

**CAPACITY ASSESSMENT AND DECISION-MAKING
FOR THE INCAPABLE PATIENT IN ENGLISH,
SCOTTISH AND INDIAN LAW.**

BY JAGAN MOHAN MUDIGONDA

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ABSTRACT

This PhD thesis has two core objectives:

- 1) To critically analyse and compare the legal provisions relating to capacity assessment in England and Wales, Scotland and India
- 2) To critically analyse and compare the legal provisions relating to decision-making on behalf of the incapable patient in England and Wales, Scotland and India.

The methodology utilised to achieve these objectives is essentially a classic literature based comparative approach. This thesis provides an original contribution to knowledge by virtue of the fact that an in-depth tripartite comparative study of capacity law provisions in England and Wales, Scotland and India has yet to be undertaken within existing literature. The research undertaken in this thesis is timely given the implementation of capacity legislation in England and Wales and the relevant provisions of the Mental Capacity Act 2005 of England and Wales and the Adults with Incapacity (Scotland) Act 2000 are compared and critiqued as part of a discussion of the key ethical, legal and procedural concepts which underpin the law of capacity. In addition, the capacity law of England and Scotland is compared with the equivalent system in Indian law, which is at a nascent stage of development in comparison to the United Kingdom. The fact that India, despite being an Eastern country, also retains the influence of U.K law through its status as a Commonwealth country, means that the differences between the English, Scottish and Indian approaches to capacity can be attributed to issues of culture or development. The research undertaken for this thesis has shown that developmental issues are of greater impact, and while cultural issues are of some relevance, there are enough underlying commonalities between the three jurisdictions to suggest that India's capacity law is at a different point developmentally speaking.

INTRODUCTION TO THIS THESIS

OBJECTIVES AND VIABILITY OF RESEARCH

The research which has been undertaken in this PhD thesis has two core objectives:

- 1) To critically analyse and compare the legal provisions relating to capacity assessment in England and Wales, Scotland and India.
- 2) To critically analyse and compare the legal provisions relating to decision-making on behalf of the incapable patient in England and Wales¹, Scotland and India.

The right of the individual to make their own decisions regarding medical treatment is a cornerstone principle in healthcare law. Significant developments have taken place in the law of capacity during the last twenty years confirming that the capacity to make treatment decisions is present unless this presumption can be rebutted. Following on from this, the law also recognises that for some, the ability to exercise this right to self-determination in the making of a valid decision may not be present. In most cases, the lack of decision-making capacity can be attributable to either mental disorder or impairment and it may therefore be necessary in such cases for decisions to be taken on behalf of the individual. Two crucial criteria can therefore be identified. First, it is essential that an individual's making capacity is thoroughly assessed in order to confirm that decisions have to be made on their behalf. Once this is confirmed, guidance must be in place to govern the process which must be followed by the proxy decision-maker. Following developments in the common law, both England and Wales and Scotland now have legislation which specifically governs these two core criteria. In the case of England and Wales, the Mental Capacity Act 2005 has been in force for approximately sixteen months at the time of writing, with the Scottish legislation, the Adults with Incapacity (Scotland) Act 2000, having been in force for the last six years. Given the relatively recent implementation of both U.K legislations, an exhaustive comparative analysis has yet to be undertaken. This thesis

¹ It should be noted that for the remainder of this thesis, any reference made to the law of 'England and Wales' will be abbreviated to refer to the law of 'England'. This is for the sake of brevity and narrative flow.

will engage in this analysis, examining the reasons why both jurisdictions deemed it important to introduce legislation to govern the law of capacity. Rather than remain a bipartite comparative study however, this thesis will undertake a tripartite study which includes an analysis of the law of capacity in India. It is this tripartite analysis which forms the basis of the original contribution to knowledge that is necessary in doctoral research.

This thesis will provide an original contribution to knowledge in a number of ways, which are outlined below.

- 1) In-depth comparative analysis of the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 has not yet been undertaken within existing literature. This thesis will analyse the common law developments of the law of capacity as well as the consultation process which led to the implementation of the English and Scottish capacity legislations. The relevant provisions of both legislations will also be compared and critiqued in detail. In addition, a number of key substantive and legal concepts will be identified and discussed. These concepts will form a comprehensive set of benchmarks against which the capacity law of England, Scotland and India will be measured and critiqued.
- 2) Academic analysis of the law of capacity in India is extremely limited. This thesis will critically examine the ways in which issues relating to capacity assessment and decision-making for the incapable adult are approached in Indian law and these will be compared and critiqued in a tripartite comparison with the English and Scottish law. India's status as an Eastern country raises the possibility of cultural differences existing between India and the United Kingdom. However, India is also a member of the Commonwealth with a legal system significantly modelled on that of the United Kingdom. This thesis will examine the impact of both cultural and developmental issues and discuss the extent to which both of these inform the similarities and differences between England, Scotland and India. The discussion of these issues in the context of a tripartite comparative study between England, Scotland and India has not been

embarked upon previously, meaning that this thesis will provide a much needed original contribution to knowledge.

- 3) As well as engage in a discussion of the substantive and legal principles which underpin the law of capacity, this thesis will also discuss the provision of procedural justice in relation to capacity law. To facilitate this discussion, a set of fundamental procedural principles will be detailed, again serving as benchmarks against which the procedural provisions outlined in English, Scottish and Indian law can be measured and critiqued. One of these principles, the principle of conciliation, is detailed in Chapter 2 of this thesis, and further illustrates the original contribution provided by this thesis. This principle has been developed specifically within this thesis and is the result of detailed analysis of the existing literature on procedural justice.

METHODOLOGY

This thesis utilises an exclusively doctrinal, literature based approach to doctoral research. Useful reference point for the methodology used in this thesis is provided by Professor Peter De Cruz. In his book, *Comparative Healthcare Law*, Professor De Cruz compares and contrasts various aspects of healthcare law in a number of countries, first by focusing upon the law in England and Wales and following this up by covering the equivalent issues in overseas jurisdictions. Professor De Cruz concludes by providing an overview of themes common across the jurisdictions. This thesis follows a similar process. Having first set out and analysed the ethical, legal and procedural concepts which underpin the law on capacity, this thesis will discuss the relevant common law and statutory provisions of the law of capacity in England, Scotland and India. Finally, the concluding chapter in this thesis will highlight and critique the commonalities and difference in approach between the three jurisdictions. This approach is entirely literature based, utilising existing books, journal articles, case law and statutory law. It should however be noted that during research on the Indian law, a brief and preliminary piece of empirical research was conducted in India in order to ascertain whether using India as a comparator in the research was viable. The research took the form of a short questionnaire consisting of twelve questions. Each question took the form of a case scenario, the majority of which were based on

cases that took place in England, (although three of them were not). The intention of the questionnaire was to ascertain how cases such as those that were heard in England would be dealt with in India. Respondents were asked to consider each case in turn in relation to the following issues:

- Firstly, was the respondent aware of any laws or rules that had to be followed when dealing with each case?
- Irrespective of any laws, how did the respondent think that each case would be dealt with in practice?
- Finally, was the respondent aware of any religious or cultural principles that may impact on the way in which each case would be dealt with?

This short empirical study ultimately had no significant impact upon the methodological approach utilised in this thesis. The results will not be included in this thesis due to the fact that the ineligibility of some of the returned questionnaires rendered some of them unusable. The merits of the empirical research was thus purely as a finding exercise and confirmed that India was viable as a third comparator in the research.

CHAPTER 1: SUBSTANTIVE ETHICAL PRINCIPLES

INTRODUCTION

The purpose of this chapter is to engage in a discussion of the substantive ethical principles which underpin the law relating to decision-making and the incapable patient. The principles which will be detailed in this chapter pertain specifically to the incapable adult themselves, in terms of the substantive rights which will come into play when a decision has to be made on medical treatment. It will be seen that the most important of these is the principle of autonomy, which permeates much of the law relating to capacity, particularly in the U.K. The other concepts which will be discussed, namely the principles of paternalism, communitarianism and non-discrimination, are all applicable at certain stages of the decision-making process depending on the capacity of the individual and the circumstances in which the decision is to be made. Before discussing these principles however, this chapter will engage in a brief discussion of two ethical concepts which relate to the obligations of the doctor to his/her patients, the principles of beneficence and nonmaleficence.

The principle of beneficence states that a doctor is under a positive duty to good on behalf of their patients. The principle does not merely refer to the act of feeling pity or sympathy for the patient. It extends beyond that to require acting in furtherance of others' well-being. Raanan Gillon explains:

“... it is undoubtedly true that members of the medical profession undertake to place the interests of their patients before their own in many circumstances... The source of this additional moral obligation of beneficence taken on by doctors is presumably a certain feeling of benevolence... there cannot be many who do not at least start off their medical careers with a large measure of sympathy for people afflicted by illness and a desire to commit their working lives to helping them”²

The duty to act in furtherance of the patient's well-being falls into the category of specific beneficence. Specific beneficence refers to positive acts directed at those with

² Gillon, R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester at 73-74.

whom a proximity of relationship exists³, be this friends, children, parents or patients. This can be contrasted with general beneficence, which refers to positive acts directed to those with whom no proximity of relationship exists, i.e. helping a passer-by in the street.

The obligation of the doctor to act beneficently towards his patient relates strongly to the obligation of the doctor to respect the patient's autonomy. If a doctor is faced with a situation where a patient is refusing life-saving treatment, does this mean that the doctor is obliged to do whatever is necessary to get the patient to have the treatment in order to preserve his life? Given that the primary purpose of the medical profession is to preserve health and life, one might be forgiven for thinking that the answer would be yes. In reality however, the duty to act beneficently is arguably as much about respecting the decision of the patient as much as it is about administering treatment. Gillon argues that a doctor is failing to act beneficently if he/she fails to respect a patient's decision regarding treatment, even if, in the eyes of the doctor, it is the 'wrong' decision:

“In most cases... of a doctor's dealings with patients, not only is there an independent moral presumption that he must respect their autonomy, but, even if he is interested only in doing them good, he must generally respect their autonomy in order to do so.”⁴

If the obligations of the doctor are thought of entirely in terms of administering treatment to patients who are suffering with a serious, non-serious or life threatening illness, then the principle of beneficence may be seen to conflict with the need to respect a patient's decision to refuse treatment; if acting beneficently entails acting positively in furtherance of the patient's well-being, then adhering to a patient's

³ see the American case of *McFall v Shimp* [1978] 127 Pitts Leg J 14, which concerned the defendant's refusal to donate bone marrow to his cousin, with the plaintiff arguing that his cousin was under a moral duty to donate and should thus be compelled to. The plaintiff lost the case and the court held that there was no legal obligation to act beneficently even to someone with whom proximity of relationship exists. However, the court also stated that from an ethical perspective, the refusal of the defendant to donate his bone marrow was hard to defend. The case thus illustrates the moral duty of an individual to act beneficently towards those with whom proximity of relationship is present.

⁴ Gillon, R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester at 75. See also, Doyal, L and Sheather, J (2005) *Mental Health Legislation Should Respect Decision-Making Capacity*; British Medical Journal; Vol.331; 1467-1469 at 1467, where the authors state that **“it is both legally and professionally unacceptable for doctors to force treatment on competent patients because they think it is in their best interests.”**

refusal could be deemed to violate the principle of beneficence. Not so according to Gillon, who submits that it is possible to harmonise the principles of beneficence and respect for patient autonomy by the doctor simply ascertaining what the patient wants, as opposed to assuming what this may be. In doing so, Gillon asserts that the patient **“is more likely to do what the doctor considers to be medically optimal if the doctor explains why the patient’s own preference is less likely to be beneficial.”**⁵ Ascertaining the wishes and feelings of the individual has now become one of the important duties of the doctor under both the Mental Capacity Act 2005⁶ and the Adults with Incapacity (Scotland) Act 2000⁷. However, ascertaining the wishes and feelings of the patient will not always be the same as acceding to patient demands on every occasion. Respecting a patient’s refusal of treatment will satisfy the principle of beneficence provided that the patient has the capacity to make the decision. If capacity is present, the patient’s wishes must be respected and having this wish overridden by the doctor on the basis that he/she feels it to be the wrong decision fails to respect the principle of autonomy, and thus fails the principle of beneficence when the principle is interpreted in a wider sense to go beyond mere physical well-being.

In addition to the duty to act positively in furtherance of the patient’s well-being, the doctor also has a duty not to commit harm to the patient. This obligation is referred to as the principle of nonmaleficence, and should be considered in tandem with the principle of beneficence. Rather than involve an obligation to act positively, nonmaleficence involves an obligation not to act negatively. The Hippocratic Oath puts both principles side by side: **“I will prescribe regimen for the good of my patients according to my ability and my judgment, and never do harm to anyone.”** In this way, it could be argued that both beneficence and nonmaleficence have been combined into a single moral obligation; safeguarding the welfare of patients ultimately entails both acting positively and not doing harm to the patient. Raanan Gillon however, argues that prioritising nonmaleficence over beneficence is implausible; the former simply has a greater area of applicability than the latter:

“While it seems entirely plausible to claim that we owe nonmaleficence, but not beneficence, to everybody, it does not follow from this that avoidance of

⁵ Ibid.

⁶ s.4(6).

⁷ s.1(4).

doing harm takes priority over beneficence. All that follows is that the scope of nonmaleficence is general, encompassing all other people, whereas the scope of beneficence is more specific, applying only to some people. Thus we can accept that each of us... has a moral duty not to harm anybody else without being committed to believing that this prima facie duty must always take priority if it conflicts with any duty...’’⁸

In the above quote, Gillon states that the duty of nonmaleficence takes priority over other duties vis a vis the patient. It is submitted that in the context of treating the patient, both beneficence and nonmaleficence are in essence two sides of the same argument. If a patient has full capacity to refuse any proposed treatment, a doctor is furthering the patient’s interests by respecting this decision. By the same token, it can be argued that overriding the wishes of a capable patient is actually causing harm to the patient; although the patient may ostensibly recover physically, the fact that their express wishes were ignored will be of little emotional benefit to the patient⁹. Gillon states that the people’s perceptions of harm are idiosyncratic, and are integral to the way that the individual lives their life¹⁰. In the English case of *Re C (Adult: Refusal of Medical Treatment)*¹¹, a sufferer of paranoid schizophrenia required an amputation of a gangrenous leg, or risk a high probability of death. C was found to have had the requisite capacity to refuse the treatment despite his illness, and this decision was thus respected. On a simplistic level, it could be argued that overriding the patient’s will and performing the operation would have been a beneficent act which would also have prevented a great harm i.e. the potential death of the patient. However, in the light of the importance of the principle of autonomy (which will be discussed later in this chapter), the concept of harm, as Gillon stated, should not be considered merely in terms of treatment and cure, but rather, in terms of respect for the patient. Failure to respect a patient’s wishes, provided that they have the capacity to make that decision, is arguably to cause harm to the patient. Similarly, a doctor deciding to accept the

⁸ Gillon, R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester at 81; see also Gifford, R W (1977) *Primum Non Nocere*; Journal of the American Medical Association, Vol 238(7), 589-590 at 589.

⁹ See O’Neill, O (2001) *Autonomy and Trust in Bioethics: The Gifford Lectures*; Cambridge University Press, at 35.

¹⁰ *Ibid* at 83-84.

¹¹ [1994] 1 All E.R 819.

decision of a patient who does not have the capacity to make such a decision will not be acting positively for the patient, nor will he/she prevent harm to the patient¹²

The principles of beneficence and nonmaleficence do not relate to the obligations or the rights of the patient but rather, to what the doctor is expected to offer the patient. How this is done will depend upon the capacity of the patient; if capacity is present, the principle of autonomy is of highest importance and the doctors obligations regarding beneficence and nonmaleficence will centre around respecting this right. If however, a patient lacks the capacity to make a treatment decision, the obligations of beneficence and nonmaleficence will centre round the doctor acting more paternalistically in the best interests of the individual, whilst also ensuring that harm does not come to the patient as a result of invalid treatment decisions.

The substantive principles which will be discussed below underpin the law of capacity and, as will be seen in later chapters, form an integral part of both the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000. These substantive principles are given greater weight by virtue of the fact that they have been endorsed by both the United Nations and the Council of Europe.

The United Nations Convention on the Rights of Persons with Disabilities 2006 was devised in order to **“promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.”**¹³ It essentially updates the principles laid down in the 1971 U.N Declaration on the Rights of Mentally Retarded Persons and the 1975 U.N Declaration on the Rights of Disabled Persons. Article 3 of the Convention contains the following general principles:

- “(a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;**
- (b) Non-discrimination;**
- (c) Full and effective participation and inclusion in society;**

¹² See *Re MB (Medical Treatment)* [1997] 38 B.M.L.R 175, the facts of which will be discussed in Chapter 3.1 of this thesis.

¹³ U.N Convention on the Rights of Persons with Disabilities 2006, Article 1.

- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;**
- (e) Equality of opportunity;**
- (f) Accessibility;**
- (g) Equality between men and women;**
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.”**

Of particular relevance in the above principles are the references to individual autonomy (principle (a)) and non-discrimination (principle (b)), both of which are cornerstone principles and will be discussed below.

In addition to the United Nations, the Council of Europe has published a number of documents which provide international guidance on issues pertaining to protection of incapable individuals. The 1997 European Convention on Human Rights and Biomedicine emphasises the primacy of the individual¹⁴ and guarantees everyone **“without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.”**¹⁵ In addition, Article 6 of the Convention states that any interventions in the health field may only be carried out for the direct benefit of the incapable individual if they are unable to consent to the proposed course of treatment.

In 1999, the Council of Europe formulated Recommendation (99)4, which concerned the legal protection of incapable adults. Sjaak Jensen explains why such an international instrument was necessary in this area of the law:

“The second half of the twentieth century has seen a greatly increased emphasis on human rights. There is a clear recognition that existing freedoms and capacities of incapable people should be preserved as much as possible and that those measures which needlessly take away people’s rights are indefensible. And no less important, there is also a much greater emphasis on personal welfare as opposed to the preservation of property. Measures of protection are nowadays often taken in order to protect and to

¹⁴ Council of Europe (1997) *European Convention on Human Rights and Biomedicine* at Article 2

¹⁵ *Ibid* at Article 1.

promote some or all of the personal affairs of the person concerned, an example being decisions taken in the medical field.”¹⁶

It can be seen that the Council of Europe was particularly mindful of the human rights issues surrounding vulnerable adults. As will be discussed below, an important aspect of human rights for an incapable adult is the endorsement of an approach that empowers the individual as much as is practicable.

Recommendation (99)4 first outlines the scope of its application. Unlike many member states, the Council of Europe stated that an ‘adult’ for the purposes of the instrument would be anybody who had attained the age of eighteen years. (99)4 would apply to any individual who is unable to make any personal or economic decisions by virtue of **“an impairment or insufficiency of their personal faculties.”¹⁷** The phrase ‘personal faculties’ could be interpreted as being comparable to the definition of incapacity as contained in s.2(1) of the English Mental Capacity Act 2005, which states that incapacity must be caused by an impairment of or a disturbance in the functioning of the mind or brain. According to (99)4, such incapacity may be caused by mental disability, disease or similar medical conditions¹⁸. This clarifies the definition of ‘personal faculties’ to some extent, by linking it to medical conditions.

