases to be clarity on the difference between mere restriction and liberty deprivation. The only interpretation to this regard has been in paragraph 2.3 of the Code of Practice which states the difference is one of 'degree and intensity'. Yet, this remains abstract with no measure to determine degree or intensity. Case law indicates that a deprivation of liberty is when there is 'complete and effective control' over the individual[72] though lack of clarification has produced differing interpretations and inconsistencies. The safeguards are often not used when required leaving individuals legally exposed and without protection[73]. Consequently, it has been estimated that some 50,000 people are unlawfully deprived of their liberty in care homes[74]. It is also not uncommon for individuals to fail the eligibility test mentioned above or warrant detention under the Mental Health Act. Therefore, a 'lost population'[75] has emerged where those who do not come under the legal remit of either legislation.

The interpretive inconsistencies are evident case law. *JE v DE*[76] provides an important starting point. This case concerned a man required to live in a care home contrary to the wishes of him and his wife. Munby J contended the issue was not whether the man's liberty was restricted in the institutional setting. Rather, the issue was whether the individual was restricted of his freedom to leave.[77] David Hewitt posits that lack of freedom to leave is only one of a combination of factors amounting to a liberty deprivation.[78] Therefore, it was necessary for Munby J to consider other elements, yet his judgement focussed solely on the lack of freedom to leave. Additional cases demonstrate this 'freedom to leave' approach. *Dorset County Council v EH*[79] focused on an individual's lack of freedom to leave their care

[71] Ministry of Justice. The Mental Capacity Act 2005. Deprivation of Liberty Safeguards. Code of Practice to supplement the Main Mental Capacity Act 2005 Code of Practice [2022].
[72] *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam).
[73] House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny [2014] HL 139, para 32.
[74] Ajit Shah and Chris Heginbotham, 'Newly Introduced Deprivation of Liberty Safeguards: Anomalies and Concerns', The Psychiatrist [2010] 34 [6] 243-245.
[75] *Ibid.*
[76] *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam).
[77] *Ibid* [115].
[78] David Hewitt, 'Re-considering the Mental Health Bill: The View of the Parliamentary Human Rights Committee' (2014) International Journal of Mental Health and Capacity Law 57.
[79] *Dorset County Council v EH* [2009] EWHC 784 Fam.

home, whilst *City of Sunderland v PS*[80] maintained that the only necessary restriction was security to ensure a patient could not leave the premises. However, other cases offer highlight different interpretations and lack this focus. McFarlane J in *LLBC v TG* [81] was reluctant to recognise a deprivation of liberty as 'it was an ordinary care home where ordinary restrictions of liberty applied'. The DoLS maintain that consideration is afforded to the individual's specific condition. Yet McFarlane J, opted for a generalised interpretation of what was considered 'ordinary' in that setting. Additionally, in *LBH v GP and MP*[82] Coleridge J concluded there was not a deprivation of liberty in a care home for two reasons. Firstly, the local authority did not consider themselves authorised to keep the patient at the care home and would apply to the Court of Protection if the patient was determined to leave. Secondly, there was evidence of the individuals' wishes to remain. The second reason is troublesome because it is not clear how it relates to liberty deprivation since the patient lacked capacity.

These examples show the differing judicial interpretations of liberty deprivation and so it is unsurprising that many find themselves illegally deprived of their liberty with judges clearly working with different understandings of the concept.

[80] *City of Sunderland v PS* [2007] EWHC 623 Fam.
[81] *LLBC v TG* [2007] EWHC 2640 Fam.
[82] *LBH v GP and MP* [2009] FD08P01058.

CHAPTER 3: THE WAY FORWARD

Introduction

The second chapter demonstrated the current framework for assessing mental capacity is narrow and simplistic. Furthermore, case law illustrates inconsistencies in application. It was subsequently contended that the law unjustifiably infringes upon what should be autonomous individuals, assesses their capacity in a facile fashion and ceases to encompass those it should protect. Therefore, the logical conclusion to derive is that there must be considerable reform. This chapter will address the two most appropriate antidotes. The first being reformation of the DoLS framework and the second being amelioration of the best interest principle with a look towards the more encompassing and expansive international framework. It will subsequently be concluded these areas remain the most important in restoring power and dignity back to incapable individuals as well as ensuring more contemporary understandings and interpretations of autonomy and capacity are adopted.

A) Reforming the Liberty Deprivation Safeguards

The Mental Capacity (Amendment) Act[83] sought to replace the DoLS with the Liberty Protection Safeguards (LPS), though their implementation has been extensively delayed due to the Covid-19 pandemic with them now due to be introduced in Autumn 2024.The safeguards intend to provide several refinements. Firstly, to control the backlog of DoLS

[83] Mental Capacity (Amendment) Act 2019.

applications which as of March 2020 stood at 129,780.[84] This is consequence of the surge in applications following the decision in *Cheshire West*[85], since which it has become evident there are far more people illegally deprived of their liberty than originally thought. Steven Neary[86], for example, was deprived of his liberty for three months without any DoLS authorisation. Secondly, the LPS will broaden the settings in which a liberty deprivation order can be authorised by extending to private domestic setting and alternative supported accommodation[87] whilst also lowering the age a deprivation of liberty can be sanctioned to encompass anyone aged sixteen and above.[88]

However, lack of judicial interpretation means it is only possible to speculate whether the LPS will be 'good law'[89]. Consequently, it is necessary to engage with conceptual frameworks to measure this. The natural law perspective, for instance, considers the moral basis of laws to determine their goodness[90]. Contrastingly, a positivist approach centred on measurement and quantifiable observation[91] disregards morality and instead deploys the recognition rule to determine validity. This perspective, adopted by Hart[92], contends that since the Act achieved royal assent, it is, by definition, good law. Certainly, the issue with this approach is it would maintain the most heinous legislation was legitimate if it passed through the necessary mechanisms. Thus, a more suitable framework is the eight sub-rules of law[93]

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[84] NHS Digital, 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2018-19' (NHS Digital 2020) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/england-2018-19> accessed March 2024.
[85] *Cheshire West and Chester Council v P* [2014] UKSC 19.
[86] *London Borough of Hillingdon v Neary* [2011] EWHC 1377.
[87] 'What are Liberty Protection Safeguards?' (Social Care Institute of Excellence, October 2022) < https://www.scie.org.uk/mca/lps/latest/#:~:text=LPS%20will%20be%20about%20safeguarding,those%20arrangements%20for%20their%20care accessed 12 April 2024.
[88] *Ibid.*
[89] Rosie Harding, 'Safeguarding Freedom? Liberty Protection Safeguards, Social Justice and the Rule of Law', Current Legal Problems Vol 74 [2021] page 339.
[90] Lon. L Fuller, *The Morality of Law: Revised Edition* (Yale University Press 1969)
[91] Understanding Pragmatic Research: Two Traditional Research Paradigms, University of Nottingham https://www.nottingham.ac.uk/helmopen/rlos/research-evidence-based-practice/designing-research/types-of-study/understanding-pragmatic-research/section02.html#:~:text=Positivism%20is%20a%20paradigm%20that,cannot%20be%20known%20for%20certain. Accessed April 2024.
[92] H.L.A Hart, *The Concept of Law* (Oxford University Press, 2012).
[93] Harding [2021] page 341.

developed by Lord Bingham[94]. The aim of this is not to provide a complete measurement which can determine how effective the safeguards will be. Rather, this framework performs an inquisitorial role by asking important questions of the legislation.

i) Clarity and Predictability

Bingham's first principle ensures the law is accessible and comprehensible[95]. Individuals warrant awareness of the law that governs them, and it is necessary to ensure knowledge of their rights under law. Schedule 1 Paragraph 14[96] obliges public bodies to publish information regarding the LPS including its process and effects as well as enforcing a duty to provide information that is understandable and accessible. Whilst this appears satisfactory, the reality of whether this is achieved will be determined by the Code of Practice. Writing in 2021, Harding noted the Code of Practice was awaiting publication and was therefore unknown. However, the following year the government published its proposed changes to the Code of Practice[97]. The changes include clarity on "best interests"[98] and on how the safeguards will apply to sixteen and seventeen-year-olds[99]. Therefore, it appears likely the safeguards will satisfy Bingham's first principle of increasing accessibility and clarity.