Part II of Recommendation (99)4 lists ten governing principles which member states would be required to incorporate into capacity legislation. The list is useful as a yardstick against which England and Scotland’s capacity law can be compared. The governing principles of (99)4 can be summarised as follows:

Principle 1: Respect for human rights – This is arguably the most important and significant of the governing principles. The Council of Europe strongly emphasise the need to respect the dignity of each individual as a human being in his/her own right, and that all procedural aspects of the law in member states must promote the dignity of the individual.

Principle 2: Flexibility in legal response – The manner in which member states protect the interests of the individual must be sufficiently flexible to allow a legal response to be made in various situations and concerning individuals with varying

¹⁶ Jansen, S (2000) *Recommendation No. R (99)4 of the Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults: An Introduction in Particular to Part V Interventions in the Health Field*; *European Journal of Health Law* Vol. 7: 333-347 at 334.

¹⁷ Council of Europe (1999): *Recommendation No. R (99)4 of the Committee of Ministers to Member States on Principles Concerning the Legal protection of incapable adults*; s.1(1).

¹⁸ *Ibid* at s.1(2).

degrees of incapacity. There should also be adequate procedures in place to pursue legal action in emergency cases, and legal protection should be simple and affordable. Individuals wishing to rely upon legal protection should not find their legal capacity restricted, whilst the legal protection available should include those which are limited to a specific act, albeit without the need to appoint a representative with continuing powers. Finally, consideration should be given to the need to provide for and regulate legal arrangements for capable individuals wishing to make provisions for future incapacity.

Principle 3: Maximum preservation of capacity – Any legislative framework must take into consideration the varying degrees of incapacity that might exist in different individuals, and also that incapacity might fluctuate. Therefore, any legal protection provided must not assume incapacity across the board in any given individual, and any restriction on an individual's rights must only be done for the protection of the individual.

Principle 4: Publicity – Any disadvantage of publicising measures of legal protection must be weighed up against the level of protection that such publicity would afford to the individual.

Principle 5: Necessity and Subsidiarity – The principle of necessity states that no measure of protection must be initiated until it is deemed to be necessary. In doing this, account must be taken of the specific circumstances of the individual in each case.

The principle of subsidiarity states that any measures of protection must take into account any less formal procedures which may be possible in order to protect the individual e.g. care provided by family members.

Principle 6: Proportionality – Any measures of protection must be proportionate to the level of incapacity of the individual in question, and consideration must be given to any specific circumstances which may influence the manner in which this protection is given. Any interference with the legal capacity of the individual must be kept to a minimum.

Principle 7: Procedural fairness and efficiency – A fair procedural system must be in place alongside for the protection of incapable adults, as well as a system of procedural safeguards of the protection of the individual's human rights.

Principle 8: Paramountcy of interests and welfare of the person concerned – In all measures of protection the welfare of the individual must be kept as a paramount

concern at all times. Any potential representative of an incapable individual must be judged on their ability to safeguard the welfare and interests of the individual.

Principle 9: Respect for wishes and feelings of the person concerned – Throughout any measures of protection which have been put in place, the past and present wishes and feelings of the individual must be considered as much as is practicable.

Principle 10: Consultation – When a measure of protection has been implemented, those having a close interest in the welfare of the individual must be consulted so far as this is reasonable and practicable. The individuals who are suitable for this duty will be determined by the law of the respective member state.

As can be seen, a clear endorsement of the principle of autonomy is prevalent throughout principles 1-10. The human rights of the individual have been emphasised from the outset, in particular, the right to be recognised as an individual. Part of this process necessitates respect for the individual's decision. The presumption of capacity in principle 4 is also an explicit endorsement of the principle of autonomy, as the Council of Europe have specified that the individual must not be assumed to be incapable simply by virtue of suffering from a mental illness or impairment¹⁹. Here, the emphasis has been placed on allowing the individual to make decisions for themselves, presumably unless a thorough assessment shows this to be impractical. Principle 9 is arguably the strongest endorsement of the autonomy principle, as it emphasises the need to respect the wishes and feelings of the person concerned. Although the principles contained within Recommendation (99)4 ostensibly deal with the correct way to initiate and carry through measures of protection on behalf of incapable adults, the Council of Europe have made it clear that the commencement of any such measure of protection does not mean that the individual's wishes, feelings and decisions are to become of secondary importance²⁰.

In addition to Recommendation (99)4, European endorsement of the relevant ethical principles is also contained within a number of articles of the European Convention on Human Rights.

¹⁹ The presumption of an individual's capacity has been explicitly stated in the Mental Capacity Act 2005, s.1(2). See Chapter 3 of this thesis.

²⁰ The importance of the individual's wishes and decisions has been emphasised in both the Mental Capacity Act 2005 s.4(6) and the Adult's with Incapacity (Scotland) Act 2000 s.1(4). See Chapters 3 and 4 of this thesis.

Article 2(1) of the Convention pertains to the right to life and states that **“No-one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law”**. Exceptions to this are; in defence from unlawful violence, in order to effect lawful arrest or prevent escape of those lawfully detained and for the purpose of preventing riot or other acts of insurrection.

Article 2 provides protection against various issues relating to the life and death of prisoners and abortion. More relevant to this thesis however, the scope of Article 2 extends to issues of end-of-life issues and the refusal of life-saving treatment. The case of *Pretty v United Kingdom*²¹ provides guidance on this issue. Dianne Pretty was a sufferer of motor neurone disease who wrote to the Department of Public Prosecutions requesting that her husband be lawfully permitted to assist in her suicide without risk of prosecution. When this request was denied, Mrs Pretty applied to the European Court of Human Rights claiming, amongst other things, that there had been a violation of Article 2 of the E.C.H.R. She argued that since Article 2 guaranteed the right to life, as opposed to simply life itself, this implied that the individual had the right not to continue living if so they wished²². Put another way, the individual had the right to commit suicide and assisting in this should not be considered a criminal act. The court however disagreed with this and held that Mrs Pretty’s argument was based upon misconstruction of the law:

“The law confers no right commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged... While the 1961 [Suicide] Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide, as section 2(1)²³ makes clear.”²⁴

²¹ [2002] 35 E.H.R.R 1.

²² Ibid at Para 35. See also Sanderson, M A (2002) *Pretty v United Kingdom*; American Journal of International Law; Vol. 96(4), 943-949 at 943.

²³ Suicide Act 1961, s.2(1): **“A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.”**

²⁴ *Pretty v United Kingdom* [2002] 35 E.H.R.R 1 at Para 35.

It can be seen that Article 2 of the European Convention on Human Rights does not confer upon the individual a right to take their own lives aided by another. However, this must be distinguished from a situation whereby treatment is refused or discontinued in order to prevent a life being unduly prolonged. Mathieu explains:

“Undue prolongation of life can be defined as the administration of treatment that is manifestly disproportionate to its expected therapeutic impact. This occurs where medical apparatus entirely replaces the natural functioning of human organs, or where life is prolonged without any medical treatment to prevent an inevitable progression towards death.”²⁵

As will be discussed in Chapter 4 of this thesis, the right not to prolong life unnecessarily without breaching Article 2 has been confirmed by the U.K law. It was held in *Airedale NHS Trust v Bland*²⁶ that doctors were not obliged to continue life prolonging treatment for patients in a persistent vegetative state when the chances of recovery were effectively nil. It could be argued that the differences between a case such as Bland and one such as that of Dianne Pretty are negligible; the latter was not going to recover from her condition, and it was her fear of an undignified and painful death that triggered her application to the European Court of Human Rights. However, Mrs Pretty also advanced the argument that she was discriminated against because her condition meant that she could not end her life without assistance, whereas those of full health could end their own lives if they wished. However, Mathieu dismisses this argument. He states that those who are physically capable of committing suicide do not have their right to do so enshrined in Article 2, but rather, the act of committing suicide is tolerated because of the individual’s right to exercise their autonomy²⁷. This is perhaps an overstatement; it is submitted that the decriminalisation of suicide is less about promotion of autonomy and more about avoiding the stigma and complications that may arise from criminalising it. This is illustrated by the case of Daniel James who, in 2008 with the aid of his parents, ended his life in Swiss assisted suicide clinic Dignitas following a rugby accident which left him paralysed. The Director of Public Prosecutions stated that although charges against Daniel James’s parents had been considered for the part they had played in their son’s death, no further action would be taken:

²⁵ Mathieu, B (2006) *The Right to Life*; Council of Europe Publishing Strasbourg at 76.

²⁶ [1993] 1 A.C 789. See Chapter 4.1.1 of this thesis at 136 for discussion of this case.

²⁷ Mathieu, B (2006) *The Right to Life*; Council of Europe Publishing Strasbourg at 77.

“This is a tragic case involving as it does the death of a young man in difficult and unique circumstances. While there are public interest factors in favour of prosecution, not least of which is the seriousness of this offence... these are outweighed by the public interest factors that say that a prosecution is not needed. In reaching my decision I have given careful consideration to the Code for Crown Prosecutors. In particular, but not exclusively, I would point to the fact that Daniel, as a fiercely independent young man, was not influenced by his parents to take his own life and the evidence indicates he did so despite their imploring him not to.”²⁸

Article 3 of the Convention states that: **“No individual shall be subjected to inhuman or degrading treatment or punishment.”** Although Article 3 is specifically aimed at the prevention of torture, it may ostensibly be invoked in relation to medical treatment. Elizabeth Wicks suggests that the provision of medical treatment without valid consent could constitute degrading treatment and thus potentially be a violation of Article 3:

“The lowest form of prohibited treatment i.e. that which is degrading – may be of relevance to the imposition of medical treatment without consent. It has been defined in the following terms: ‘Treatment or punishment of an individual may be said to be degrading if it grossly humiliates him before others or drives him to act against his will or conscience’.²⁹ This emphasis on the humiliation caused by the treatment is consistent with an ordinary dictionary meaning of degrading treatment. The key to prohibited treatment under Article 3, therefore, appears to be the concept of human dignity rather than individual self-determination or autonomy... The right and ability to make a free choice as regards what is done to one’s body is a fundamental aspect of the dignity of a human being.”³⁰

²⁸ Director of Public Prosecutions Statement (09/12/2008) *No Charges Following Death by Suicide of Daniel James*; accessed on 17/04/09; available online at http://www.cps.gov.uk/news/press_releases/179_08/index.html. See also *R (On the Application of Purdy) v Director of Public Prosecutions* [2009] E.W.C.A Civ 92.

²⁹ See *Denmark, Norway, Sweden and the Netherlands v Greece* [1969] 12 Y.B. 1 at 186.

³⁰ Wicks, E (2001) *The Right to Refuse Medical Treatment Under the European Convention on Human Rights*; *Medical Law Review*; Vol. 9(1), 17-40 at 21-22.

It was held in *Herczegfalvy v Austria*³¹, which concerned the forced feeding and restraint of a mentally ill patient, that measures which are deemed a therapeutic necessity cannot be a violation of Article 3, although the necessity must be appropriately proven³². Any treatment carried out for therapeutic reasons without consent will only invoke Article 3 if a minimum level of severity is proven. *Kudla v Poland*³³ states that in order to invoke Article 3, any suffering involved **“must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment.”**³⁴ Many therapeutic procedures may ostensibly involve some degree of discomfort, and this would not be sufficient to come under the scope of Article 3. The issue is whether the discomfort or suffering involved is so disproportionate so as to be classed as inhuman or degrading. Bartlett, Lewis and Thorold also refer to the court’s judgment in *Herczegfalvy*, in which reference was made to preserving the physical and mental health of patients who are **“entirely incapable of deciding for themselves”**³⁵. They further submit that on this interpretation, Article 3 may, prima facie, not be invoked in the context of capable adults who simply choose to refuse treatment. However, this is in itself a potentially complex issue, given that involuntary medical treatment may be carried out on capable individuals in exceptional circumstances, e.g. emergencies and when the patient poses a danger to themselves or others: **“If the essence of this apparent violation is intrusive treatment over the objection of the competent person, it is at best questionable whether these exceptions would be allowed under Article 3.”**³⁶

Article 8(1) states that: **“Everyone has the right to respect for his private and family life, his home and his correspondence”**. Wicks states that the right to a private life should be distinguished from the right to privacy: **“A right to ‘privacy’ suggests the protection of confidential information; a right to a ‘private life’ suggests the freedom to live life as one chooses.”**³⁷ Wicks interprets this right in the

³¹ [1993] 15 E.H.R.R. 437.

³² *Ibid* at Para 82.

³³ [2002] 35 E.H.R.R. 11.

³⁴ *Ibid* at Para 92.

³⁵ *Herczegfalvy v Austria* [1992] 15 E.H.R.R. 437 at Para 82.

³⁶ Bartlett, P, Lewis, O and Thorold, O (2006) *Mental Disability and the European Convention on Human Rights*; Martinus Nijhoff Publications, Leiden and Boston at 127.

³⁷ Wicks, E (2001) *The Right to Refuse Medical Treatment Under the European Convention on Human Rights*; *Medical Law Review*; Vol. 9(1), 17-40 at 26.

context of medical treatment, stating that Article 8 in essence grants the right to make one's own decisions. However, Article 8(2) allows exceptions **“in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”**.

The European Court of Human Rights has held that Article 8 can theoretically be invoked in relation to any compulsory medical treatment, whether the individual in question has capacity or lacks it, since the concept of 'private life' would cover the **“physical and psychological integrity of a person.”**³⁸ The relevant question would therefore be whether an infringement would be justified under Article 8(2). The court held in *Y.F v Turkey* that interference with a person's physical integrity should be prescribed by law with the consent of the individual³⁹. However, as Bartlett, Lewis and Thorold point out, this statement would presuppose that the individual had the requisite capacity to consent in the first place. The question then remains as to the situation for incapable individuals.

Guidance on this point is provided by the Council of Europe's Recommendation (2004)10 which concerns the protection of the human rights and dignity of persons with mental disorder. Article 12(2) of the Recommendation states that:

“...treatment may only be provided to a person with mental disorder with his/her consent if he/she has the capacity to give such consent, or, when the person does not have the capacity to consent, with the authorisation of a representative, authority, person or body provided for by law.”

It will be seen in subsequent chapters of this thesis that the capacity legislations of England and Scotland both contain provisions allowing for persons to be appointed as representatives for the incapable individual, who may be consulted in the event of treatment being needed. Bartlett, Lewis and Thorold highlight potential complications with respect to Article 8 if the representatives who have been appointed are family members; Given that Article 8 involves respect for both family and private life, conflict may occur if the individual does not wish their family to become involved in their private affairs vis a vis medical and welfare decisions. However, the authors also highlight the fact that under E.C.H.R law, an application to the court may be made in

³⁸ See *Y.F v Turkey* [2004] 39 E.H.R.R 34.

³⁹ *Ibid* at Para 43.

order to have the designated nearest relative replaced⁴⁰, meaning that the individual has their needs met without having their right to private life infringed under Article 8.

Article 9(1) of the European Convention on Human Rights pertains to the right to freedom of thought and religion and reads as follows:

“1) Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.”

In terms of medical treatment decisions, Wicks argues that Article 9 becomes relevant when medical treatment is refused on the basis of religious beliefs⁴¹. Under Article 9, treatment may be refused on religious grounds even if doing so will result in death or deterioration of health. Any doctor who overrides such a decision because they themselves are not of the same faith as the patient, will be deemed to have violated Article 9. To illustrate this point, Wicks refers to *Re T (Adult: Refusal of Medical Treatment)*⁴² which concerned the refusal of a blood transfusion by a patient whose mother was a Jehovah’s Witness. The court held in that case that the patient’s refusal of the transfusion was invalid because she had been unduly influenced by her mother. Crucial to the decision was the fact that T herself was not a Jehovah’s Witness. Had she been of the faith herself, it is entirely possible that her decision would have been valid. Wicks explains the decision of the case in relation to Article 9:

“In respect of Article 9, the significant point in *Re T* is that T did not regard herself as a Jehovah’s Witness. It seems doubtful therefore, that her refusal of a blood transfusion was a manifestation of her religion. What *Re T* demonstrates most clearly in respect of religious-based refusals of treatment is that the belief is rarely shared by other people concerned: in this case, the medical staff and most of the patient’s family. A refusal of treatment based on religion may appear irrational to others (indeed, any religious belief may be irrational to non-believers) and, although it has been clearly stated that

⁴⁰ Bartlett, P, Lewis, O and Thorold, O (2006) *Mental Disability and the European Convention on Human Rights*; Martinus Nijhoff Publications, Leiden and Boston at 133. See also *JT v United Kingdom* [2000] 1 F.L.R 909.

⁴¹ *Ibid* at 30.

⁴² [1992] 4 All E.R 649.

this will not vitiate a refusal of consent, it may cause a reluctance to accept the decision by others.”⁴³

Although Article 9 appears to be most relevant to medical decisions made on religious grounds, it can ostensibly be invoked in relation to any system of belief. It is submitted that the reference made in Article 9(1) to ‘freedom of thought’ in effect pertains to any beliefs that may extend beyond religion, which, as discussed above, has specifically been accounted for in Article 9(1). As an illustration of this, consider the principle of communitarianism as discussed in Chapter 1 of this thesis. Let us say for the sake of argument that an individual is part of a family with a long held tradition of deferring important medical treatment decisions to the elders in the family. Upon requiring a medical treatment, the individual tells the doctor that he has decided to allow his father to make the decision, as he has complete faith in his father’s ability to make decisions in his best interests. Provided that there is no evidence to suggest that the individual has been coerced or manipulated into giving this statement, the individual could argue that the act of deferring decisions to other family members is a manifestation of belief which is protected under Article 9(1). This would therefore be of potential relevance to persons of Indian origin living in the United Kingdom, who may be used to a communitarian approach to decision-making. Article 9 and the notion of freedom of thought was another issue raised in *Pretty v United Kingdom*. Mrs Pretty argued that her desire to commit suicide came under the cope of Article 9 and her husband should therefore not be prosecuted for assisting her in exercising her freedom of thought⁴⁴. The Government rejected this argument stating that **“Article 9... did not confer any general right on individuals to engage in any activities of their choosing in pursuance of whatever beliefs they may hold.”⁴⁵** The Court agreed with this viewpoint and held that Article 9 had not been breached. Dianne Pretty’s case therefore illustrates that Article 9 guarantees the right to hold a particular belief, but it does not follow from this that one will always be permitted to actually carry out their beliefs in all circumstances, particularly when in relation to highly contentious issues such as suicide.

⁴³ Wicks, E (2001) *The Right to Refuse Medical Treatment Under the European Convention on Human Rights*; Medical Law Review; Vol. 9(1), 17-40 at 32.

⁴⁴ *Pretty v United Kingdom* [2002] 35 E.H.R.R 1 at Para 80.

⁴⁵ *Ibid.*

The documents which were formulated by the United Nations and The Council of Europe highlight a number of important principles which will be drawn out and discussed below. The central message is clear: unless one is sure that an individual is incapable of making a particular decision or performing a particular action, the autonomy of the individual is paramount. In the light of this, discussion on the substantive ethical principles which underpin the law of capacity will begin with the most important principle of all: the principle of autonomy.