ii) Application of the Law

The second principle maintains that legal disputes are resolved by application of the law rather than arbitrary discretion to ensure consistency and predictability. Fortunately, the LPS makes it explicit when it is legal to deprive one of their liberty in its 'authorisation

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[94] Tom Bingham, *The Rule of Law* (Penguin, 2011).
[95] *Ibid.*
[96] Mental Capacity (Amendment) Act 2019 Schedule 1 Paragraph 14.
[97] Consultation on proposed changes to the Mental Capacity Act 2005 Code of Practice and implementation of the Liberty Protection Safeguards: Including the Liberty Protection Safeguards secondary legislation [2022].
https://assets.publishing.service.gov.uk/media/62b096338fa8f5357549faad/changes-to-the-MCA-code-and-implementation-of-the-LPS-consultation-document-extension.pdf
[98] *Ibid* page 20.
[99] *Ibid* page 31.

conditions'.[100] These include incapacity to consent, a mental impairment and that the deprivation is necessary and 'proportionate in relation to the likelihood and seriousness of harm to the cared-for person'.[101] Any deprivation of liberty will be illegal under the LPS unless it satisfies these requirements. Although, there are certain factors that may need additional clarification. For instance, contention surrounds what it means to suffer from mental disorder. Presumably it would be those pursuant to the Mental Health Acts[102] and not merely an individual of unsound mind as in the ECHR, although this is uncertain.[103] Therefore, it appears as though there will be adequate application of the law and abstinence from arbitrary and inconsistent decisions so long as there is further elucidation as to what it means to suffer from mental illness.

iii) Equality Before the Law and International Obligations

The third and eighth principle are somewhat interconnected and therefore it is necessary to consider them in unison as they are the central limitations of the incoming safeguards. The third, guarantees equality before the law, something the LPS will almost certainly not achieve. The LPS founded on the right to liberty and security enshrined in Article 5 ECHR which permits the liberty deprivation of individuals of unsound mind. Contrarily, Article 14 of the Convention on the Rights of Persons with Disabilities (CRPD)[104] maintains the mere presence of disability does not vindicate a deprivation of liberty. The UK has ratified, and therefore bound by, both conventions. It is certainly possible the European Court of Human Rights (ECtHR) will absorb the principles of the CRPD, however until this there will be a looming conflict between the two. The LPS can therefore not fulfil both commitments unless both adopt the same understanding and interpretation of disability and impairment. This permits recognition of Bingham's eighth principle that domestic law fulfils international obligations[105]. The conflict between the two conventions means to satisfy one is in violation of the other. The Human Rights Act[106] incorporates ECHR principles into domestic law and it appears the ECtHR affords

[100] Harding [2021] page 344.
[101] *Ibid.*
[102] Mental Health Act 1983 and 2007.
[103] European Convention on Human Rights Article 5 [1][e] [1950].
[104] Article 14 United Nations Convention on the Rights of Persons of Disabilities 2006.
[105] Harding [2021] page 346.
[106] Human Rights Act 1998.

greater legal authority to this treaty than its contemporaries. Consequently, not only will the LPS struggle to maintain equality before the law given the people champions but it will suffice to satisfy its international obligations unless the two international treaties move closer to the same ideal.

iv) Acting in Good Faith and Protecting Fundamental Rights

The fourth principle ensures those responsible for implementation act in good faith and not abuse their powers. This is relatively unproblematic for the LPS. Those responsible for implementation, healthcare providers, local authorities or patient representatives will be sufficiently aware of acting within their powers to avert legal condemnation. The fifth rule requires the promotion and protection of fundamental rights. It is a principle of the LPS to do this, though how this will be done practically will determine success. The LPS intends to reduce the costs of the DoLS which will be achieved by addressing authorisation renewals. The authorisations under the LPS may be renewed up to three months succeeding an initial renewal period of one year with no set time limit for frequent reviews. Renewals will additionally not require formal assessments of one's capacity. The review and renewal process is crucial for upholding fundamental rights as it determines when one can reclaim liberty[107] and whilst costs will be reduced, the potential for the renewal of the authorisation of a deprivation of liberty to live up to three years is troublesome and it stands to reason the costs are justified in order to uphold the patient's right to frequently question their deprivation. The need for frequent reviews has been supported by ECtHR caselaw such as *Kadusic v Switzerland*[108] and *Herz v Allemagne*[109] which demonstrated that psychiatric reports exceeding eighteen months were not considered recent enough to justify a deprivation of liberty[110]. Therefore, it seems reasonable to conclude those responsible for implementation will operate within their power boundaries and accordingly be held accountable. However,

[107] Harding [2021] page 345.
[108] *Kadusic v Switzerland,* application no.43977/13 at [44].
[109] *Herz v Allemagne,* application no 44672/98 at [50].
[110] Rosie Harding, 'The 'Adjusted' Liberty Protection Safeguards: Some Concerns' Legal Capacity Research (2018) https://legalcapacity.org.uk/everyday-decisions/the-adjusted-liberty-protection-safeguards-some-concerns/#_ftn2 Accessed March 2024.

the safeguards must ensure that in their aspiration to practically reduce costs they do not infringe upon a patient's right to undergo regular reviews of their conditions.

v) Dispute Resolution and a Fair Trail

Bingham's sixth principle ensures the means are provided for individuals to solve civil disputes they cannot resolve themselves without incurring significant cost. This maintains the equal accessibility of justice and legal remedies. As Harding astutely refers to[111]the fact public bodies are obliged to publish information regarding the rights to request a review suggests satisfaction. Similarly, the duty on Approved Mental Capacity Professionals to carry out pre-authorisation reviews if it is thought the cared-for person objects to their care and treatment provides encouragement. Lastly, the seventh principle warrants the impartiality of the judicial system to permit a fair and equal trial. The Court of Protection will govern disputes on the LPS and will ensure impartiality whilst a 'non-means tested legal aid'[112] will be afforded to challengers of an LPS authorisation. However, the consistency of how this aid is distributed will stand the test of time. One may, for instance, face obstacles if they are to challenge a deprivation of liberty order that does not come under the jurisdiction of the LPS but a separate element of the MCA.

With all these elements considered there is reason to be optimistic that the LPS will be successful. However, what is determined to be success will be subjective and down to interpretation, but it will almost certainly provide vital improvements such as greater clarity, accessibility, inclusion and. However, whether it will be able to counter the significant backlog of DoLS orders is questionable with similar issues remaining present. Moreover, the Law Commission's influence on the incoming safeguards suggests it will most likely provide much-needed renovations of the previous legislation. There are also various other conceptual frameworks by which to judge the incoming safeguards, and this is by no means a flawless

[111] Harding [2021] page 346.
[112] *Ibid.*

and absolute model however they have provided crucial questions in order to cross-examine the legislation.

B) A New Direction for Best Interests

The primary issue with the best interests principle is the discretion left to decision-makers. Consequently, the wishes and values of individuals are often not afforded equal consideration as other elements.[113] The case law demonstrates a balancing act. Benefits and consequences are balanced and only when an account is "in significant credit"[114] can a decision be deemed in ones's best interests[115]. Lack of hierarchy between factors means some become "magnetic"[116] and swing decisions a certain way. Paradoxically, the courts appear to want to give considerable weight to patient's wishes evidenced in *Aintree*[117] where the Supreme Court stressed a focus on individual preferences. The Law Commission later confirmed its support for this. Yet, failure to do this has meant the MCA trails behind international developments.

i) DOMESTIC LAW TRAILING BEHIND?

The Convention on the Rights of Persons with Disabilities[118] (CRPD) signifies a major paradigm shift in the rights of impaired individuals.[119] Article 1 places those with disabilities on an equal standing as their abled counterparts. As opposed to treating disabled individuals as burdensome,[120] the CRPD adopts a social model framework holding that disability is symptom of an individuals' engagement with their environment[121]. Therefore, it is not a duty of individuals to abide by society's constructed norms and attitudes, rather, it is society's