1.1: THE PRINCIPLE OF AUTONOMY

The principle of autonomy can be defined as follows: **“...the capacity to think, decide and act on the basis of such thought and decision freely and independently and without, as it says in the British passport, let or hindrance.”**⁴⁶

It is synonymous with the notion of respect for the person, which John Harris states as being **“the fundamental basis of any ethics involving human beings.”**⁴⁷ As an ethical concept, particularly in the light of changes made to the law within the United Kingdom, autonomy is inseparable from any discussion relating to capacity. The principle of autonomy necessitates treating people as individuals and as ends within themselves, rather than simply as a means to an end for another individual. This was summed up by Justice Cardozo in the American case of *Schloendorff v New York Hospital*:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault.”⁴⁸

One of the leading proponents of the principle of respect for Autonomy was John Stuart Mill, who wrote extensively on the subject in his seminal work *On Liberty*. Mill argued that every human being must be treated as an individual in their own right, which includes the right to **“form opinions, and to express their opinions without reserve.”**⁴⁹ More importantly, Mill stated that individuals should be allowed

⁴⁶ Gillon, R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester at 60

⁴⁷ Harris, J (2003) *Consent and End of Life Decisions*; Journal of Medical Ethics, Vol. 29, 10-15 at 10.

⁴⁸ [1914] 211 N.T 125 per Cardozo J at 126.

⁴⁹ Mill, J S (1859) *On Liberty and Other Essays*; Oxford University Press at 62.

to live their lives and make decisions as they see fit, but with one proviso – any opinions and actions should not in any way result in harm to others:

“No one pretends that actions should be as free as opinions... even opinions lose their immunity, when the circumstances in which they are expressed are such as to constitute their expression a positive instigation to some mischievous act... Acts of whatever kind, which, without justifiable cause, do harm to others, may be, and in more important cases absolutely require to be, controlled by the unfavourable sentiments, and, when needful, by the active interference of mankind.”⁵⁰

To put Mill’s assertions into a medical context, the self-protective principle would ethically permit individuals to make their own decisions regarding medical treatment, and to have their own opinions regarding what they feel would be best for them in the circumstances. Gillon further states that in the context of medical treatment, there are essentially three forms of autonomy: Autonomy of thought (**“thinking for oneself... making decisions, believing things... aesthetic preference, making moral assessments.”**⁵¹); Autonomy of will (**“the freedom to decide to do things on the basis of one’s deliberations.”**⁵²); and Autonomy of action (**“Specific actions may be autonomous even though they are not the immediate or direct results of a thought process.”**⁵³) All three of these sub-categories relate directly to capacity and decisions on medical treatment. Autonomy of action has a particular resonance with English capacity law, in as much as Lord Donaldson specified in *Re T (Adult: Refusal of Medical Treatment)*⁵⁴ that an individual has the right to decide whether to accept or refuse medical treatment, and need not provide a rational reason or even a reason at all⁵⁵. Provided that the individual has the requisite capacity to make a particular decision, the reasons and the decision itself must be respected.

Autonomy of thought can be considered in terms of both positive and negative obligation. With regards to positive obligations, it is the moral duty of the relevant healthcare professional to foster an environment of autonomy in the workplace, by giving their patients as much information as possible about any proposed treatment,

⁵⁰ Ibid.

⁵¹ Gillon R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester at 61.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ [1992] 4 All E.R 649.

⁵⁵ per Donaldson MR at 663.

and letting the patient know that the ultimate decision as to whether to accept or refuse treatment is theirs, provided that they have the requisite capacity. Beauchamp and Childress state that healthcare professionals would successfully promote the autonomy of the individual by actually probing for understanding from the patient⁵⁶, thereby ensuring that the decision the patient gives is in fact fully autonomous. This necessitates a thorough assessment of the individual's capacity and ergo, an assessment of whether the individual is capable of exercising their right to autonomy.

Developments in the law of capacity have provided assessment criteria for determining whether the individual is autonomous to the level which is required for making treatment decisions. Grisso and Appelbaum have provided arguably the most authoritative criteria through their MacArthur project⁵⁷. Four core criteria are identified for determining an individual's decision-making capacity: The individual must be able to communicate a choice, understand relevant treatment information, appreciate the nature of the situation and its likely consequences and be able to manipulate the information given in a rational manner⁵⁸. It will be seen in Chapter 2 that these criteria have been adapted to a great extent into the law of capacity in England⁵⁹. Through their work on decision-making ability, Grisso and Appelbaum have identified that it is essential for individuals to be assessed properly without their incapacity being simply assumed. Incapacity in one sphere of life does not necessarily equate to incapacity in another and the assessment criteria proposed by Grisso and

⁵⁶ Beauchamp T L and Childress J F (2009) *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 104.

⁵⁷ See Cairns, R et al (2005) *Reliability of Mental Capacity Assessments in Psychiatric In-patients*; British Journal of Psychiatry, Vol. 187, 372-378 and Kitamura, F et al (1998) *Method for Assessment of Competency to Consent in the Mentally Ill*; *International Journal of Law and Psychiatry*, Vol. 21(3), 223-224. Both articles highlight the importance of Grisso and Appelbaum's work in competency assessment.

⁵⁸ Grisso, T and Appelbaum, P (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2); 105-126. For further information on the work of Grisso and Appelbaum in the field of capacity assessment, see also; Grisso, T, Appelbaum, P.S, Mulvey, E.P and Fletcher, K (1995) *MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment*; Law and Human Behaviour, Vol. 19(2), 127-146; Grisso, T and Appelbaum, P.S (1995) *MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*; Law and Human Behaviour, Vol. 19(2), 149-174; Grisso, T and Appelbaum P (1995) *Comparison of Standards for Assessing Patient's Capacities to Make Treatment Decisions*; American Journal of Psychiatry; Vol. 152(7), 1033-1037; Appelbaum, P.S and Roth, L H (1982) *Competency to Consent to Research*; Archives of General Psychiatry, Vol. 39, 951-958.

⁵⁹ See *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All E.R 819; *Re MB (Medical Treatment)* [1997] 38 B.M.L.R 175.

Appelbaum takes into account the various issues surrounding a treatment decision. As they explain:

“After the middle of the twentieth century, the assumption that people with mental illness were uniformly deficient in decision-making abilities and should be legally incompetent began to be called into question. Advocates argued that persons with mental illness... often suffered selective impairment of decision-making abilities or none at all, with retention of competence for many purposes. It was unfair therefore, to deprive them of decision-making rights, especially about treatment, without an individualised determination of their residual capacities.”⁶⁰

Alisdair Maclean identifies three criteria for determining decision-making competence:

“1. They must hold beliefs supported by evidence that is acceptable to a responsible body of persons who share the required expertise to evaluate the evidence.

2. They must be capable of making some, but not necessarily all, of the sound inferences appropriate to their beliefs.

3. Any decision must be based on the patient’s acceptable belief set and will necessarily involve balancing social, emotional, spiritual and economic concerns with any physical effects that may follow from their decisions.”⁶¹

Certain aspects of Maclean’s exposition of the assessment criteria are logical enough; Maclean’s reference to balancing concerns is a salient one and has been emphasised in the common law of England⁶². However, Maclean’s criteria are ultimately unconvincing due to his recommendation that the individual must hold a set of beliefs which are deemed acceptable to a responsible body of persons. Such a statement is difficult to support, as it is akin to saying that an individual who refuses medical treatment on religious grounds can have their will overborne if the doctor is not of the same faith as the patient. Lord Donaldson’s statement in *Re T* is considerably more

⁶⁰ Grisso T and Appelbaum P S (1995) *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour Vol. 19(2) 105-126.

⁶¹ Maclean A (2000) *Now You See It, Now You Don’t: Consent and the Legal Protection of Autonomy*; Journal of Applied Philosophy; Vol. 17(3); 277-289 at 281.

⁶² See *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All E.R 819 and *Re MB (Medical Treatment)* [1997] 38 B.M.L.R 175.

compelling than Maclean's: provided that the individual has the requisite capacity to make a decision i.e. satisfied the criteria set out by Grisso and Appelbaum, the fact that the doctor might not find this acceptable is of no relevance at all.

It has been seen that exercising one's autonomy in relation to a treatment decision is possible without having to make a well thought out argument. However, this will only be the case if the individual has the ability to make a rational decision; the decision itself need not have a rational reason behind it, but the ability to make it should be present. In the light of this, it is important to analyse the issue of rationality, and how it relates to the principle of autonomy.

The issue of rationality is discussed in depth by Marc Stauch, who illustrates it by way of three fact-based examples:

“1) a patient who will, in the event of the treatment survive only in great pain and without many of his mental or physical faculties; 2) a Jehovah's Witness who believes that the form of treatment (a blood transfusion) will bar his eternal salvation⁶³; 3) a patient who is under the delusion that she is or will be a great actress and the treatment would have the effect of preventing this”⁶⁴

Stauch asserts that there are three grounds for refusal of treatment which relate to rationality: Rational grounds, non-rational grounds and irrational grounds. Example 1) above is an example of a decision made on rational grounds, defined by Stauch as **“being founded upon commonsense... a set of beliefs which are derived from concepts given to us in our normal everyday experience of the world”⁶⁵**. In the event of a patient refusing treatment on the grounds that he will be in great pain and with diminished faculties, the question arises as to whether such a decision would be rational or not. It could be argued that such a decision would not be rational simply because of the stigma attached to the idea of voluntarily ‘choosing death’. However, it

⁶³ For discussion on the validity of the tenets of the faith on this issue, see Muramoto, O (1998) *Bioethics of the Refusal of Blood by Jehovah's Witnesses*; Journal of Medical Ethics; Vol. 24; 223-230 and Ridley, D T (1999) *Jehovah's Witnesses' Refusal of Blood: Obedience to Scripture and Religious Conscience*; Journal of Medical Ethics; Vol. 25; 469-472.

⁶⁴ Stauch, M (1995) *Rationality and the Refusal of Medical Treatment: A Critique of the Recent Approach of the English Courts*; Journal of Medical Ethics; Vol. 21, 162-165 at 163.

⁶⁵ Ibid.

is submitted that cases such as the one just described are nonetheless illustrative of a rational decision. Marc Stauch explains thus:

“In the case of a choice which results in death, such as a decision by a patient to refuse life-saving treatment, a difficulty arises in that the nature of the life foregone cannot be compared with a state which remains unknown. Nevertheless, in certain... circumstances, we may be justified in regarding such a choice as rational. This would be the type of case where the quality of life to be renounced is certain to be intolerable”⁶⁶.

Ultimately, it is too one-dimensional to consider a life or death decision without considering the quality of life that is at stake. A more pragmatic approach to the concept of rationality would be to say that an individual might be perfectly justified in giving up a life which they themselves consider to be so lacking in quality as to be no longer desirable.

Example two in Marc Stauch’s article – the Jehovah’s Witness refusing a blood transfusion – is deemed to be a decision made on ‘non-rational grounds’. Note carefully the phrase ‘non-rational’, which is not to be confused with the term ‘irrational’: **“[Non-rational grounds]... are founded upon ideas that are not given to us in our normal experience of the world...[but] are typically found within systems of religious faith, where reference is made to ‘truths’ which lie ‘beyond’ our experience of the world”⁶⁷**. There is cogency in the argument that treatment refusal on the grounds of religious belief, is effectively in a special category of its own. Michael Wreen is one of those who subscribes to such a line of reasoning. Wreen directs our attention first to the argument that a decision based on religious beliefs is not an autonomous one, and is therefore invalid:

“Despite its [religious freedom’s] widespread use, someone may ask, ‘isn’t the concept really self-contradictory, or at least self-undermining?’... The argument for this view is that religion is actually antithetical to autonomy, because it psychologically limits the number of possible causes of action that the believer considers, and more importantly, makes him unable even to

⁶⁶ Ibid.

⁶⁷ Ibid.

entertain causes of action proscribed by his convictions... The result is not autonomy, but heteronomy,⁶⁸

Wreen highlighted the argument in order to refute it, which he does by stating that a refusal of treatment based on religious views does not contravene the principle of autonomy, because a belief in something such as religion involves exercising a free choice in order to arrive at that belief⁶⁹. Opponents of this viewpoint may argue that following a particular religion is not in fact an autonomous process because many people do not 'select' a religion as such but instead follow the religion that they have been brought up in i.e. a person born into a Hindu family will invariably follow the example of their parents or guardian by practising Hinduism; this could be argued as not being a choice as such, but rather, something which is done without an in-depth examination of whether the religion of one's parents is in fact the right religion for the individual themselves. This argument is logical, but it is nonetheless submitted that following the religion that one has been brought up in is not automatically in conflict with the principle of autonomy. It is accepted that one is less likely to explore the merits of different religions during childhood, simply because the majority of children defer to parents or guardians in most aspects of life. The issue of whether religious (and indeed, non-religious beliefs) involves the exercise of a free choice is perhaps more applicable to adulthood, when an individual is in more of a position to act and think independently of parents or primary caregivers. At this point, although religious beliefs may be significantly ingrained into the mind of the individual, there is far greater scope for investigating and practising different religions should the individual wish to do so. For example, an individual raised as a Hindu may choose to continue practising the religion they were brought up with, or if they are unhappy with this, may also choose to study the tenets of Buddhism and convert if this proves to be a preferable option. The fact that many elect to continue practising the religion that they were brought up with does not make it any less of an autonomous process. The point where such a decision ceases to be autonomous is when an individual is under such control of the parent or primary caregiver that they are in effect denied the right to exercise the beliefs of their choice.

⁶⁸ Wreen, M J (1991) *Autonomy, religious views and the refusal of lifesaving treatment*; Journal of Medical Ethics; Vol. 17, 124-130 at 126.

⁶⁹ Ibid at 127.

Such a scenario could be indicative of being brainwashed, something which, according to Wreen, has become, “**a caricature of the great majority of the world’s religions**”⁷⁰. This is an interesting point which is worthy of further elaboration. In situations where an individual’s religious beliefs may lead to a refusal of life-saving treatment, the temptation on the part of the doctor might be to denounce the individual’s decision as invalid on the grounds that it was not made autonomously – it was the tenets of religion which demanded that the patient make that decision. However, this is only really likely to be the case if the patient had been visibly ‘brainwashed’, by which it is meant that ideas had been so forcibly implanted into the patient’s head, that there is no longer any sense of rationale or objectivity left⁷¹. The difficulty in distinguishing between those who have been brainwashed from those who merely hold strong beliefs should not be underestimated. Consider for example, a Jehovah’s Witness who refuses a life-saving blood transfusion on the basis of their beliefs, and a member of a religious splinter group who is admitted to hospital having consumed large quantities of bleach at the behest of their leader and is refusing all treatment because they have been told that accepting treatment would be contrary to God’s will? Essentially, is there any difference between a religion and a cult in the context of medical treatment decisions?

Take the real-life example of the members of the Peoples Temple organisation who, in 1978, took part in a mass poisoning at the behest of their leader, the Reverend Jim Jones. Suppose for the sake of argument that one of the members who had consumed the poison had not died and had been admitted to hospital, but refused treatment because that is not what their leader would have wanted; should their wishes be respected in the way as those of a Jehovah’s Witness refusing a blood transfusion? It is submitted that the issue is not whether an individual is a member of an ‘organised’ religion or a cult, but whether a particular treatment decision is ultimately an autonomous one. It is submitted that this is what Wreen is essentially referring to when he writes about being ‘brainwashed’; the term relates to an individual being subjected to a high level of outside influence which would result in a treatment decision being vitiated. However, it would be incorrect to say that a Jehovah’s Witness, Christian or Muslim, by virtue of being part of more ‘established’ religions,

⁷⁰ Ibid at 127.

⁷¹ See Schwab, A P (2006) *Formal and effective autonomy in healthcare*; Journal of Medical Ethics; Vol. 32; 575-579 at 576, where the author briefly but clearly dismisses the idea that decisions made by ‘brainwashed’ individuals are autonomous.

are always less susceptible to outside influence than less established, 'cult' organisations. Specific circumstances in cases involving both groups can make the difference between an autonomous decision and a decision that is invalid because of outside influence or brainwashing.

Difficulty may present itself if healthcare professionals construe a strong passionate belief as meaning that the patient has been brainwashed. Add to this the fact that the patient has elected to die, and the ability of the individual to make an autonomous informed decision may be called into question. However, Stauch states that religious beliefs can be described as non-rational because **“such ideas do not derive from claims about the world of objective experience... the effect of this is that such beliefs are empirically unverifiable”**⁷². However, just because a belief cannot be scientifically proven does not mean that it is devoid of validity:

“Religion has to do with... explaining the human condition at its most fundamental level; providing a person with a unique concept of personal identity, in the fullest sense of the term; and making sense of ourselves and the world around us in a complete and satisfying way... it [religion] reconciles us, at a deep existential level, to ourselves to our world, to each other, and most of all, to our limitations and relative impotence. Religious beliefs... are therefore not on a par with other beliefs and values a rational person might have... [they] circumscribe and infuse other beliefs and values, and permeate all of them to some extent”⁷³

The fact that religion is not scientifically verifiable does not mean that its tenets are devoid of rationality. From an ethical standpoint, if a doctor were to attempt to persuade a patient that his decision was wrong simply on the basis that he himself subscribed to a different religious view, it would be tantamount to telling the patient that his religion and his faith are factually inaccurate or invalid. This would clearly be a violation of the principle of respect for autonomy, as there would simply be no way in which the patient's beliefs could be proven to be demonstrably false. Indeed, the right to freedom of religion is provided for under Article 9 of the European

⁷² Stauch, M (1995) *Rationality and the refusal of medical treatment: a critique of the recent approach of the English Courts*; Journal of Medical Ethics; Vol. 21, 162-165 at 163

⁷³ Wreen, M J (1991) *Autonomy, religious values and refusal of lifesaving medical treatment*; Journal of Medical Ethics; Vol.17; 124-130 at 128.

Convention on Human Rights, and as previous discussion in this thesis highlights⁷⁴, this right could encompass the right to make medical treatment decisions on the basis of religious and other beliefs. It could even be argued that failure to respect religious beliefs would be tantamount to discrimination, in as much as it involves dismissal of an opinion which may be considered different from the norm. However, does the non-verifiable nature of religion mean that the right to make treatment decisions on religious grounds can never be questioned? There may be circumstances in which the right to religious freedom will clash with other fundamental freedoms such as the right to bodily integrity. Arguably the most contentious example of this is the issue of female genital mutilation which, according to the World Health Organisation, is a procedure which carries serious health risks which are entirely disproportionate to the benefits, which, from a clinical context, are essentially nil⁷⁵. The primary motivations for such procedures taking place are generally thought to be related to cultural and religion, rather than medical reasons, although the British Medical Association does state that no existing religion actually demands female genital mutilation⁷⁶. By contrast, male circumcision although not uncontroversial, is more accepted and has not been condemned in the same way, despite the fact that, like for females, the procedure is also often motivated by cultural and religious reasons. This is ultimately because the operation is comparatively more straightforward for men and is less likely to have severe health risks. However, cases such as *Re J (A Minor) (Prohibited Steps Order: Circumcision)*⁷⁷ illustrate that circumcision for male children will not be granted simply as a matter of course; in J's case, the court held that the operation was not justified because he was unlikely to be brought up in the Muslim religion and more crucially, that the medical and psychological risks of the operation outweighed any benefits of the procedure. This shows that although religion is undoubtedly a crucial issue in many medical procedure decisions, it will not always be an overriding factor. Other factors will be important in deciding whether a particular procedure can and should be carried out and, as will be discussed in Chapter 2 of this thesis, the

⁷⁴ See this Chapter of this thesis at 18.

⁷⁵ World Health Organisation (2008) *Eliminating Female Genital Mutilation: An Interagency Statement* at 9. See also British Medical Association (2006) *Female Genital Mutilation: Caring for Patients and Child Protection*; accessed online on 13/09/08; available online at <http://bma.org.uk/ap.nsf/Content/FGM>.