[113] Mental Capacity Act 2005 Section 4.
[114] Law Commission, Mental Capacity and Deprivation of Liberty, Law Com No 372 [2017] page 157.
[115] *Re A* [2000] 1 FCR 193, 206.
[116] Law Commission [2017] page 157.
[117] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.
[118] Convention on the Rights of Persons with Disabilities [2006].
[119] Renu Barton-Hanson, 'Reforming Best Interests: The Road Towards Supported Decision-Making', Journal of Social Welfare and Family Law Vol 40 3 [2018].
[120] Genevra Richardson, 'Mental Disabilities and the Law: From Substitute to Supported Decision-Making?', Current Legal Problems Vol 65 [2012] page 351.
[121] Robert D. Dinerstein, 'Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road From Guardianship to Supported Decision-Making', Human Rights Brief Vol 19 2 [2012] page 9.

inadequacies to accommodate these individuals that needs acknowledgment[122]. It recognises the detriment social and environmental forces inflict on one's decision-making and ensures their legal capacity is maintained as is a mechanism through which they can exercise their rights. Obtaining legal capacity allows their participation in the decision-making process through which they are supported as opposed to delegating to a substituted decision-maker.

Devi at al posit this increased participation[123] produces the most appropriate decisions[124] since it upholds self-government by placing individuals at the centre of decisions. However, 'appropriate' decisions do not equal right decisions, nor does this address the potential for incapacitated individuals to regret their decision should they regain their capacity. For instance, an individual may reacquire their capacity and wish they had received more assistance from others when incapacitated to have prevented them from making a decision they come to regret.

The case of Chloe Cole in the US highlights the consequences of not adequately assisting an individual in their decision-making when not of full capacity.[125]Aged thirteen Cole was prescribed the puberty blocker Lupron and received testosterone injections to transition to a male. Aged fifteen, Cole underwent a double mastectomy to remove her breasts. However, two years later, Cole realised her desire to breastfeed and wished to detransition. She subsequently sought treatment to reverse the effects of the hormones and received breast reconstruction surgery. Now, Cole advocates against the prescription of such treatment for those too young to fully comprehend the long-term impacts should their mind change. She contends her age impacted her ability to understand the potential consequences and that she was not adequately informed by doctors.

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[122] Michael Bach and Lana Kerzner, 'A New Paradigm For Protecting Autonomy And The Right To Legal Capacity' Law Commission of Ontario [2010].
[123] Nandini Devi, Jerome Bickenbach and Gerold Stucki, 'Moving Towards Substituted Decision-Making? Article 12 of the Convention on the Rights of Persons with Disabilities', Alter Vol 5 4 [2011] pages 249-264.
[124] Gavin Davidson, Berni Kelly, Geraldine Macdonald, 'Supported Decision Making: A Review of the International Literature', International Journal of Law and Psychiatry Vol 38 (2015) pages 61-67
[125]Albert Eisenerg [2023].
https://go.gale.com/ps/i.do?id=GALE%7CA748991721&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=00280038&p=AONE&sw=w&userGroupName=anon%7E1a7c12a1&aty=open-web-entry
Accessed 1 April 2024.

Use of this case is not suggestion that obtaining transition treatment is evidence of one's incapacity. Rather, this case highlights the importance of assisting individuals without full capacity in making decisions in their long-term interests and prevent decisions that may be regrettable once full capacity is acquired. Cole's case does not indicate incapacity due to disorder, however, it does demonstrate incapacity due to age and whilst age is not necessarily indicative of *incapacity* neither is it of *full capacity*. This is proven by the fact there is an abundance of legislation that exists to protect young people from their lack of full capacity. Accordingly, it is necessary to provide those who may be mentally incapable for whatever reason, age or disorder, with the support and guidance they require to prevent them making decisions they may, once fully capable, regret.

Therefore, a balance must be struck. There is a moral obligation to act to the best interests of one another and there is an inevitability about this that conflicts with one's ability to self-govern. This is a price worth paying. It is easy to be deluded in what one wants. Desires are fickle and inconsistent, no more so than when one is incapacitated. There is also a moral duty aide the understanding of others. There must be a middle-ground between enabling individual autonomy but also having a duty to others. It is not only wrong to allow people to make harmful decisions it is an ethical duty to prevent it. The moral status of omissions is contentious, yet it can reasonably be declared that they are morally accountable when there is a norm or standard attached that requires one to act.[126] Surely, it is a reasonable norm or standard to hold that individuals retain a level of responsibility to act in the best interests of each other. 'Best interests' is contentious, yet it cannot mean to simply yield to the individuals will and preferences otherwise it would cease to exist, it must refer to an objective standard operating independent of one's subjective sense of right and wrong.

Consequently, this paper contends whilst the wishes and preferences paradigm should carry more weight, to discard of the best interest's principle entirely is not advantageous. It may

[126] Randolph Clarke, 'Omissions, Abilities, and Freedom', *Omissions: Agency, Metaphysics, and Responsibility* (New York: Oxford University Press, 2014) pages 87-104.

be more appropriate to provide a set of guiding principles and alter the terminology[127]. It is undisputable that the objective understanding of best interests is lost in the MCA, however, the solution to this is not to adopt a wills and preferences paradigm. It would be more prudent to replace the term 'best interests' with a set of guiding principles that reflect the multifaceted and complexity of decision-making.[128] The Assisted Decision-Making (Capacity) Act in Ireland, for instance, adopts eleven guiding principles for interveners to consider.[129] These adopt many of the principles in the MCA but provide guiding instructions for interveners to follow and demonstrates a more focussed and transparent criteria than to merely act in a patients 'best interests'. This however may not provide convenient use as it lacks shorthand expression and has consequently occasionally had refer to the use of the term 'benefit'[130] when instructing interveners on how to act with regards to the patient. Therefore, these guiding principles may be more instructive and considerate of other factors, but it would also require a shorthand expression. Additionally, it may be more appropriate to refer to a terminology of rights[131] which would necessitate that any action respect the rights of the individual. This would perhaps be as unclear and abstract as the best interest principle although it would at least ensure that significance consideration is given to the individuals wills and preferences.

[127] Mary Donnelly, 'Best Interests in the Mental Capacity Act: Time to say Goodbye', Medical Law Review Vol 24 3 [2016] pages 318-332.
[128] *Ibid.*
[129] Assisted Decision-Making (Capacity) Act 2015 (Ireland) s8.
[130] *Ibid* s 8 [7][e].
[131] Donnelly [2016].

CONCLUSION

In conclusion, it has been made evident through the examination of legal and medical principles as well as analysis of the current legislation on capacity that the misinterpretations of autonomy and capacity means the law is falling disastrously short.

Firstly, chapter one navigated its way through different interpretations of autonomy and capacity and their relationship. This was enabled by placing them within their medical and legal context where their significance was further maintained. It was concluded that it would be unjust to deduce a definitive explanation of both concepts due to their contested interpretations, yet for the purposes of this paper, autonomy can be understood to as self-government and capacity a tool one uses to access this. These understandings provided a sufficient basis by which to scrutinise the current capacity law, its contorted interpretations of both concepts and deficient liberty deprivation framework.

Following this, chapter two examined the shortcomings of the Mental Capacity Act and demonstrated its narrow interpretations of autonomy and incapacity. This preceded analysis of the liberty deprivation framework for incapacitated individuals and how it is prevented from fulfilling its obligation to uphold fundamental rights. It was established that in the vicennial since the legislation's passing there have been evolvements in the understandings

of autonomy and capacity and their place in decision-making that the law has simply failed to evolve with them.

Thirdly, chapter three analysed two central areas of reform and considered if they would fulfil the intended objectives. The incoming Liberty Protection Safeguards were analysed through use of Bingham's eight principles of 'good law' through which it was concluded that there remains reason to be optimistic that the incoming safeguards will be effective, however, much of this depends on how it is put into practice and whether it provides greater clarity for those responsible for its implementation. Whilst this framework provided functional questions to ask of the safeguards, it is by no means a complete model through which to assess the effectiveness of a law not yet in practice. A law can surely only be deemed 'good' if it delivers its desired purpose, which is not yet certain. Secondly, the best interest principle was analysed and juxtaposed with international conventions and understandings. Accordingly, it was concluded that the principle as it currently is affords too much discretion to the decision-maker and not enough value is given to the patient's wishes and preferences. Consequently, it lags behind international advances such as the CRPD. It was ultimately inferred that whilst more value should be placed on individual wishes and preferences, abandonment of the best interest principle is undesirable and unrealistic, and alterations rather than banishment is more appropriate.