⁷⁶ British Medical Association (2006) *Female Genital Mutilation: Caring for Patients and Child Protection* at 2; accessed online on 13/09/08; available online at <http://bma.org.uk/ap.nsf/Content/FGM>.

⁷⁷ [2000] 52 B.M.L.R 82.

most important issue is whether the proposed treatment will be in the best interests of the child. As the British Medical Association explain, it is possible that a procedure that has no medical benefit can still be considered to be in a child's best interests from a socio-cultural perspective:

“It is important that doctors consider the child’s social and cultural circumstances. Where a child is living in a culture in which circumcision is required for all males, the increased acceptance into a family or society that circumcision can confer is considered to be a strong social or cultural benefit. Exclusion may cause harm by, for example, complicating the individual’s search for identity and sense of belonging. Clearly, assessment of such intangible risks and benefits is complex.”⁷⁸

This links in to Stauch's discussion of the non-rational; the risks and benefits associated with procedures carried out for religious or cultural reasons cannot be directly verified in the way that procedures designed to preserve life or prevent deterioration in health can be.

Further weight will also be added to a decision based upon religious grounds if there is a consistency of belief – that is, the patient has been asked his opinion on a given treatment on more than one occasion, and the decision has remained the same. This would show that the patient has given a lot of consideration and thought over a sustained period of time, and that there has at least been an established belief system influencing the decision. The words of John Stuart Mill are once again analogous to this particular scenario:

“It is important to give the freest scope possible to uncustomary things, in order that it may in time appear which of these are fit to be converted into customs... If a person possesses any tolerable amount of common sense and expertise, his own mode of laying out his existence is best, not because it is the best in itself, but because it is his own mode.”⁷⁹

One might argue that a decision made on religious grounds is really not an autonomous decision, since the individual has in effect allowed someone or something else i.e. religion, to shape their way of life. However, this argument can

⁷⁸ British Medical Association (2006) *The Law and Ethics of Male Circumcision* at 2; accessed online on 13/09/08; available online at http://www.bma.org.uk/images/Circumcision_tcm41-147277.pdf.

⁷⁹ Mill, J S; *On Liberty* taken from *On Liberty and other essays* (1998) Oxford University Press at 75.

easily be negated. In most cases, an individual will have been presented with, or sought out the tenets of one or more religions, after which the individual has chosen to follow them. In this way, autonomy has been exercised, and thus making treatment decision based upon religious belief is merely an extension of this.

Going back to Marc Stauch's assertions on rationality, example three – the patient who believes that she will be a great actress if she refuses treatment – is an illustration of a decision made on irrational grounds; that is, **“where the decision involves a belief of some form, but one based upon concepts that fly in the face of our normal experience of the world”**⁸⁰. Herein lies the difference between irrational and non-rational grounds: non-rational grounds for refusal may not be verifiable, but they often cannot be proven as false either. On the other hand, irrational grounds for refusal can be proven to be patently false. A patently false belief which actively interferes with an individual's decision-making could be indicative of the presence of a mental disorder. In such a case, the precise effect of the belief on the individual's decision-making capacity requires review. The English common law approaches the issue of patently false belief by considering whether the belief is the product of a delusion brought about by the presence of a mental disorder. Saks elegantly highlights the reasons why delusions may be indicative of a lack of decision-making capacity:

“The law defines a delusion as a belief for which there is no evidence. According to this definition, only extreme distortions, or patently false beliefs, count as delusions... If the standard reliably singles out patent falsehoods, it is not finding incompetency on the basis of unusual ways of looking at the world – or worse yet, prescribing beliefs that misconstrue reality. Rather, it rules out beliefs that plainly fail to do what they purport to do, that is, portray the world accurately. These beliefs are the kinds that pose a serious impediment to adequate decision-making.”⁸¹

However, the presence of a delusion is not necessarily enough to render an individual incapable. The issue is whether the delusion has a significant enough impact upon the

⁸⁰ Stauch (1995) *Rationality and the Refusal of Medical Treatment: A Critique of the Recent Approach of the English Courts*; *Journal of Medical Ethics*; Vol. 21, 162-165 at 163.

⁸¹ Saks, E R (1991) *Competency to Refuse Treatment*; *North Carolina Law Review*; Vol. 69; 945-999 at 962-963.

decision-making process so as to render the individual incapable⁸². This is illustrated in the English case of *NHS Trust v Ms T*⁸³, which concerned a sufferer of borderline personality disorder who refused blood transfusions through an advance directive on the grounds that her blood was evil and that the transfused blood would become corrupted once it entered her body. The refusal was deemed to be invalid due to a patently false belief which could in turn be attributed to a disorder of the mind⁸⁴ and ultimately, the delusion was deemed to have sufficiently impacted upon Ms T's capacity⁸⁵.

Ultimately, the current shift towards promoting patient autonomy means that patients are far more likely to have their views respected in relation to treatment than ever before. However, this is not to say that doctors will, and indeed should respect the decision of an individual whose treatment decision is completely removed from reality. In such cases, it is essential to assess whether the belief is indicative of the presence of a delusion brought about by mental disorder. If this is the case, it is then a matter of ascertaining whether the delusion has sufficient impact upon the decision-making process so as to indicate incapacity. If an individual is deemed incapable of making a valid treatment decision, the doctor is then able to intervene on the patient's behalf. At this point, the principle of autonomy gives way to the principle of paternalism.

1.2: THE PRINCIPLE OF PATERNALISM

Paternalism has been defined by Beauchamp and Childress as follows:

“The intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the

⁸² See *Banks v Goodfellow* [1870] L.R. 5 Q.B 549 at 565, in which the court stated the following with regards to testamentary capacity: **“It is essential to the exercise of such a power that a testator shall understand the nature of the acts and effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and with a view to the latter object, that no disorder of the mind shall poison his affections, perverts his sense of right, or prevent the exercise of his natural faculties – that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.”** See also Gunn, M J (2005) *Decision-Making Capacity and the Mental Capacity Act 2005: Some Difficult Issues and some Possible Means of Resolution*; unpublished.

⁸³ [2004] E.W.H.C 1279.

⁸⁴ Ibid per Charles J at Para 62.

⁸⁵ See also *Doncaster and Bassetlaw Hospitals NHS Trust v C* [2004] E.W.H.C 1657.

goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.”⁸⁶

As the definition suggests, the principle of paternalism exists in direct conflict to the principle of autonomy, and proponents of the principle would argue that the duty to act in the best interests of the patient by overriding a treatment refusal should take priority over respecting the patient’s refusal⁸⁷. However, this approach is not accorded real priority in capacity law, with the principle of paternalism only becoming important if an individual is incapable of exercising their autonomy.

Paternalism can be divided into two sub-categories: soft paternalism and hard paternalism. Soft paternalism involves intervention only when an individual’s decisions are not, or cannot be based upon, a particular rationale. In other words, the individual is incapable of making fully autonomous decisions.

Hard paternalism involves intervention even when an individual is fully capable of making autonomous decisions, but makes a decision which the paternalist does not consider to be in the best interests of that person: **“The hard paternalist will restrict forms of information available to the person or will otherwise override the person’s informed and voluntary choices”⁸⁸**

While both soft and hard paternalism are both relevant from a mental health context, soft paternalism is far easier to justify ethically. Consider the hypothetical example of an individual with severe learning disabilities who is unable to comprehend the nature of his proposed treatment sufficiently enough to make an autonomous decision. If the treatment would provide great benefit to the patient with very little or no distress, one could argue that the doctor in fact has a duty to adopt a paternalistic approach in order to fulfil his obligation to improve the patient’s health. It would be difficult to argue

⁸⁶ Beauchamp, T L and Childress, J F (2009) *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 208.

⁸⁷ See Savulescu J (1995) *Rational Non-Interventional Paternalism: Why Doctors Ought to Make Judgments of What is Best for Their Patients*; *Journal of Medical Ethics*; Vol. 21, 327-331, in which the author argues in favour of a paternalistic approach to healthcare on the grounds that medicine is in a special category which may often involve serious measures to be taken on behalf of a patient. See also Jiwa, M (1996) *Autonomy: the need for limits*; *Journal of Medical Ethics*; Vol. 22; 340-343, in which the author argues that autonomy should be limited in order to deal with patients who abuse their rights within the N.H.S. See also Buchanan, A (2004) *Mental Capacity, Legal Competence and Consent to Treatment*; *Journal of the Royal Society of Medicine*; Vol. 97; 415-420.

⁸⁸ Beauchamp, T L and Childress, J F (2009) *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 210.

this as morally indefensible. There cannot be a duty to respect autonomy when the individual in question is not capable of exercising his right to it.

Hard Paternalism presents a greater ethical dilemma. Opponents of the paternalistic approach might argue that it would be a violation of fundamental human rights such as freedom of speech or freedom of choice. Attempting to impose a particular decision upon individuals capable of making that decision themselves, say anti-paternalists, would be to show that person disrespect, because it would be giving the impression that their decisions and opinions were less valid. Beauchamp and Childress state that opponents of hard paternalism believe the concept to be too broad⁸⁹. This is a point worthy of consideration. If the overall motivation for adopting a paternalistic approach were for the prevention of harm to the individual, then this would mean that there were innumerable scenarios which would suddenly be regarded as morally indefensible. One could argue for instance, that a paternalist would have a moral duty to stop another individual defending the country by going to fight in a war, on the grounds that it may result in the loss of that individual's life. However, anti-paternalists might conversely argue that if that individual has made a clear and rational decision to fight for his country, it would be disrespectful to prevent them doing so. In a healthcare context, opponents of paternalism argue that **“it [paternalism] would authorise health-care institutions, physicians and nurses to override patient's plans and preferences in many cases”**⁹⁰. Again, this assertion appears logical. Healthcare law contains many cases where patients have made treatment decisions that were perceived to have gone against 'the norm'. Individuals have refused life-saving blood transfusions because of religious beliefs⁹¹; refused Caesarean operations on the grounds of 'needle-phobia'⁹², and refused life-saving treatment for a gangrenous leg because of a desire to die with two legs rather than one⁹³, to name but a few examples.

According to Beauchamp and Childress, hard paternalism is morally defensible if: the patient is at risk of significant, preventable harm; if the act of paternalism is likely to

⁸⁹ Ibid at 213.

⁹⁰ Beauchamp, T L and Childress, J F (2009) - *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 213.

⁹¹ See *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649.

⁹² See *Re MB (Adult: Medical Treatment)* [1997] 38 B.M.L.R 175.

⁹³ See *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All E.R 819.

prevent the harm; if the benefits of the act outweigh the risks to the patient; there is not viable alternative to limiting the patient's autonomy and if a least-autonomy restrictive alternative is adopted wherever practicable.⁹⁴

Decisions based on religious beliefs can also be controversial in this respect. In the case of a Jehovah's Witness who refuses a life-saving blood transfusion, the doctor's overwhelming desire might be to override the patient's wishes and administer the transfusion regardless⁹⁵. However, a doctor would not be ethically justified in administering a blood transfusion to a Jehovah's Witness on the grounds of hard paternalism, providing that the patient had made a conscious decision to join the faith themselves, and had not been coerced by a third party. If a belief is deeply held and it is clear that the patient made their decision based upon these beliefs, the decision is autonomous and does not warrant a strongly paternalistic stance from the doctor, regardless of how well intentioned the doctor's motives were. Marc Stauch's analysis of non-rational beliefs becomes relevant here; a deeply held religious belief is in complete contrast to a patently false belief; the former can be neither proven nor disproved and has a sound basis through well-established tenets. By contrast, patently false beliefs can demonstrably be proven false and potentially indicate a lack of decision-making capacity. It is in such a case where a doctor will be justified in acting paternalistically in order to safeguard the welfare and interests of the individual.

1.3: THE PRINCIPLE OF NON-DISCRIMINATION

The principle of non-discrimination states that an individual suffering with a mental disorder or mental impairment should retain the same rights as those who are not suffering with any such conditions. This principle has been given great importance in recent years in relation to mental health provisions. The 1999 Richardson Committee Report highlighted the importance of the principle as follows:

“We [the Richardson Committee] regard the principle of non-discrimination as central to the provision of treatment and care to those suffering from

⁹⁴ Beauchamp, T L and Childress, J F (2009) *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 216.

⁹⁵ See *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649.

mental disorder and by non-discrimination in this context we are referring to non-discrimination on grounds of mental health.”⁹⁶

The Richardson Committee, in highlighting the importance of non-discrimination, stated strongly that any powers used under mental health legislation should be exercised without any direct or indirect discrimination on the grounds of disability, age, gender, sexual orientation, race, colour, language, religion or ethnic origin⁹⁷.

In examining the importance of non-discrimination, it is submitted that a significant aspect of this is the stigma that surrounds mental illness, in terms of attitudes and preconceptions. In order for the principle of non-discrimination to be adequately satisfied within capacity law, it is essential that work is done to increase awareness of the link between mental health and capacity, this ideally eliminating any stigma that may be attached to individuals suffering with mental disorder or impairment.

According to Mukherjee et al, **“Stigmatisation of psychiatric illness has been evident for as long as illness has existed. Despite efforts to try to change attitudes by both individuals and by groups such as Mind and the World Health Organisation, it still exists.”⁹⁸** Jim Bolton defines stigma as follows:

“Stigma marks an individual out as being different and evokes some form of sanction. Illnesses can often be the stigmatising characteristic. However, whereas the stigma of physical conditions such as cancer and epilepsy has declined, mental disorders remain some of the most stigmatised illnesses.”⁹⁹

The stigma of mental illness often outweighs that of physical illness where in some cases, stigma may not exist at all. Bolton further states that societal attitudes play an important part in explaining the cause of this stigma. He then highlights a number of beliefs commonly associated with mental illness sufferers. The following are of particular relevance to the issue of mental capacity: **“Mental illness reflects a weakness of character... Outcome is poor... Disorders are incurable... It is difficult to communicate with people with mental illnesses.”¹⁰⁰** Such preconceived ideas regarding the capabilities of those suffering with mental illness or impairment

⁹⁶ *Review of the Mental Health Act 1983: Report of the Expert Committee* (1999) at Para 2.14.

⁹⁷ *Ibid* at Para 2.21(vii).

⁹⁸ Mukherjee R et al (2002) *The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital*; *Psychiatric Bulletin* Vol. 26, 178-181 at 178.

⁹⁹ Bolton, J (2003) *Reducing the stigma of mental illness*; *Student BMJ*; Vol. 11, 104-105 at 104.

¹⁰⁰ *Ibid*

ultimately means that such individuals will be deemed unable to voice their wishes, opinions and feelings, and also incapable of making important life decisions.

In order to highlight the scale of the issue, Mukherjee et al presented a questionnaire in 2002 to 832 medical students and 441 doctors at a London teaching hospital with the intention of ascertaining attitudes and opinions towards psychiatric illness. The results showed that individuals suffering with schizophrenia drew the most significant amount of negative opinion¹⁰¹, with more than fifty per cent of respondents considering sufferers of the illness to be dangerous. Beyond this however, negative attitudes towards mental illness sufferers diminished:

“More often doctors and medical students were less likely to blame the individual and, with the exception of dementia where there appears to be a general pessimism despite recent symptomatic advances, felt that the conditions listed would improve and the individual would eventually recover.”¹⁰²

The above response can be seen as positive in as much as that there appeared to be some recognition of the fact that not all mental illnesses and impairments are incurable. Ergo, this can be applied in principle to conditions affecting capacity, in the sense that if a condition is curable, the resulting incapacity would also be reduced or disappear. However, it should be noted that the respondents to the questionnaire were all doctors or medical students, and therefore can hardly be considered representative of the general public. Indeed, it is perhaps telling that even respondents educated in matters of mental illness still have negative preconceptions of certain mental disorders. By this token, it cannot be assumed that the general public will not have similar, if not increased negative preconceptions of mental illness/impairment sufferers. Jim Bolton highlights the fact that stigma of mental illness within the medical profession is an issue which should not be taken lightly:

“Fear and ignorance of mental illness can result in an insufficient focus on a patient’s physical health needs... The belief that mental illness is incurable or self-inflicted can also be damaging, leading to patients not being referred for appropriate mental health care.”¹⁰³

¹⁰¹ This view of schizophrenia was also found in a survey conducted by Crisp et al amongst the British adult population in 2000. See Crisp et al (2000) *Stigmatisation of people with mental illness*.

¹⁰² Mukherjee R et al (2002) *The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital*; *Psychiatric Bulletin* Vol. 26, 178-181 at 179.

¹⁰³ Bolton, J (2003) *Reducing the stigma of mental illness*; *Student BMJ*; Vol. 11, 104-105 at 104.

This exposition can certainly be applied to the issue of capacity. If an individual is deemed incapable without any investigation as to the duration of that incapacity, this might ostensibly result in an individual being unnecessarily deprived of the right to make important decisions vis a vis medical treatment. It is therefore essential that any education relating to mental disorders and mental impairment be directed at healthcare professionals as well as the general public.

Hayward and Bright also comment that the stigma of mental illness may also be prevalent amongst sufferers themselves. If an individual is aware that they are a sufferer of a mental disorder, then any negative opinion of this group will ultimately have a negative effect upon that individual's ability to cope with the condition¹⁰⁴. Again, the key to improving this situation is to educate sufferers as to the true nature of their illness, as Hayward and Bright explain:

“By this argument, patients who do not believe that that they are mentally ill should cope better. However, there is an opposite view, which we might call ‘the medical model’, which holds that acceptance of the fact of illness should lead to a better outcome. The argument here would be that patients who accept that they suffer from mental illness will show better adherence to treatment and better understanding of how to cope with their illnesses.”¹⁰⁵

The above comments from Hayward and Bright highlight the fact that sufferers of a mental disorder or impairment must not simply be ignored or treated as incapable of understanding the nature of their condition. Through empowering the individual to recognise that they suffer from a mental disorder or impairment, it is hoped that the stigma associated with the particular condition will be alleviated, providing the individual with greater awareness and thus potentially greater autonomy to handle their condition in a manner best suited to them.

This notwithstanding, Hayward and Bright acknowledge that the results of research conducted in this area have produced contradictory results:

“On the one hand, there is considerable research evidence to confirm the early findings that those who suffer from mental illness have stigmatising

¹⁰⁴ Hayward, P and Bright, J (1997) *Stigma and Mental Illness: A Review and Critique*; Journal of Mental Health, Vol. 6(4), 345-354 at 349.

¹⁰⁵ Ibid.

views very similar to those of the general public. When asked to offer ratings of approval or social distance to ‘mental patients’ or the ‘mentally ill’, many findings suggest that patients will be just as negative as the general public... One might therefore assume that a diagnosis of mental illness would lead to a sharp decline in self-esteem, as labelling theory would predict. In fact, this does not seem to be the case, as is indicated by a number of studies... Further, those patients who have received relief from troubling symptoms seem to evaluate the experience of being in hospital positively. The key point here would seem to be that those who suffer from mental illness evaluate themselves much more positively than they do ‘the average mental patient’.’¹⁰⁶

The above comments can be applied via analogy to capacity issues. Ultimately, if patients suffering from mental illness react positively to symptomatic treatment vis a vis self-image, the same effect is likely to occur when individuals are encouraged to take decisions for themselves in important areas, subject to assessment as to whether this is practical. If stigma can be linked to self esteem within sufferers of mental disorder/impairment, then it is submitted that the best way of alleviating this stigma is for policy-makers to acknowledge that sufferers of mental conditions must be treated as ‘normally’ as is practicable. Later chapters will discuss the extent to which the relevant jurisdictions have been successful in achieving this.