Finally, it is concluded that autonomy is the cornerstone of the individuality and capacity is the tool one uses to access it. Autonomy upholds the integrity of the individual and so any infringement where must be necessary. This said, there must also be adequate intervention to assist those who require aide in their decision-making without accusations of paternalism. It can ultimately be said that there has been considerable ground gained in understandings of how individuals engage manoeuvre in decision-making processes, but we are not there yet.

Bibliography

2005 GBPH of LSC on the MCA, *The Mental Capacity Act 2005: Post-Legislative Scrutiny, Report of 2013-14* (Stationery Office 2014)

admin, "The Six Key Assessments for DoLS – Mental Capacity Ltd" (*Mental Capacity Ltd*, December 4, 2023) <https://mental-capacity.co.uk/six-assessments-dols-application/> accessed April 2024

Auckland C, "The Cusp of Capacity: Empowering and Protecting People in Decisions about Treatment and Care - ORA" (*Oxford University Research Archive*, January 1, 2019) <https://ora.ox.ac.uk/objects/uuid:ae83cf82-86b3-4816-a4ea-af59c67990c5> accessed April 2024

"Autonomy" (*Vocabulary.com*) <https://www.vocabulary.com/dictionary/autonomy> accessed April 2024

"Autonomy Noun - Definition, Pictures, Pronunciation and Usage Notes" (*Oxford Advanced American Dictionary at OxfordLearnersDictionaries.com*) <https://www.oxfordlearnersdictionaries.com/definition/american_english/autonomy> accessed April 2024

Bach M and Kerzner L, "A New Paradigm For Protecting Autonomy And The Right To Legal Capacity" [2010] Law Commission of Ontario

Bartlett P, "Re- thinking the Mental Capacity Act 2005: Towards the Next Generation of Law" (2022) 86 The Modern Law Review 659

Barton-Hanson R, "Reforming Best Interests: The Road towards Supported Decision-Making" (2018) 40 Journal of Social Welfare and Family Law 277

Beauchamp TL and Childress JF, *Principles of Biomedical Ethics* (Oxford University Press, USA 2001)

Bingham T, *The Rule of Law* (Penguin UK 2011)

Box GEP, “Science and Statistics” (1976) 71 Journal of the American Statistical Association 791

“Capacity Noun - Definition, Pictures, Pronunciation and Usage Notes” (*Oxford Advanced American Dictionary at OxfordLearnersDictionaries.com*) <https://www.oxfordlearnersdictionaries.com/definition/american_english/capacity> accessed April 2024

“——” (*Oxford Advanced American Dictionary at OxfordLearnersDictionaries.com*) <https://www.oxfordlearnersdictionaries.com/definition/american_english/capacity> accessed April 2024

Clarke R and Clarke RK, *Omissions: Agency, Metaphysics, and Responsibility* (Oxford University Press, USA 2014)

Coggon J, “Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?” (2007) 15 Health Care Analysis 235

Coggon J and Miola J, “AUTONOMY, LIBERTY, AND MEDICAL DECISION-MAKING” (2011) 70 The Cambridge Law Journal 523

Commission GBL, *Mental Capacity and Deprivation of Liberty* (2017)

Commons HO, *Mental Incapacity Law Commission Law Com No 231: Item 9 Of The Fourth Programme Of Law Reform. ; Mentally Incapacitated Adults* (1995)

Damasio A, *Descartes’ Error: Emotion, Reason and the Human Brain* (Random House 2008)

Davidson G and others, “Supported Decision Making: A Review of the International Literature” (2015) 38 International Journal of Law and Psychiatry 61

Devi N, Bickenbach J and Stucki G, “Moving towards Substituted or Supported Decision-Making? Article 12 of the Convention on the Rights of Persons with Disabilities” (2011) 5 Alter 249

Dinerstein R, “Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making” (2012) <https://deliverypdf.ssrn.com/delivery.php?ID=174093090115100069030070088090106027052072023065091036126127064087082096005124003086061123008063054013023106085097068105001008041010074040047002099026077117017031046064063083099005100120083119074065121003094070006031082019010005005115031100124021113&EXT=pdf&INDEX=TRUE> accessed April 2024