It is submitted that the principle of non-discrimination will be best upheld through increased education and awareness of the issues relating to mental illness and capacity. A review of the literature relating to India shows that there is stigma still attached to mental illness which would ultimately make it more difficult for the principle of non-discrimination to be upheld. The Constitution of India makes vague reference to the right of persons with disabilities to work¹⁰⁷, but interestingly does not include them within Article 15, which relates to prohibition of discrimination on the grounds of **“religion, race, caste, sex or place of birth”**. This suggests that the

¹⁰⁶ Ibid.

¹⁰⁷ Constitution of India, Article 41: **“The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.”**

potential for the mentally disordered and impaired to be discriminated against has not been adequately recognised. Literature on the subject suggests that those suffering with mental disorder or impairment are thought of as having little or no capacity for understanding¹⁰⁸ and have very little chance of living life unaided¹⁰⁹. However, the literature also highlights the attempts made by Non-Governmental Organisations to increase awareness and education which will lessen the stigma attached to mental disorders and impairments. Padmavati explains:

“While the mentally ill patients do elicit negative responses such as fear, disgust, pity or hostility from society, families continue to take care of them. Temples and other religious institutions have also helped shelter these patients, who are left there by relatives who cannot cope. Rural communities have offered refuge to many patients who have wandered into their localities. Thus non-institutional care, a core concept of community psychiatry, has always been practiced in India through the ages, although this has been rather disorganised in structure and in function.”¹¹⁰

Padmavati states also that it is the work of Non-Governmental Organisations rather than the government itself which is helping to increase awareness, which in turn can be attributed to a significant lack of resources. Padmavati states that as of 2005, there were approximately 3500 psychiatrists, 1000 social workers and 900 psychiatric nurses for the whole of India and its billion plus population¹¹¹. The practicalities of healthcare provision in India means that increasing awareness and providing education becomes more difficult. Consequently, it becomes harder to dispel the myths surrounding mental illness and impairment that may stigmatise sufferers.

U.K capacity law¹¹² now emphasises the need to recognise that the presence of mental disorder or impairment does not necessarily equate to an inability to make all decisions relating to medical treatment. Although this has yet to happen in India to a significant extent, there is evidence to suggest that progress is being made in this area.

¹⁰⁸ Varma, L.P; *Mental Disorders: Some Misconceptions*; Souvenir III Conference of Eastern Zone; I.P.S, Guwahati.

¹⁰⁹ Tilak, D (1992) *Mentally Handicapped: Care, Financial Security and Guardianship Needs*; Indian Journal of Social Work; Vol. 53(1), 1-15.

¹¹⁰ Padmavati, R (2005) *Community Mental Health Care in India*; International Review of Psychiatry; Vol. 17(2), 103-107 at 103.

¹¹¹ Ibid.

¹¹² See Chapters 3 and 4 of this thesis.

In 1999, India passed the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 1999 (known as the National Trust Act 1999). The objectives of the Act were stated as follows:

- “a) to enable and empower persons with disability to live as independently and as fully as possible within and as close to the community to which they belong;**
- b) to strengthen facilities to provide support to persons with disability to live within their own families;**
- c) to extend support to registered organization to provide need based services during the period of crises in the family of persons with disability;**
- d) to deal with problems or persons with disability who do not have family support;**
- e) to promote measures for the care and protraction of persons with disability in the event of death of their parent or guardian;**
- f) to evolve procedure for the appointment of guardians and trustees for persons with disability requiring such protection;**
- g) to facilitate the realisation of equal opportunities, protection of right and full participation of persons disability; and**
- h) to do any other act which is incidental to the aforesaid object”¹¹³**

Despite references to the empowerment of the individual, critics of the 1999 Act have argued that it does not fully acknowledge that those persons with disabilities may retain full capacity in some or many areas of their lives. Dhanda and Gambos highlight the fact that in 2008, India ratified the U.N Convention on the Rights of Persons with Disabilities 2006, and as a result, all relevant domestic legislation must be in line with it. Given that the 2006 U.N Convention emphasises that persons with disabilities are not automatically incapable and in need of intervention¹¹⁴, Dhanda and Gambos criticise the National Trust Act 1999 for its failure to include similar provisions: **“The N.T.A accepts that in a particular case, persons with disability could be found to possess capacity; but it does not presume that persons with**

¹¹³ National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 1999, Chapter 3; see also Guha, A (date unspecified) *The National Trust Act: Legislation for the New Millennium*; accessed online on 24/01/09; available online at: www.unescap.org/esid/psis/disability/decade/otsujapan2002/doc/A_Guha.doc.

¹¹⁴ United Nations Convention on the Rights of Persons with Disabilities 2006, Article 12(3): **“States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”**

disability possess capacity like non-disabled persons.”¹¹⁵ Whilst the 1999 Act might indeed fail to recognise that those affected by mental illness or impairment may retain some or all of their decision-making capacity, the issue has nevertheless been recognised and critiqued by academics in the field and there is thus scope for this awareness to develop further and ideally, influence the law. English law itself did not recognise that persons with disabilities could retain capacity until the case of *Re C (Adult: Refusal of Medical Treatment)*¹¹⁶ in 1994. Similarly, one cannot discount the possibility of the law in India developing in the same way, particularly given that discussion of the issue is already underway.

1.4: THE PRINCIPLE OF LEAST RESTRICTIVE ALTERNATIVE

The 1999 Richardson Committee Report highlighted the principle of least restrictive alternative as one of the express principles which should be included in any future mental health legislation. The principle was defined in the report as follows:

“Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking into account the safety of other patients.”¹¹⁷

The principle of least restrictive alternative has two aspects: first, any treatment or care given to the individual should be administered in as unrestrictive a method as possible. Examples of this could be, say, leaving the door unlocked in a patient’s room if they pose no danger or problem. The second aspect to this principle is that treatment should always be administered proportionately to the nature of the patient’s condition. This principle has been supported by both the English and Scottish Governments and enshrined in the respective capacity legislations in both jurisdictions.

¹¹⁵ Dhanda, A and Gambos, G (2008) Harmonising National Laws with U.N.C.R.P.D: Suggested Amendments to the National Trust Act 1999; accessed online on 25/01/09; available online at <http://uncrpdandlaw.nileshsingit.org>.

¹¹⁶ [1994] 1 All E.R 819.

¹¹⁷ *Review of the Mental Health Act 1983: Report of the Expert Committee* (1999) at Para 2.21(ii).

1.5: THE PRINCIPLE OF COMMUNITARIANISM

The principle of communitarianism states that the needs and wishes of the individual are subordinate to the promotion of the values and relationships pertaining to the community in general. Beauchamp and Childress state that in this theory, **“communal values, the common good, social goals, traditional practices and cooperative virtues are fundamental in ethics.”**¹¹⁸

In addition, Beauchamp and Childress argue that to the communitarian, the ethics which bind the healthcare professional are too focussed upon the protection of the individual’s rights¹¹⁹. In the context of capacity law (and particularly the ethical underpinnings of the English and Scottish law), a greater emphasis upon patient autonomy is in essence a contravention of a communitarian outlook. Consider the hypothetical example of a Jehovah’s Witness who refuses a blood transfusion, but whose family are not members of the religion and are not in favour of refusing treatment which could save the life of the individual. A communitarian might ostensibly consider the needs and wishes of the family to be as, if not more important than the right of the individual to refuse the treatment, in as much as the individual must not simply consider their own needs, but also the impact that the decision might have on others. In this way, it is submitted that communitarianism need not specifically involve the community at large, but could also involve a group of persons close to the individual, such as family.

In the context of this thesis, it is submitted the principle of communitarianism plays a potentially crucial role in the context of decision-making in India. Laungani highlights the importance of community in Indian society:

“A community in India is not just a collection of individuals gathered together for a common purpose. A community in the sense in which it is understood in India has several common features. People within a group are united by a common caste rank, religious grouping and linguistic and geographical boundaries. The members within a community generally

¹¹⁸ Beauchamp, T L and Childress, J F (2009) *Principles of Biomedical Ethics* 6th Ed; Oxford University Press at 356.

¹¹⁹ Ibid.

operate on a ranking or a hierarchical system. Elders are accorded special status within the community and their important role is very clearly recognised. On important issues the members of a community may meet and confer with one another, and any decisions taken are often binding on the rest of the members within the community”¹²⁰

This view of the hierarchical family structure is given further exposition by Ahmad:

“A joint household is not simply a number of unitary families living together. It is, instead, a structure of various hierarchical relationships. Norms relating to joint family living and strong extended family ties are traditionally kept up when the family is living in unitary households. For instance, members of a joint family may still share or jointly own many of their resources. They rely on family elders for major decisions and keep up mutual obligations to each other... Moreover, the hierarchical relationships within the unitary households are usually modelled after the basic structural paradigm of the extended family.”¹²¹

Such an approach to decision-making could be argued to conflict with Mill’s notion that the decisions of the individual should take maximum priority. As stated above, Mill commented that human beings had the right to form opinions and to express these opinions without reserve¹²². He does not specifically mention that others have the right to collaborate in this process. Laungani also contrasts the communitarian approach with the Western approach, which he says espouses a more individualistic way of life:

“At an abstract level, the concept itself has come to acquire several different meanings: an ability to exercise a degree of control over one’s life, the ability to cope with one’s problems, an ability to change for the better, reliance upon oneself, being responsible for one’s actions, self-fulfilment and self-realisation of one’s internal resources.”¹²³

¹²⁰ Laungani, P (1997) *Mental Illness in India and Britain: Theory and Practice*; Medicine and Law; Vol. 16(3), 509-540 at 522.

¹²¹ Ahmad, I (2003) *Between the Ideal and the Real: Gender Relations within the Indian Joint Family*; chapter in Pernau, M; Ahmad, I and Reifeld R (2003) *Family and Gender: Changing Values in Germany and India*; Sage Publications New Delhi at 39.

¹²² Mill, J S (1859) *On Liberty and Other Essays*; Oxford University Press at 62.

¹²³ *Ibid* at 518.

In the light of these comments, it is submitted that to the communitarian, any decision making should essentially be a collaborative process, in particular with those closest to the individual, such as the family. Venkoba Rao states that the role of elders is accorded great importance within the family and their opinions and blessings will often be sought after¹²⁴. Laungani's submissions on the importance of family should be noted in the context of collaborative decision-making:

“In an Indian family’s life, one’s individuality is subordinated to collective solidarity, and one’s ego is submerged into the collective ego of the family and one’s community. Consequently when a problem – financial, medical, psychiatric or whatever – affects an individual, it affects the entire family. The problem becomes one of concern for the whole family”¹²⁵

How then does a communitarian approach impact upon the decision-making process? Suppose for the sake of argument that a second or third generation family member, i.e. a son or daughter, requires a particular course of treatment and needs to take a decision over whether to accept or refuse the treatment. If Rack and Venkoba Rao are correct in their assertions about the emphasis placed upon the opinions of family members, particularly the elders, then this ostensibly informs the manner in which the treatment decision of the individual is made. The individual would be expected to consider the impact of the decision upon other family members, and it is possible that the views of the elders will be considered very important to the overall decision. It must be stressed that this does not mean that such an approach to decision-making equates to the presence of coercion by other family members upon the individual. If an individual is required to make a treatment decision, and in doing so, chooses either to collaborate extensively with his family, or defer the decision to his family entirely, this is no less an autonomous decision than if the individual had made a decision entirely on their own. It simply means that the individual has chosen to exercise their autonomy in a different way. Hellsten further comments on the link between the principles of communitarianism and autonomy:

“Any conception of an individual presupposes always some view of society and community, since all individuals are social beings. All the values and

¹²⁴ Venkoba Rao A (1981) *Mental Health and Ageing in India*; Indian Journal of Psychiatry; Vol. 23(1), 11-20 at 13.

¹²⁵ Laungani, P (1997) *Mental Illness in India and Britain: Theory and Practice*; Medicine and Law; Vol. 16(3), 509-540 at 521.

norms we have chosen as members of a particular community, ethnic group or social collective. More often than not, these social attachments are involuntarily acquired during the course of our upbringing and socialisation, independent rational choice having played no role whatsoever in this. We do not choose the society we are born in, and thus we have not voluntarily chosen our culture and traditions either. Social influence, communitarians argue is not merely a contingent fact of our social and morel identities, but the original social context of a human life which shapes it to be the kind of life it is.”¹²⁶

Hellsten is essentially refuting the individualist premise that a communitarian approach to decision-making cannot be autonomous and is therefore invalid. He argues that one’s individuality does not exist in spite of community influence, but rather, exists because of it. The practices and beliefs that we accrue as the result of being brought up in a particular community or group become part of us and will ostensibly serve as the catalyst for many of the decisions that are made in everyday life. Hellsten explains further:

“Despite their methodological differences, both liberals and communitarians base their emphasis on the importance of culture and community on the assumption that culture and community provide the common good and value standards for its members. For the communitarians, membership of a community is seen to have its own intrinsic value for an individual as a social being. Being a part of a community is an essential part of human life and human flourishing. The community, as a body with some common values, norms and goals, in which each member regards the common goals as his or her own, is intrinsically good, because it is a precondition of the moral autonomy of the individual.”¹²⁷

Hellsten’s analysis could arguably be summed up by John Donne’s famous statement that **“No man is an island”**¹²⁸. It is ultimately unrealistic to expect the individual to conduct their life entirely independently of others, and by the same token, unrealistic to expect decisions to be made entirely in isolation without giving any consideration to how a decision may affect community or family members. One of course may wish

¹²⁶ Hellsten, S; *Cultural Diversity and the Limits of Tolerance*; chapter can be found in Parker, M (1999) *Ethics and Community in the Healthcare Professions*; Routledge Publications London at 120.

¹²⁷ Ibid at 124.

¹²⁸ Donne, J (1623) *Meditation XVII* as can be found in *Devotions upon Emergent Occasions*.

to make a decision in this way, but it is submitted that decisions made in any other way should not be deemed invalid on the grounds of not being autonomous.

The process of actively choosing to collaborate or defer a decision to family members must be distinguished from a scenario whereby an individual is coerced or manipulated into making a decision they might not have otherwise made. As will be discussed in Chapter 3, the latter scenario means that a decision is not fully autonomous and the decision is therefore not valid. However, being unduly influenced by family members through coercion or manipulation must not be confused with accepting sound advice in order to aid in the decision-making process¹²⁹. The Mental Capacity Act 2005 states that account should be taken of beliefs and values that would be likely to influence a particular decision¹³⁰. It is submitted that this must also include situations where the individual chooses to adopt a more communitarian approach to decision-making, by considering the impact of the decision upon their family and any opinions of family members. Jones states that as well as factor such as cultural and religious background, one's beliefs and values can include **“past behaviour and expressions of conviction”**¹³¹ which, it is submitted, would include evidence of a consistently used communitarian approach to decision-making. If such a process forms part of a deeply held system and the individual is entirely comfortable with it, then there is no reason why the principle of communitarianism should conflict with the principle of autonomy. If however, an individual has been unduly influenced by another family member, and thus makes a treatment decision which considers the wishes and needs of the family in this manner; this is contrary to the principle of autonomy and is not a valid decision.

It is difficult to provide a blueprint for the components of a communitarian approach to decision-making that is also sufficiently autonomous. This is because different families will have different approaches to decision-making and each case must therefore be decided on the individual facts. However, it may be possible to identify different aspects of communitarian decision-making and distinguish between them. First, although communitarianism requires the wishes, opinions and feelings of others

¹²⁹ For an illustration of this contrast, see the cases of *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R. 649 and *Mrs U v Centre for Reproductive Medicine* [2002] E.W.C.A Civ 565. Both of these are discussed in Chapter 3.1.1 of this thesis.

¹³⁰ Mental Capacity Act 2005, s. 4(6)(b).

¹³¹ Jones R (2008) *Mental Capacity Act Manual* 3rd Ed; Sweet and Maxwell London at Para 1.054.

to be taken into account, the question remains as to who retains the right to the final decision. It is submitted that for a communitarian approach to be valid, there must be sufficient evidence to show that the individual has exercised their autonomy in making the decision, even if in doing so, they have chosen to give greater weight to the opinions of other family members. The manner in which collaborative decision-making takes place within families will vary; the individual may retain the final say, with the views of other family members being considered more as persuasive authority; the views of all family members may be given equal weight, or the views of the elders in the family may be given the highest priority if a hierarchical family structure is in place. It is also possible, although by no means definitive, that the views of the male members of the family may be accorded greater importance than that of the female family members. A United Nations report published in 2001 suggests that women may have little say in the decision-making process:

“Indian women are marginalised in decision-making and leadership by a variety of processes that begin in infancy. In contrast to boys, girls are encouraged to play passive roles and given little opportunity to make decisions or develop leadership skills outside the family context. Instead, they are taught to accept the decisions that others – parents, teachers, brothers – make on their behalf.”¹³²

In the context of medical treatment, Menon-Sen and Shiva Kumar’s report provides statistics regarding the percentage of women in India that were involved in decisions regarding medical treatment. The figures vary from state to state, with 81% of women in the state of Himachal Pradesh being involved in healthcare decisions, compared to just 45% in Uttar Pradesh¹³³. Figures however, varied in relation to other spheres of decision-making. 97% of women in Punjab were involved in decisions regarding cooking for example, compared to Uttar Pradesh which had the lowest percentage in this category with 78%. It could be inferred that the involvement of women in familial decision-making will vary depending on the ‘seriousness’ of the material decision and the ‘gender’ aspects of it – healthcare is a serious issue which may in turn lead to women having less involvement, whereas cooking is an issue which stereotypically comes under the domain of the female family members.

¹³² Menon-Sen, K and Shiva Kumar, A K (2001) *Women In India: How Free? How Equal?* United Nations at 61; accessed on 03/01/09; available online at http://www.un.org.in/IMAGES/kmsbk_1-22.pdf.

¹³³ Ibid at 64.

In the same way that female and younger family members may choose, or be expected to collaborate on important family decisions with the family, such a scenario is arguably more likely if the family member in question is incapable. Depending upon the degree of incapacity, the individual may still retain some or most of their decision-making ability. However, because of the prevailing condition that resulted in the individual's incapacity, this decision-making ability may not be recognised, and the individual in turn seen as too vulnerable to be able to cope with making important decisions. Again, it is possible that some form of coercion may take place, which would invalidate any treatment decision, or alternatively, the individual may fully accept the role of the family in aiding with making important decisions.

Whatever the basis on which a collaborative decision-making process is predicated, it is submitted that this is not the crux of the matter. The central issue regarding a valid communitarian approach is whether the individual in question has themselves made the choice to defer decisions to others or to collaborate extensively with them. The above quote from Menon-Sen and Shiva Kumar refers to the fact that women are taught to accept the decisions that are made on their behalf. One could interpret their statement as meaning that women are effectively denied the right to exercise their autonomy. Whilst such a situation is of course possible, it is submitted that this need not be the case. Menon-Sen and Shiva Kumar's report details the percentage of women across India that are involved with decisions in various aspects of family life. What the statistics do not tell us is the extent to which the women accepted this. Just as one cannot rule out the possibility of coercion in some families, one equally cannot rule out the possibility that individuals may accept that their position within the family would necessitate the involvement of other family members in important decision-making.

Similarly, consider the hypothetical example of an eighteen year old who lives with in a joint family household along with his parents and grandparents. He has attained the age of majority and so is an adult in the eyes of the law and entitled to make decisions for himself. Since birth, this individual has been brought up in an environment where important welfare decisions are shared with the entire family, with the final say often being with the grandfather as the eldest in the family. The individual has complete faith in the ability of the elders to make important decisions wisely, and has never had any issue with this process even after he has attained the age of majority and is legally

permitted to make decisions himself. Opponents of a collaborative approach to decision-making may argue that such a scenario is not indicative of an autonomous decision, because the individual has not had the opportunity to experience making his own decisions and has simply become accustomed to deferring to the family elders. It is submitted however, that this is ultimately an invalid criticism. It is of course possible that family members may be coerced into adopting a certain way of life or making certain decisions, in which case decisions made in such circumstances would not be autonomous. However, it is also entirely possible for an individual to follow a particular way of life and continue to do so after attaining majority, on the grounds that they are happy with the status quo and therefore see no reason to question it. If the individual states clearly that they have chosen to defer to their elders and the relevant healthcare professional is satisfied with this, the decision should be regarded as autonomous and therefore valid. In deferring to the elders in the family, the individual has in effect chosen not to make a decision. If an individual grows up incorporating their family's religion into their own belief system, this is not usually seen as indicative of a lack of autonomy on their part, since their upbringing in effect shapes their personality. Also, if an individual is brought up to believe that in their family, the elders or the males should be given a greater say in important decisions, this may also be accepted and form part of their overall personality in the same way.

It is submitted that a communitarian approach to decision-making is not in conflict with an autonomous one, and is potentially equally as valid as a decision made on an individualistic basis.

CHAPTER 2: LEGAL AND PROCEDURAL CONCEPTS

LEGAL CONCEPTS

2.1: CAPACITY

Capacity is the cornerstone concept behind the law relating to healthcare¹³⁴. From an ethics perspective, respect for one's decision-making capacity underpins the substantive principle of autonomy, which as discussed in Chapter 1, is the most fundamental of ethical principles relating to human beings.

According to Bellhouse et al: **“The concept of capacity lies at the heart of an adult's right to make legally significant decisions such as giving or withholding consent to treatment, making a will, entering into a contract and marrying.”**¹³⁵

Gunn highlights the fact that giving maximum priority to capacity is often difficult, particularly when the decision is thought by others to be questionable from an objective point of view¹³⁶.

In order to be deemed legally competent to make decisions, it is necessary to satisfy the prescribed criteria for mental capacity. The existing definitions of capacity have undergone significant developments over the last two decades. A useful starting point is the definition given by Bristow J in the case of *Chatterton v Gerson*¹³⁷. In that case, his Lordship stated that in order to demonstrate capacity, the individual must be provided with enough information to be able to understand the broad terms of any proposed medical treatment. It will be seen that the threshold proposed by Bristow J is not of a high level, which ensures that individuals do not have their decision-making rights overridden unnecessarily. This ethos has remained constant throughout the development of both the common law and the legislation relating to capacity, and is undoubtedly important. Nevertheless, the ‘broad terms’ principles espoused by Bristow J came at a time when capacity was still a nascent concept in the eyes of the law and, as a result, it is vague in as much as it contains no assessment criteria for determining capacity. Further guidance was provided by the Law Commission of

¹³⁴ Report of the Expert Committee (1999) *Review of the Mental Health Act 1983*. See also Szmukler, G and Holloway, F (2000) *Reform of the Mental Health Act: Health or Safety?* British Journal of Psychiatry; Vol. 177, 196-200 at 196.

¹³⁵ Bellhouse, J et al (2001) *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice*; Advances in Psychiatric Treatment; Vol. 7; 294-301 at 294.

¹³⁶ Gunn, M J (2005) *Decision-Making and the Mental Capacity Act 2005: Some Difficult Issues and Some Possible Means of Resolution*; unpublished.

¹³⁷ [1981] 1 All E.R. 257.

England and Wales who outlined three possible broader approaches to capacity in their 1995 report *Mental Incapacity*. These were the status, outcome and functional approaches¹³⁸. Both the status and outcome approaches have been rejected outright in favour of the functional approach for reasons which will be explained below. First, it is necessary to define the three approaches.

The status approach places emphasis upon an individual's place within society i.e. as a minor or as a sufferer of mental illness. This approach carries with it a significant risk, namely that it may lead to a generalised conclusion that an individual suffering from a mental disorder or impairment will be incapable of taking any important decisions relating to their lives. The status approach was ultimately rejected because, according to the Law Commission, it was **“quite out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take.”**¹³⁹ It is submitted that the Law Commission was entirely correct to reject the status approach; it is antiquated and perpetuates the stereotype that individuals suffering with mental disorder or impairment have no decision making capacity whatsoever¹⁴⁰. From an ethics point of view, adopting a status approach to capacity would also contravene the substantive principle of non-discrimination, which states that sufferers of a mental disorder or impairment should not be treated differently from those who are not suffering with such conditions. To adopt a status approach is thus to erroneously discount the notion that an individual suffering with a mental disorder or impairment could be capable of making treatment decisions in the same way as any other person. Dhanda highlights the potentially damaging effect of a status approach:

“A label of incompetence can often play out as a self-fulfilling prophecy. Once a finding is reached that a person is incompetent to perform certain tasks, such a person shall not be given any opportunity to engage in or learn those tasks. It follows... that if a person is denied the opportunity to fulfil

¹³⁸ see Law Commission Report No. 231 (1995) *Mental Incapacity*.

¹³⁹ *Ibid.*

¹⁴⁰ See Carson D (1993) *Disabling Process: The Law Commission's Proposals on Mentally Incapacitated Adults' Decision-Making*; *Journal of Social Welfare and Family Law*; 304 at 309, where the author states that **“disability is caused in part, by non-disabled people. It is not something real experienced by individuals, but something affected by our responses to it.”** See also Freeman, M (1994) *Deciding for the Intellectually Impaired*; *Medical Law Review*; Vol. 2, 77-91 at 81.

certain life activities, he or she fails to develop the capabilities required to perform those activities.”¹⁴¹

The second approach which was outlined and rejected was the outcome approach.

According to the Law Commission:

“[The outcome approach] focuses on the final content of an individual’s decision. Any decision which is inconsistent with conventional values, or with which the assessor disagrees, may be classified as incompetent. This penalises individuality, and demands conformity at the expense of personal autonomy.”¹⁴²

The main disadvantage with this approach is that the opinions, wishes and feelings of the individual are deemed invalid or of secondary importance if they contradict established opinion or conventional norms. In the context of medical treatment decisions, a doctor permitted to adopt the outcome approach could, hypothetically speaking, override the wishes of a Jehovah’s Witness who is refusing a blood transfusion; this could be done on the grounds that the patient’s decisions conflicted with the doctor’s own beliefs. The Law Commission also stated that such an approach had been indirectly adopted by doctors in the past, in as much as if a patient’s decision matched that of the doctor, he/she would be deemed to have capacity. If on the other hand, a patient’s decision conflicts with that of the doctor, despite having been reached with all due care and consideration, the patient could be ruled as incapable and their decision subsequently overruled¹⁴³. It will be seen in Chapter 3 that this approach is incompatible with the common law position in the U.K, in particular, the judgment in *Re T (Adult: Refusal of Medical Treatment)* which stated that the reasons for making a treatment decision may be rational, irrational or non-existent provided the individual has the capacity to make the decision¹⁴⁴. This was subsequently confirmed in the s.1(4) of the Mental Capacity Act 2005.

¹⁴¹ Dhanda, A (2007) *Legal Capacity in the Disability Rights Convention: Stranglehold of the past or lodestar for the future?* Syracuse Journal of International Law and Commerce; Vol. 34, 429-462 at 436.

¹⁴² Law Commission Report No. 231 (1995) at Para 3.4.

¹⁴³ Ibid.

¹⁴⁴ *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649 at 663.

The functional approach was the test which had garnered the most support by respondents to the Consultation process and is now the standard approach for assessing capacity. The Law Commission defined this approach as follows:

“In this approach, the assessor asks whether an individual is able, at the time when a particular decision has to be made, to understand its nature and effects. Importantly, both partial and fluctuating capacity can be recognised. Most people, unless in a coma, are able to make at least some decisions for themselves, and many have levels of capacity which vary from week to week or even from hour to hour.”¹⁴⁵

The functional approach is the only test which does justice to the objectives given by the Law Commission. It fully considers the various states of capacity which exist, and does not treat capacity as an ‘all or nothing’ concept¹⁴⁶. This allows for the possibility that adults with incapacity may be able to make certain decisions for themselves. The overriding of an individual’s right to make decisions is something which should never be done unless the incapacity of the individual has been confirmed. In order for this to happen, it is essential that a thorough assessment of capacity takes place. Adopting the functional approach necessitates this assessment, and requires that it is carried out for each particular decision, rather than simply requiring a general non-specific assessment of an individual’s capacity.

Further guidance on a functional approach to capacity was provided through the MacArthur Treatment Competence study, conducted by Thomas Grisso and Paul Appelbaum in 1995. The objective of the MacArthur project was to **“develop reliable and valid clinical information with which to address clinical and policy questions regarding the abilities of persons with mental illness to make decisions about psychiatric treatment.”**¹⁴⁷ In order to achieve this objective, the authors proposed four legal standards which should be used to determine whether an individual has the ability to make treatment decisions.

¹⁴⁵ Law Commission Report No. 231 (1995) at Para 3.5.

¹⁴⁶ see Bellhouse et al (2003) *Capacity-based mental health legislation and its impact on clinical practice 1) Admission to hospital and 2) Treatment in Hospital*; Journal of Mental Health Law; August 2003, 9-37 and Bellhouse et al (2001) *Families and new medical dilemmas – capacity to make decisions*; Child and Family Law Quarterly; Vol. 13(4), 383-398, all of which concern research conducted utilising the functional approach to capacity.

¹⁴⁷ Appelbaum, P.S and Grisso, T (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2); 105-126 at 105.

First, the individual must demonstrate the ability to communicate a particular choice. This, according to Grisso and Appelbaum, is the least strict of the four standards. The standard requires simply that an individual must be able to communicate a particular decision to the relevant caregiver. Those who are unable to do so will have failed to satisfy this particular standard¹⁴⁸.

Secondly, the individual must be able to understand relevant information presented to them. This standard **“emphasises the importance of patients’ comprehension of information related to the issue at hand.”**¹⁴⁹ This is somewhat comparable to Lord Thorpe’s requirement that the individual be able to take in and retain the information given to them. In order for somebody to be able to retain information, it is necessary that they first be able to understand it.

Thirdly, the individual must be able to appreciate the nature of the situation and its likely consequences. According to Grisso and Appelbaum:

“This standard differs from an ability to understand information in requiring that patients be able to apply the information abstractly understood to their own situation. Thus, patients who understand that their physicians believe they are ill, but, in the face of objective evidence to the contrary, deny that this is so, or who understand that an effective treatment exists, but refuse to believe that it is likely to help them, will be said to lack appreciation.”¹⁵⁰

Grisso and Appelbaum’s exposition of the appreciation requirement makes reference to patients ‘denying’ that they are ill when doctors state otherwise, which could be construed as indicative of a patient not believing the information presented to them. In addition, Grisso and Appelbaum refer directly to the issue of belief in relation to patients not acknowledging that a particular course of treatment will help them and how this would be an indication of a failure to appreciate the information.

Finally, Grisso and Appelbaum state that the individual must have the ability to manipulate any information given in a rational manner. Furthermore:

¹⁴⁸ Ibid at 109.

¹⁴⁹ Ibid.

¹⁵⁰ Ibid at 110.

“This standard emphasises patient’s abilities to employ logical processes to compare the benefits and risks of treatment options. Even in the presence of good understanding and appreciation, decision-making still might be impaired if patients fail to process information logically. Conversely, the rational manipulation standard might be met even by patients who have impaired understanding or defective appreciation if their reasoning processes are intact.”¹⁵¹

The key element to this standard is the ability to compare the benefits and risks of any proposed treatment. Note however that the **ability** to manipulate information rationally is what is necessary here, and this should be distinguished from the individual actually being required to manipulate information in a rational manner. For example, an individual who is both mentally and physically healthy would ostensibly have the ability to balance up benefits and risks of a particular treatment. However, he may choose to make a decision based on the flip of a coin. In this way, the individual is making a conscious choice not to manipulate the information rationally, but instead leave the decision to chance. As long as he/she has at some point demonstrated the ability to balance up the information available, this need not necessarily be utilised in the final decision. Grisso and Appelbaum state that a decision is not irrational simply by virtue of being unconventional¹⁵², an ethos which has also been applied in U.K capacity law¹⁵³. The irrationality, say Grisso and Appelbaum, comes from the inability to process the information logically¹⁵⁴. It is also worth noting that under the Mental Capacity Act 2005, s.3(1)(c) stipulates that the individual must be able to **“use or weigh that information as part of the process of making the decision.”** However Grisso and Appelbaum do not make reference to belief of information as one of their four assessment criteria specifically, although they do highlight this as being one aspect of an individual appreciating the information.

¹⁵¹ Ibid.

¹⁵² Ibid. See also the American case of *Re Maida Yetter* [1973] 96 D & C 2d 619.

¹⁵³ See *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649 and Mental Capacity act 2005 at s. 1(4).

¹⁵⁴ Ibid at 110.

2.2: DECISION-MAKING FOR THE INCAPABLE ADULT: THE CONCEPTS OF BEST INTERESTS AND BENEFIT

The issue of decision-making for the incapable adult becomes relevant only when a capacity assessment has revealed conclusively that the individual is incapable of making treatment decisions without assistance. In such a case, the relevant healthcare professional must make a decision based on what they consider to be in the best interests of the individual. This concept has undergone significant development over the last two decades, more in terms of content than definition.

In England and Wales, the common law position on best interests held that a proposed treatment will be in a patient's best interests only if that treatment is carried out with a view to saving the patient's life, or to ensure an improvement or prevent deterioration in the patient's condition¹⁵⁵. The common law has also confirmed that even though a medical procedure will be at the heart of a best interests determination, the concept must extend beyond mere therapeutic medical interests¹⁵⁶. The common law of England has thus interpreted best interests in the light of non-therapeutic issues, such as the desire not to cause emotional distress to the individual. On this point, the Law Commission stated that the principles of least restrictive alternative and normalisation¹⁵⁷ were in essence based upon non-medical interpretations of best interests¹⁵⁸.

The concept of best interests is to be utilised to help individuals who cannot make decisions for themselves and the discussions relating to the reform of English capacity law which have ultimately led to the implementation of the Mental Capacity Act 2005 have resulted in an ideological shift for the best interests test.

During the consultation process, the Law Commission highlighted two possible methods of making treatment decisions on behalf of incapable adults. These were the

¹⁵⁵ *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C 1 per Lord Brandon at 55.

¹⁵⁶ See *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C 1; *Re A (Medical Treatment: Male Sterilisation)* [2000] 53 B.M.L.R 66; *Re SL (Adult Patient: Medical Treatment)* [2000] 2 F.C.R 452, all of which will be discussed in detail in Chapter 4 of this thesis.

¹⁵⁷ See Chapter 1 of this thesis.

¹⁵⁸ Law Commission Consultation Paper No. 129 (1993) *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research* at Para 3.47.

best interests tests and the substituted judgment test. Whilst the best interests test places the opinion of the decision-maker very much at the centre of the decision, the substituted judgment test places more importance upon the wishes and feelings of the individual, with the decision-maker acting more as an agent of the individual. According to the Law Commission, **“Under the substituted judgment standard, decisions made for an incapacitated person attempt to arrive at the choice that particular person would have made had he been competent to do so.”**¹⁵⁹ However, the fact that both best interests and substituted judgment appear to have separate approaches does not mean that they are mutually exclusive. Indeed, the manner in which the best interests test has been laid down in the Mental Capacity Act 2005 shows this clearly.

During the consultation process for the Mental Capacity Act 2005, the Law Commission discussed whether it would be appropriate to adopt either the best interests or substituted judgment test exclusively. With regards to the appropriateness of the two tests, the Law Commission stated that the substituted judgment test was in principle preferable to the best interests test, the latter being thought of as too restrictive and paternalistic in nature. In practice however, the Commission felt that a blanket application of the substituted judgment test would also be problematic: **“It [the substituted judgment test] is more difficult to apply in the case of someone who has never had capacity... most significant decisions in such a person’s life will invariably have been taken by others and any choices made by him will have been from a very restricted range of options.”**¹⁶⁰ Ultimately, the best interests test included in the Mental Capacity Act 2005 was an amalgamation of both the common law best interests test and the substituted judgment test. While best interests under the 2005 Act retains the primary objective of allowing intervention on behalf of an incapable adult, it also requires the decision-maker to ascertain the individual’s past and present wishes, feelings, beliefs and values as far as is practicable¹⁶¹. It is here where elements of the substituted judgment test can most clearly be seen. As stated above the Law Commission’s definition of substituted judgment stated that the decision-maker using the test must try and arrive at the choice that the incapable adult

¹⁵⁹ Law Commission Consultation Paper No.119 (1991) *Mentally Incapacitated Adults and Decision-Making: An Overview* at Para 4.22.

¹⁶⁰ *Ibid* at Para 4.23.

¹⁶¹ Mental Capacity Act 2005 s.1(6).

would have arrived at were they capable of taking this decision themselves¹⁶². If the decision-maker is required to ascertain the person's wishes, feelings, beliefs and values, the ultimate purpose of doing so is to help the decision-maker 'substitute' their own wishes, feelings and opinions for that of the individual. Wrigley criticises a pure substituted judgment approach from a philosophical perspective: **“we have neither the ability to mentally simulate another person's thought process nor an adequate psychological theory to represent and predict their thoughts and wishes.”**¹⁶³ Wrigley is correct inasmuch as decision-making on the basis of substituted judgment decision-making can never be as effective as if a decision had been made by the individual themselves. However, the fact remains that this will not always be possible, and it is thus essential that measures for making decisions on behalf of incapable adults are provided for in capacity legislation. No system can be perfect, but an imperfect system does not necessarily equate to an ineffective system.

In essence, the decision-maker making a best interests decision is an agent for the incapable adult who should use the wishes, feelings and beliefs of the individual to make the decision if possible, rather than come to their own conclusions as a purer best interests model would permit. It is submitted that this was the correct approach for two reasons: First, discarding the best interests test completely would fail to safeguard the needs of individuals who are profoundly or entirely incapable of making treatment decisions themselves. Secondly, discarding the substituted judgment test entirely fails to uphold the pro-autonomy ethos of the legislation by failing to acknowledge the wishes and feelings of the individual. In this way, the best interests test in its current form represents a departure from the common law version, and is as much about promoting the autonomy of the individual as it is about intervening on their behalf. Ultimately, it can be seen that both tests contain aspects which are useful and pertinent to incapable adults. McCubbin and Weisstub state that the difference between best interests and substituted judgment is ultimately a question of mere semantics: **“The [best interests test] involves an external assessment and balancing of interests, while the [substituted judgment test] requires the decision-maker to stand in the shoes of the incompetent person... in reality any**

¹⁶² Law Commission Consultation Paper No. 119 (1991) *Mentally Incapacitated Adults and Decision-Making: An Overview* at Para 4.22.