Donnelly M, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press 2010)

——, “Best Interests in the Mental Capacity Act: Time to Say Goodbye?” (2016) 24 Medical Law Review 318

Dworkin G, *The Theory and Practice of Autonomy* (Cambridge University Press 1988)

Eisenberg A, “The Plight Of the Detransitioners: Listen to Their Marginalized Voices. - Document - Gale Academic OneFile” (2023) 75 National Review 35

Fuller LL, *The Morality of Law* (Yale University Press 1969)

Gillon R, “Ethics Needs Principles--Four Can Encompass the Rest--and Respect for Autonomy Should Be ‘First among Equals’” (2003) 29 Journal of Medical Ethics 307

Government H, “Consultation on Proposed Changes to the Mental Capacity Act 2005 Code of Practice and Implementation of the Liberty Protection Safeguards”

Harding R, “Safeguarding Freedom? Liberty Protection Safeguards, Social Justice and the Rule of Law” (2021) 74 Current Legal Problems 329

Hart H, *The Concept of Law* (OUP Oxford 2012)

Haselton MG, Nettle D and Andrews PW, “The Evolution of Cognitive Bias” [2015] The Handbook of Evolutionary Psychology 724

Hewitt D, “Re-Considering the Mental Health Bill: The View of the Parliamentary Human Rights Committee” (2014) 1 International Journal of Mental Health and Capacity Law 57

Hotopf M, “The Assessment of Mental Capacity” (2005) 5 Clinical Medicine 580

Justice M of, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards: “Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice”* (Grangis LLC 2022)

Kant I, *Grounding for the Metaphysics of Morals: With On a Supposed Right to Lie Because of Philanthropic Concerns* (Hackett Publishing 1993)

Lidz CW, Fischer L and Arnold RM, “The Meaning of Autonomy in Long-Term Care,” *The Erosion of Autonomy in Long-Term Care* (Oxford University PressNew York, NY 1992) <http://dx.doi.org/10.1093/oso/9780195073942.003.0001> accessed April 2024

“Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2018-19” (*NHS England Digital*, 2020) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/england-2018-19> accessed April 2024

“Mental Incapacity HC 189” [1995] Law Com No 231.

Mill JS, *On Liberty and Other Essays* (Oxford University Press, USA 1991)

Richardson G, “Mental Disabilities and the Law: From Substitute to Supported Decision-Making?” (2012) 65 Current Legal Problems 333

Shah A and Heginbotham C, “Newly Introduced Deprivation of Liberty Safeguards: Anomalies and Concerns” (2010) 34 The Psychiatrist 243

Skowron P, “The Relationship between Autonomy and Adult Mental Capacity in the Law of England and Wales” (2018) 27 Medical Law Review 32

“The ‘Adjusted’ Liberty Protection Safeguards: Some Concerns - Legal Capacity Research” (*Legal Capacity Research - Researching how mental capacity law works in everyday life*, July 13, 2018) <https://legalcapacity.org.uk/everyday-decisions/the-adjusted-liberty-protection-safeguards-some-concerns/#_ftn2> accessed April 2024

Thomasma EDP and DC, “The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution” (1987) 3 Journal of Contemporary Health Law and Policy

“Understanding Pragmatic Research” <https://www.nottingham.ac.uk/helmopen/rlos/research-evidence-based-practice/designing-research/types-of-study/understanding-pragmatic-research/section02.html> accessed April 2024

“What Are Liberty Protection Safeguards?” (*SCIE*, September 23, 2023) <https://www.scie.org.uk/mca/lps/latest/> accessed April 2024

“What Is Legal Capacity? - Legal Capacity Research” (*Legal Capacity Research - Researching how mental capacity law works in everyday life*, March 29, 2017) <https://legalcapacity.org.uk/everyday-decisions/what-is-legal-capacity/> accessed April 2024

Williams V and others, “Best Interests Decisions: Professional Practices in Health and Social Care” (2013) 22 Health & Social Care in the Community 78

Wilson S, “Mental Capacity Legislation in the UK: Systematic Review of the Experiences of Adults Lacking Capacity and Their Carers” (2017) 41 BJPsych Bulletin 260

(2014) <http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf> accessed April 2024