¹⁶³ Wrigley, A (2007) *Proxy Consent: Moral Authority Misconceived*; *Journal of Medical Ethics*; Vol. 33, 527-531 at 529.

decision made for a mentally incompetent person will inevitably rely on a combination of the two patterns of decision-making.”¹⁶⁴

Scottish capacity law, whilst being ideologically very similar to English capacity law, has elected to discard best interests in favour of an alternative test for deciding how to intervene on behalf of the incapable adult. This was referred to as the benefit test, and the term has been also been adopted by the Council of Europe in the 1997 Convention on Human Rights and Biomedicine, in which Article 6(1) states that any intervention carried out on a persons incapable of consenting may only be carried out **“for his or her direct benefit”**. While the Scottish Law Commission stressed that the concept of benefit was distinguishable from the concept of best interests, the differences between the two are perhaps more apparent than real.

In the 1995 *Report on Incapable Adults*, the Scottish Law Commission explained its reasons for rejecting the best interests test:

“We consider that ‘best interests’ by itself is too vague and would require to be supplemented by further factors which would have to be taken into account. We also consider that ‘best interests’ does not give due weight to the views of the adult, particularly to wishes and feelings which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child’s level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles... are framed without express reference to best interests.”¹⁶⁵

¹⁶⁴ McCubbin, M and Weisstub, D N (1998) *Toward a Pure Best Interests Model of Proxy Decision Making for Incompetent Psychiatric Patients*; International Journal of Law and Psychiatry; Vol. 21(1), 1-30 at 12, quoting Tomossy, G F and Weisstub, D N (1997) *The Reform of Adult Guardianship Laws: The case of Non-therapeutic Experimentation*; International Journal of Law and Psychiatry, Vol. 20, 113-139. See also Hale, B (1997) *Mentally Incapacitated Adults and Decision-Making: The English Perspective*; International Journal of Law and Psychiatry; Vol. 20 (1), 59-75 at 65.

¹⁶⁵ Scottish Law Commission Report No. 151 (1995) *Incapable Adults* at Para 2.50.

As an alternative to best interests, the Scottish Law Commission elected to introduce the concept of ‘benefit’ into the new legislation as the first general principle. The Scottish Law Commission said the following:

“Our first general principle is based on benefit to the incapable adult. The person intervening should be satisfied that the intervention will benefit the adult and that the benefit cannot reasonably be obtained without the intervention.¹⁶⁶ By intervention we mean any decision by a court, a guardian or any other person on whom functions are conferred under our recommendations which directly affect the welfare or affairs of the incapable adult. The category of ‘any other person’ would include the Public Guardian and managers of establishments who are looking after the finances of their incapacitated patients or residents.”¹⁶⁷

The two crucial elements of the concept of benefit are thus: First, any intervention on behalf of the incapable adult must provide some tangible benefit, and secondly, the one making the intervention must be satisfied that the same benefit cannot be achieved without having to intervene on behalf of the individual¹⁶⁸. It was held in *M, Applicant*¹⁶⁹ that **“benefit can accrue even though the adult may now have lost the capacity to appreciate or understand the benefit.”¹⁷⁰**

In terms of the ethical principles that underpin ‘benefit’ as a concept, successful application of the concept necessitates a paternalistic approach to some extent. Like the best interests test, the concept of benefit is intended to provide proxy decision makers with a benchmark against which decisions can be made. If the individual is capable of making their own decisions on treatment, the concept of benefit in essence becomes irrelevant, as the doctor must respect the reasons for the decision made by the patient¹⁷¹.

Beyond this, very little guidance has been given in the legislation and in the Code of Practice, as to what constitutes ‘benefit’. This could be explained on the grounds that

¹⁶⁶ for the briefest of descriptions of this concept, see Kay, A (2001) *Changes in the Legal Framework for incapacity in Scotland*; Primary Health Care; Vol. 11(3), 20-21.

¹⁶⁷ Ibid at Para 2.51.

¹⁶⁸ see Wilkinson, H (2001) *Empowerment and decision-making for people with dementia: the use of legal interventions in Scotland*; Aging and Mental Health; Vol. 5(4), 322-328 at 326.

¹⁶⁹ [2007] S.L.T (Sh Ct) 24.

¹⁷⁰ per Sheriff Baird at 26.

¹⁷¹ *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649 per Donaldson M.R at 663.

The Scottish Law Commission intended the concept to be given as broad an interpretation as possible by the courts. As stated earlier, The Scottish Law Commission emphasised clearly that assessments of capacity must be done according to the individual circumstances in each case. Therefore, it could be argued that deliberately opting for a broad interpretation of the benefit concept would in fact help the relevant third party to take into consideration whatever circumstances he or she feels is appropriate to the case being dealt with at the time. This is in contrast to having to defer to a list of guidelines devised by the legislators. Adrian Ward provides one possible interpretation of the term:

“With due caution, ‘benefit’ can be reasonably be interpreted as encompassing overcoming the limitations created by incapacity, so as to permit something which the adult could reasonably be expected to have chosen to do if capable, even though of a gratuitous or unselfish nature.”¹⁷²

If one were to concur with Ward’s interpretation, then s.1(2) could be argued to be endorsing some form of substituted judgment, as it would require ascertaining what the individual might have chosen if he/she had the requisite capacity. However, it is submitted that such an interpretation would not necessarily be accurate. As s.1(2) refers to ‘benefit’, it cannot always be assumed that an individual, if capable, would always make a decision that would be of benefit to themselves. A Jehovah’s Witness requiring a blood transfusion for instance might refuse the operation on religious grounds, and it would be within his/her right to do so¹⁷³. However, such a decision could not necessarily be argued to be of benefit to the patient in the traditional sense of the term. One might argue that greater benefit would be achieved in accepting the operation and returning to health. However, this would not be justifiable ethically, particularly considering the emphasis placed on autonomy throughout the consultation process and the 2000 Act itself. This raises the question of whether acting in order to benefit the individual is in fact the same as acting in the best interests of the individual. Given that both concepts have been given a wide interpretation, the answer to this question ultimately depends upon one’s interpretation of benefit.

¹⁷² Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 4.8.

¹⁷³ See *Malette v Schulman* [1990] 67 D.L.R (4th) 321 (Ontario CA) and *R v Blaue* [1975] 1 W.L.R 1411.

As stated earlier, the concept of benefit becomes most relevant in proxy decision-making, which is paternalistic by nature. However, if a doctor is required to consider what a patient would have done if they had the requisite capacity, this dilutes the paternalistic aspect somewhat, since the doctor would in essence be carrying out the will of the individual, rather than base the decision upon his/her own opinions and feelings. It is of course unrealistic to expect that proxy decision-making can ever be fully autonomous; that is an impossibility. However, the Scottish approach to proxy decision making allows for a balance to be struck between the duty to promote the autonomy of the individual and, if this is not practicable due to the severity of the individual's incapacity, the duty to intervene in order to provide a tangible benefit.

When analysing the concept of benefit as adopted in Scottish capacity law, one important factor should be immediately apparent; there is very little difference between the ethos behind both the benefit test and the best interests test. Both tests require any intervention to be solely in furtherance of the individual's welfare, and both require consideration of what the individual would have chosen to do if capacity was present. It will be recalled that one of the main reasons for the rejection of the best interests test in Scottish capacity law was that it failed to consider the wishes and feelings of the individual¹⁷⁴. Given that Report No. 151 was published in 1995 before the best interests test had developed to the extent that it has, the Scottish Law Commission's statement was more than likely true at the time. However, the best interests test as laid down in the Mental Capacity Act 2005 explicitly requires the decision-maker to consider the wishes and feelings of the individual¹⁷⁵, which ultimately means that there is little substantive difference between the best interests and benefit tests as both appear in the English and Scottish capacity statutes.

2.3: PROCEDURAL PRINCIPLES

The purpose of procedural justice in the context of capacity law is essentially twofold: First, mechanisms must be in place to permit the individual to exercise their autonomy over relevant healthcare decisions. Schwab explains thus: **“A procedural account defines autonomy in terms of following certain procedures. If the appropriate**

¹⁷⁴ Scottish Law Commission Report No.151 (1995) *Report on Incapable Adults* at Para 2.50.

¹⁷⁵ Mental Capacity Act 2005 s.4(6).

procedures are followed, then the outcome is autonomous – regardless of the content of the outcome or the characteristics of the decision-maker.”¹⁷⁶ In addition to this, procedural justice must exist to protect the welfare of the individual. In essence, procedural justice is integral to the upholding of the substantive principles outlined in Chapter 1 of this thesis.

Procedural justice has been defined by Lawrence Solum as follows:

“In the context of a modern nation-state, procedural justice is concerned with the adjudicative methods by which legal norms are applied to particular cases and it is also concerned with the legislative processes by which the shares of social benefits and burdens are divided.”¹⁷⁷

This section will engage in a discussion of the important principles of procedural justice which underpin the law of capacity alongside the substantive ethical principles discussed in Chapter 1 of this thesis. Given that both England and Scotland now have specific capacity legislation in place, the principles which will be discussed are at this time more pertinent to the United Kingdom than India. As will be seen in Chapter 5 of this thesis, capacity law in India has not yet developed to the extent that it has in the United Kingdom. However, one of the issues which will be addressed in this thesis is whether India will develop a system of capacity law in a similar manner to that of the United Kingdom. In the light of this, it is submitted that any developments in the law of capacity that may take place in India in the future should be underpinned by the procedural principles discussed below. However, before examining the methods in which procedural justice is administered in both jurisdictions, it is important to discuss the elements of an effective system of justice. Once this has been done, it will then be possible to examine whether England and Scotland have adequately discharged their duties vis a vis effective procedural justice.

John Rawls writes extensively on procedural justice in his book *A Theory of Justice*. In his book, Rawls divides procedural justice as a concept into three sub-categories: perfect, imperfect and pure procedural justice. Perfect procedural justice essentially

¹⁷⁶ Schwab, A P (2006) *Formal and effective autonomy in healthcare*; Journal of Medical Ethics; Vol. 32, 575-579 at 576.

¹⁷⁷ Solum, L.B (2004) *Public Law and Legal Theory Research Paper Series No. 04-02: Procedural Justice* at 50. Accessed on 23/03/2007; Can be found online at <http://ssrn.com/abstract=508282>.

states that a just outcome will occur in every case, and deals also with the mechanisms whereby such a scenario might come about. According to Rawls, perfect procedural justice has two important components:

“First, there is an independent criterion for what a fair division, a criterion defined separately from and prior to the procedure which is to be followed. And second, it is possible to devise a procedure that is sure to give the desired outcome... The essential thing is that there is an independent standard for deciding which outcome is just and a procedure guaranteed to lead to it.”¹⁷⁸

Ultimately, perfect procedural justice can merely be considered as a theoretical model of justice. It is unworkable in practice as it necessitates not only an acceptable system of procedure to be in place, but also that the system always produce a just result. This is of course impossible to guarantee in reality.

By contrast, a system of imperfect procedural justice involves a procedural system which aims to deliver justice, for example, through the punishment of a criminal.¹⁷⁹ The important aspect of imperfect procedural justice is that an acceptable system of procedures must be in place, irrespective of the result that derives from the system. While a just outcome would be ideal, the delivery of justice in an imperfect procedural system derives from the right to pursue a just result through an acceptable system.

Pure procedural justice rejects the notion that, unlike perfect and imperfect procedural justice, there should be independent criteria for what a just result it. Instead, whatever result occurs will be deemed fair provided that the procedure in that particular situation has been followed correctly. As Rawls explains, **“a distinctive feature of pure procedural justice is that the procedure of determining the just result must actually be carried out; for in these cases there is no independent criterion by reference to which a definite outcome can be known to be just.”**¹⁸⁰

The notion of pure procedural justice appears to be distributive rather than retributive in nature, i.e. it is concerned mainly with appropriate distribution of assets as opposed

¹⁷⁸ Rawls J (1971) *A Theory of Justice*; Harvard University Press London at 85.

¹⁷⁹ *Ibid* at 85-86.

¹⁸⁰ *Ibid* at 86.

to delivery of punishment for criminals/compensation for victims. It is perhaps therefore inapplicable to capacity law. It is submitted that the procedural system which was implemented under the Mental Capacity Act 2005 in October 2007, could best be equated to one of imperfect procedural justice. Although John Rawls contextualised the concept in terms of a criminal trial, it is submitted that any system whereby independent criteria of justice are specified, could potentially be considered as imperfect systems of procedural justice.

There are three documents which must be considered when addressing the issue of procedural justice and capacity law. Once these are analysed, it will then be possible to extract the key principles which must underpin the procedural aspects of the law. These documents are: The United Nations Convention on the Rights of Persons with Disabilities 2006, The European Convention on Human Rights and Recommendation (99)4 on Principles concerning the Legal Protection of Incapable Adults. The relevance of each of these will now be discussed in turn.

The U.N Convention on the Rights of Persons with Disabilities 2006 is a document that deals predominantly with substantive ethical principles and its relevance is discussed in Chapter 1 of this thesis. With regards to procedural principles, Articles 12 and 13 should be noted. Article 12 states that any persons with disabilities have the right to be recognised anywhere as persons before the law, and should enjoy legal capacity on an equal basis with others in all aspects of life. In addition, Article 12(4) states that States Parties must provide for effective safeguards to prevent any abuse of the individual, and any such measures relating to the rights, will and preferences of the individual must be proportional and consider the specific circumstances of the individual. Article 13 of the U.N Convention states that individuals with disabilities must have access to an effective system of justice, which is on an equal basis with others. This must be achieved through **“the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.”**

As can be seen, Articles 12 and 13 of the 2006 U.N Convention acknowledge the vulnerability of persons with disabilities and should thus be safeguarded against any

potential abuse. In order to achieve this, it is vital that appropriate procedural mechanisms are put in place. In addition, Article 13 of the U.N Convention refers to the role of the individual as a direct or indirect participant; a clear endorsement of the right of the individual to participate in any proceedings relating to him/her as much as is practicable. This principle will be discussed in detail below.

Another important aspect of procedural justice in the context of European jurisdictions is compliance with the European Convention on Human Rights. Article 6(1) of the Convention relates to the right of access to court and reads as follows:

“1) In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly by the press and public maybe excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.”

Article 6 of the European Convention on Human Rights in essence grants the individual the right of access to a court. Therefore, any provisions relating to procedural issues must allow for challenge within the European Court of Human Rights within a reasonable time. Adrian Ward explains the importance of Article 6 in relation to the right to decision-making:

“The right to act for oneself and make one’s own decisions in matters of one’s own personal welfare, or about one’s own property and financial affairs, is a fundamental civil right. A determination that one is incapable of acting deciding, and that someone else should take over, is a matter which one is entitled to have determined by a fair and (except for the qualifications) public hearing by an independent and impartial tribunal established by law... The imposition of such a determination *de facto* or by a court or tribunal without a fair hearing, breaches Article 6.”¹⁸¹

¹⁸¹ Ward, A D (2003) *Adult Incapacity*; W Green/Sweet and Maxwell Edinburgh at Para 1.47.

One interpretation of Ward's statement is that Article 6 will only be satisfied if a court or tribunal hearing takes place prior to a decision being taken on behalf of an incapable individual. Evidence for this could be found through Ward's reference to 'de facto' determinations of individuals' capacity. However, it is unlikely that this interpretation of Ward's statement is correct; ultimately, it is not practical for hearings to take place in a court or tribunal every time a decision needs to be made on behalf of an incapable individual, and if failing to do so infringes Article 6, that is a disproportionately high burden to place upon member states. The relevant issue is whether cases can be brought before the courts without unnecessary barriers to access. With regards to Ward's use of the term 'de facto', it is submitted that he was referring to determinations of incapacity which are made effectively at random, without any consideration of the relevant assessment criteria or the procedural mechanisms that capacity legislation has in place to ensure that the individual's right to decision-making is not overridden without just cause.

In the context of the law of capacity, compliance with Article 6 means that individuals must have the right to challenge a finding of incapacity and whether an action undertaken on behalf of an incapable adult is lawful. Article 6 will be breached if there is anything which prevents the individual from accessing the court within a reasonable period of time. The case of *Airey v Ireland*¹⁸² concerned a plaintiff seeking separation from her abusive husband. Mrs Airey was unable to secure the judicial separation she required due to high costs that were involved. The European Court of Human Rights subsequently held this to be a violation of Article 6 because the plaintiff was effectively prevented from accessing the court¹⁸³. In the context of capacity law, a breach of Article 6 might take place if an individual with some form of incapacity wishing to apply to the court, is prevented from doing so effectively because of a difficult applications process which fails to adequately take into account the incapacity of the individual. If for example, the individual is unable to communicate wishes and opinions, he/she must be provided with means of overcoming this, such as an advocate.

¹⁸² [1979] 2 E.H.R.R. 305.

¹⁸³ See also the case of *Golder v United Kingdom* [1975] 1 E.H.R.R. 524, which concerned a prisoner wishing to sue for libel who was denied access to a solicitor. In this case, the court held that the denial of access to a solicitor impeded the plaintiff's ability to access the court, this breaching Article 6.

The case of *X and Y v Netherlands*¹⁸⁴ is a further useful illustration of this by way of analogy. The case concerned a mentally impaired girl, Y, who was raped on the day after her sixteenth birthday. Following this incident, her father, X attempted to file a complaint and asked for criminal proceedings to commence. Since Y's condition meant that she was not capable of signing the complaint, X was informed that he himself could do this. Subsequently, X was informed that Y did not seem capable of expressing her wishes on the issue of criminal proceedings¹⁸⁵. An application was then made to the European Court of Human Rights. Although Article 6 was not at the heart of the application, the grounds for the case nevertheless could be applied to it. X alleged that the right to respect for family life, guaranteed under Article 8, meant that the parents of abuse victims should have adequate recourse to remedy through the courts. The fact that criminal proceedings were not brought against Y's attacker meant that this remedy was effectively not available. As stated, the application was not made under Article 6, yet the facts of the case suggest that it is relevant; ultimately, Y's condition, and the fact that her father was unable to commence criminal proceedings on her behalf, meant that she was prevented from accessing the court within a reasonable time. The issue at the heart of Article 6 is not that the individual would ever be expressly stopped from making an application to the court, but rather, whether the procedural mechanisms in place are such that the individual would be able to make an application effectively.

Of the E.C.H.R articles that are pertinent to capacity law, it is submitted that Article 6 is the most significant. Although Articles 3, 8 and 9 of the Convention are ostensibly relevant, they are not so closely linked to it so as to make challenges to the European Court particularly likely. What is crucial however, is that the individual is always provided with access to the court within a reasonable time should they wish to challenge a finding of incapacity. It is submitted that the crucial aspect of challenges to the court in capacity law is whether the individual is actually capable of making treatment decisions themselves and consequently, if an individual is unable to bring a case to court in the first place, it makes little difference which Article of the Convention has been breached in the process.

¹⁸⁴ [1986] 8 E.H.R.R. 235.

¹⁸⁵ *Ibid* at Para 10.

Extensive guidance on important procedural principles relevant to capacity law has been provided by the Council of Europe. In 1999, the Council formulated *Recommendation (99)4 of the Committee of Member States on Principles Concerning the Legal Protection of Incapable Adults* (hereafter referred to as Recommendation (99)4). The Recommendation contained guidelines relating to both substantive¹⁸⁶ and procedural principles. The most relevant procedural principles of the Recommendation are numbered from 11-14¹⁸⁷ and can be summarised as follows:

Principle 11: Institution of proceedings – the list of individuals entitled to institute proceedings for the protection of incapable adults must be exhaustive enough to guarantee that all circumstances which may arise during proceedings have been taken into consideration. Provisions must be in place to allow proceedings to be initiated by a public body.

The individual concerned must be informed of the institution of proceedings promptly, and in a manner or language which he/she will understand. Furthermore, the individual must be informed that the proceedings may affect his/her legal capacity and the exercise of rights, unless informing him/her of this may cause a severe danger to the health of the individual.

Principle 12: Investigation and assessment – Appropriate procedures must be in place to facilitate the investigation and assessment of the individual's personal faculties. No measures of protection must be undertaken which restricts the legal capacity of the individual unless the individual has been seen by the person undertaking the measure of protection. In addition, at least one suitably qualified expert must publish an up-to-date report which must be in writing.

Principle 13: Right to be heard in person – The individual concerned has the right to be heard in person during any proceedings which relate to his/her legal capacity.

Principle 14: Duration, review and appeal – Any measures of protection must ideally be of limited duration, reviewed upon any change in circumstances, and terminated if the requisite conditions for protection no longer apply. There must also be appropriate rights of appeal.

The above three documents have provided information that can be used to extract fundamental principles that should be applied to any procedural mechanisms relating

¹⁸⁶ see Introduction to Chapter 1 of this thesis.

¹⁸⁷ See also Gunn, M (2005) *Decision Making*; unpublished.

to the incapable individual. These principles are discussed below and are: The principle of participation, the principle of accuracy and the principle of conciliation.

2.3.1: THE PRINCIPLE OF PARTICIPATION

The principle of participation requires that the individual who is the subject of proceedings should be able to participate in the proceedings in question. Lawrence Solum argues that this principle is essential for a legitimate system of procedural justice. Specifically, Solum states that legitimate proceedings do not necessarily require the presence and participation of the individual, but rather, it is the presence of the option and the right of the individual to do so which provides this legitimacy¹⁸⁸. In addition, Solum submits that the option of participation must be exercisable at important stages of proceedings, and also, that this participation is in essence important in its own right; that this participation may not result in a favourable outcome for the individual does not devalue it¹⁸⁹. As stated earlier, the U.N Convention on the Rights on the Rights of Persons with Disabilities 2006 emphasises the role of the individual as a direct or indirect participant. Similarly, the participation principle can be found in principle 13 of Recommendation (99)4, where it states that the individual has the right to be heard in person during any proceedings which relate to his/her capacity. The principle also appears to echo Solum's assertion that it is the right to be heard in person which is crucial, and principle 13 does not specifically state that the individual must be present at proceedings in order to legitimise them. Indeed, there may be genuine issues of welfare which dictate that an individual would not be able to attend hearings in person. Ultimately, no procedural principles relating to capacity should compromise the welfare of the individual. The crux of the principle of participation is therefore simply that the incapable adult has the right to be heard if circumstances allow.

Of central importance in capacity law is the need to promote the autonomy of the individual as far as is practicable. This is the substantive principle which drives the law of capacity forward. However, the procedural principle of participation is

¹⁸⁸ Solum, L (2004) *Procedural Justice*; Berkley Electronic Press Paper 141 at 65; accessed online on 23/10/2007, available at <http://law.bepress.com/expreso/eps/141>.

¹⁸⁹ Ibid.

necessary in order to better ensure that the substantive principle of autonomy is upheld as much as is practicable. As discussed earlier, it is unrealistic to expect that the inclusion of an exhaustive set of procedural and substantive principles will always produce a just result. The presence of procedural principles, however, help to increase the possibility of a just result occurring, and subsequently, the principle of participation arguably makes a great contribution to this end. As well as helping to safeguard the substantive principle of autonomy, the principle of participation in the context of incapable adults will also help to safeguard the procedural principle of non-discrimination. Encouraging adults with varying degrees of incapacity to participate in their own proceedings would ideally normalise the individual and reduce stigma by dispelling the idea that incapable adults automatically lack the ability to make valuable contributions to issues in their own lives.

2.3.2: THE PRINCIPLE OF ACCURACY

The principle of accuracy corresponds to the idea that the structure of any proceedings should be designed in such a way so as to **“maximise the likelihood of achieving the legally correct outcome in each proceeding.”**¹⁹⁰ In essence, the accuracy principle corresponds to the Rawlsian notion of perfect procedural justice, which relates to a just outcome being achieved in each case, and the procedures which are utilised to bring this about. However, Solum highlights a number of circumstances in which the principle of accuracy need not and perhaps should not be prioritised, thus arguably rendering its workability as unrealistic in practice:

First, Solum states that the principle of accuracy must not take priority over the substantive rights of the individual¹⁹¹. In the context of the incapable adult therefore, this means that substantive principles, such as the autonomy and the welfare of the individual, cannot be devalued in order to ensure that proceedings relating to him/her produce a just result.

Secondly, Solum submits that the accuracy of outcome is subordinate to systemic accuracy: **“... so long as the procedures are announced in advance and create general rules with which parties can comply by making a reasonable good faith**

¹⁹⁰ Ibid at 86.

¹⁹¹ Ibid.

effort...¹⁹² This is somewhat related to the principle of participation, in that although the inclusion of the participation principle may not guarantee an accurate outcome, it essentially contributes to the guarantee of systemic accuracy. Solum further states that the proviso of systemic accuracy is important, as it

“...attempts to strike a fair balance between systemic accuracy and accuracy in the particular case. On the one hand, the basic statement of the accuracy principle expresses the judgment that procedural justice aims to resolve the case that is being decided accurately; the baseline notion is that case accuracy takes priority over system accuracy. Our notion of procedural justice requires the fair treatment of individuals, and making systemic accuracy the baseline would fail to take the differences between individuals seriously. On the other hand, there are situations in which systemic accuracy can be promoted without treating the individual unfairly. Where a rule promoting systemic accuracy is announced in advance and parties can reasonably comply with the rule, imposing a case-accuracy distorting sanction is not unfair to those affected – the opportunity to comply places the responsibility for the distortion on the party who disobeyed the procedural rule.”¹⁹³

Thirdly, Solum argues that the accuracy principle should not result in disproportionate costs in relation to the interests which are at stake in a particular set of proceedings.¹⁹⁴

With regards to the law of capacity, it could be argued that the traditional methods of dispute resolution through the courts may not always be suitable for resolving capacity issues. One of the reasons is that such a system is perhaps too adversarial, and this principle will be discussed below. Another reason relates to the cost of court proceedings versus the accuracy principle. Since case accuracy cannot be guaranteed in every case, it is arguably better to consider a system of Alternative Dispute Resolution which may help to reduce costs whilst potentially providing as much possibility of a favourable outcome as traditional court proceedings.

The essence of Alternative Dispute Resolution (ADR) schemes are that they provide further avenues for resolving disputes which do not necessarily involve financial redress¹⁹⁵. This is of particular relevance to cases pertaining to capacity, since cases in this field are ostensibly more likely to concern the challenge of treatment decision, or

¹⁹² Ibid.

¹⁹³ Ibid at 87.

¹⁹⁴ Ibid.

¹⁹⁵ see Lord Woolf (1996) *Access to Justice Final Report* at Para 15.50.

findings of incapacity. Financial redress is therefore unlikely to be a significant priority, although encouraging more informal methods of dispute resolution such as mediation schemes, might help to avoid disproportionate court costs.

Another important aspect of the accuracy principle as it relates to capacity law is the need to thoroughly investigate the capacity of the individual. This is particularly important if the proceedings are concerned with a possible intervention on behalf of the individual for the purposes of safeguarding their welfare. This must only be done if the decision-maker is entirely satisfied that the individual is in fact incapable of making the relevant decision. To intervene when this is not the case would clearly be contravening the principle of accuracy and would thus compromise the legitimacy of the proceedings.

Of the three key documents discussed at the beginning of this section, Recommendation (99)⁴ provides arguably the most in-depth exposition of the principle of accuracy. First, principle 12 states that appropriate procedures must be in place to facilitate the investigation and assessment of the individual's personal faculties. Furthermore, no measures of protection must be undertaken which restricts the legal capacity of the individual, unless the individual has been seen by the person undertaking the measure of protection. In addition, at least one suitably qualified expert must publish an up-to-date report which must be in writing. This pertains to the principle of accuracy by virtue of the fact that inadequate investigation of an individual's faculties might lead to an individual being deemed as incapable of making a particular decision, when in fact this might not be the case. Consequently, measures of intervention may be implemented unnecessarily and more importantly, inaccurately. Such a scenario effectively nullifies the chances of an accurate result being achieved, and the fact that inadequate investigation measures have been implemented would also illustrate a lack of systemic accuracy.

Principle 14 relates to duration, review and appeals during proceedings, and states that any measures of protection must be of a limited duration, reviewed upon any change of circumstances, and terminated if the requisite conditions for protection no longer apply. There must also be appropriate rights of appeal for all proceedings. The link to the principle of accuracy comes from the fact that as with principle 12, it is essential that as well as an investigation into the faculties of the individual, procedural

mechanisms must be in place to review the individual's capacity in order to ascertain whether the incapacity that triggered an intervention is still present. This is obviously of particular importance when the incapacity is of such a nature that it may fluctuate or disappear entirely. It is therefore essential to satisfy the principle of accuracy by regularly investigating and reviewing an individual's capacity and withdrawing any intervention measures made on their behalf if these are no longer needed.

2.3.3: THE PRINCIPLE OF CONCILIATION

The objective of this section of this thesis is to highlight the important principles of procedural justice as they relate to capacity law in England, Scotland and India. As will be discussed later in this section, it is submitted that the law of capacity does not lend itself particularly well to an adversarial system of justice, and would arguably benefit more from a more inquisitorial system of procedural justice. To this end, the principle of conciliation plays an important role, as it requires any proceedings to be conducted in such a way so as to promote compromise between parties, and emphasises any common ground that may exist, rather than the difference between the parties.

Thibaut et al identify five models of adjudicatory systems which encompass the important aspects of both adversarial and inquisitorial justice. The authors write with specific reference to the United States of America, throughout whose system the five models discussed below are featured. However, Thibaut et al's discussion of these five models are worthy of inclusion here in order to show the advantages and shortcomings of the current systems adopted by the three jurisdictions which provide the focus for this thesis. The discussion is also useful in order to see how the principle of conciliation fits into these models.

The first model highlighted by Thibaut et al is the purely inquisitorial model. This system, as defined by the authors: **“is characterised by an activist decision-maker directly developing the facts in interaction with involved persons and then**

reaching a decision.”¹⁹⁶ The emphasis of the inquisitorial model is upon the decision-maker, i.e. the judge, interacting with the parties in the form of interviewing, rather than simply listening to the biased testimonies of the parties and making a decision on that basis. In effect, there is more direct involvement from the decision-maker in an inquisitorial system.

The second model is a variant on the pure inquisitorial system, and is entitled ‘the single investigator model’. Thibaut et al define this model as follows:

“Here, a moderately activist decision-maker is assisted by an investigator whose rewards are controlled by the decision-maker and whose role definition is that of an impartial and unbiased truth-seeker. The disputants are largely restricted to furnishing requested information, though the opportunity to interact with an investigator may slightly increase the disputants’ opportunity to control the procedure.”¹⁹⁷

The ‘single investigator’ model derogates slightly from the pure investigator model in as much as the primary decision-maker has an assistant investigator to oversee the important aspects of the proceedings. The investigator is impartial and is therefore an extension of the primary decision-maker. As with a purely inquisitorial model, the parties are restricted to answering questions which are put to them, rather than being given the opportunity to present their case in the traditional manner.

The third model is known as the ‘double investigator’ system. As the name suggests, this model involves a primary decision-maker and two investigators who are responsible for investigating the claims of both parties and who must then report back to the primary decision-maker for a ruling. By way of reference to the court-martial of the United States, Thibaut et al illustrate the fact that the primary decision-maker (in that case, the military judge) has less of a pivotal role in proceedings:

“Military judges are relatively passive; they are not charged with planning or developing the case nor with interrogating the witnesses. Considerable responsibility is assigned to the representatives of the Government and the accused, but both representatives of the Government and the accused, but

¹⁹⁶ Thibaut, J et al (1974) *Procedural Justice as Fairness*; Stanford Law Review, Vol.26(6), Symposium on Law and Psychology, 1271-1289 at 1273.

¹⁹⁷ Ibid.

both representatives are paid by the same authority, which also employs the decision-maker. Thus a considerable amount of cooperative behaviour is facilitated.”¹⁹⁸

The fourth model is referred to as the ‘adversary system’ and represents more of a significant derogation from the variants of the inquisitorial model described above. In the ‘adversary system’, the primary decision-maker again has less of a pivotal role, and instead, the parties control much of the proceedings by arguing their cases through advocates. This model leaves considerable room for bias through the testimonies of the opposing parties. This system is the model of choice for the civil procedure system of the United Kingdom.

The fifth and final model of adjudicatory systems is the ‘bargaining system’, which, like the adversary system, is predominantly controlled by the parties. However, it is also different in the sense that the parties attempt to resolve their disputes without the aid of an independent third party.

As can be seen, the five models of adjudicatory systems can be placed along a spectrum which each model requiring less involvement from the primary decision maker:

“At one end of the continuum is the inquisitorial procedure in which nearly all of the control over the hearing process is allocated to the decision-maker; at the other end is the bargaining procedure from which the decision-maker has vanished, leaving total control over the process in the hands of the disputants.”¹⁹⁹

Following Thibaut et al’s discussion of these five models, the question arises as to which model might be the more appropriate for promoting the principle of conciliation.

It is submitted that a purely adversarial system is inappropriate in the context of capacity law and the principle of conciliation. Cases relating to capacity law are rarely about seeking retribution upon the other party. Upholding the principle of conciliation

¹⁹⁸ Ibid at 1274.

¹⁹⁹ Ibid at 1275.

therefore requires a shift away from apportioning blame to the other party and fostering a confrontational atmosphere during proceedings, particularly because in the context of capacity law, both parties are in essence fighting for the same objective, namely safeguarding the best interests of the incapable adult. Take for instance the hypothetical example of a health authority who wishes to stop the administration of artificial nutrition and hydration to patient in a persistent vegetative state. In such a case, the purpose of seeking court involvement is simply to seek the opinion of an impartial observer who will listen to both sides of the argument and rule accordingly. In such a case, there is arguably no real need for an adversarial process of justice to take place. The issue is not retribution; it is simply a matter of dispute resolution. In the light of this, is an overtly adversarial system of procedural justice appropriate for dealing with cases relating to incapacity? It could be argued that a shift towards a more inquisitorial system would be more beneficial to litigants involved in capacity cases. This is in contrast to adversarial justice, in which the judge in essence acts as an ‘umpire’ between two parties, and is **“expected to listen to what the opposing parties present to him by way of their respective positions and to pronounce the winner at the end of the day.”**²⁰⁰

In theory, a purely inquisitorial model is likely to be the simplest and most effective model for promoting the principle of conciliation. In cases involving the health and welfare of an individual, where emotions are likely to be heightened, the most will be achieved by having one primary decision-maker interact with the disputing parties as informally as is practicable, rather than encourage a more adversarial, confrontational form of dispute resolution. Furthermore, although court involvement may often be necessary for resolving disputes relating to medical treatment for incapable adults, i.e. through the process of court declarations, an effective way of utilising a more inquisitorial process of dispute resolution may be to do so without the involvement of the courts, with the involvement of a judge being used as an option of last resort. As with the principle of accuracy, Alternative Dispute Resolution schemes may also be extremely useful in promoting a less formal and less adversarial atmosphere, which may ultimately be more conducive to promoting the welfare of the individual in a manner which would ideally place less pressure upon and cause less stigma to the

²⁰⁰ Jolowicz, J A (2003) *Adversarial and Inquisitorial Models of Civil Procedure*; International and Comparative Law Quarterly, Vol.52, 281-295 at 281.

individual. However, whilst this may be the case in theory, the fact remains that attempts at resolving disputes on an inquisitorial basis will not always be successful. In highly controversial or difficult cases, relying upon a more traditional court system which may utilise more adversarial processes may be the most effective way of safeguarding the best interests of the individual, and therefore, the adversarial system cannot realistically be done away with entirely. However, this does not mean that any formal court system cannot uphold the principle of conciliation during any proceedings. As will be discussed in Chapter 5 of this thesis, it is envisaged that the new Court of Protection set up under the Mental Capacity Act 2005 will deal with disputes in a more informal manner; it is an official court and has all the requisite powers of one, but at the same time, is intended to be used as an option of last resort, with the main objective being to uphold the general principles of the Mental Capacity Act, including promoting the interests of the individual in a manner which will cause minimum discomfort and stigma.

CHAPTER 3: CAPACITY ASSESSMENT IN ENGLISH, SCOTTISH AND INDIAN LAW

3.1: CAPACITY ASSESSMENT IN ENGLISH LAW

3.1.1: CAPACITY ASSESSMENT IN ENGLAND AND WALES PRIOR TO THE MENTAL CAPACITY ACT 2005

Prior to the implementation of the Mental Capacity Act 2005 in October 2007, any guidance on the issues of capacity were derived from the common law. This thesis focuses upon these issues in relation to medical treatment and this chapter will therefore provide a history of the common law developments in relation to decision-making in relation to medical treatment, as well as an in-depth analysis of the relevant provisions of the Mental Capacity Act 2005.

However, it should first be noted that the common law of England and Wales has only provided guidance in relation to medical treatment in the last two decades. Prior to this, capacity issues had been brought before the court, but in relation to issues such as testamentary capacity and capacity to marry. It is therefore important to provide a brief history of common law guidance in relation to these matters before examining the common law position in relation to decision-making and medical treatment.

The case of *Banks v Goodfellow*²⁰¹ concerned the testamentary capacity of John Banks, who had made a will in favour of his niece, Margaret Goodfellow. The plaintiff in the case challenged the validity of the will on the grounds that the testator did not have the requisite capacity to make the will. John Banks, prior to the making of the will, had been confined to an asylum as a result of mental disorder. His condition manifested itself through the delusional belief that he was being pursued and molested by a recently deceased individual as well as devils and evil spirits. These delusions had been attested by a medical practitioner and a member of the clergy and these attestations formed an important part of the evidence against Banks' capacity to make the will. The central issue in the case was whether at the time of making the will, the testator was capable of appreciating the relevant facts and was

²⁰¹ [1870] L.R. 5 Q.B 549.

“so far master of his intentions, free from delusions, as would enable him to have a will of his own in the disposition of his property, and act upon it.”²⁰²

It was held that the will was entirely valid on the grounds that the testator’s delusions had no bearing or influence upon the making of the will at the time that he had made it. As well as the evidence which illustrated the severity of Banks’ delusions, evidence was also provided which showed that he managed his own financial affairs and was diligent when doing so. Evidence from a witness who had collected rent on Banks’ behalf from his properties stated that he had always been capable of conducting business with the agent²⁰³. Although it had been admitted that the testator had been incapable of making a will on some occasions, there was ultimately no evidence to suggest that he lacked capacity at the material time:

“In the case before us two delusions disturbed the mind of the testator; the one that he was pursued by spirits, the other that a man long since dead came personally to molest him. Neither of these delusions... could have had any influence upon him in disposing of his property. The will, though in one sense an idle one, inasmuch as the object of his bounty was his heir at law, and therefore would have taken the property without its being devised to her, was yet rational in this, that it was made in favour of a niece, who lived with him, and who was the object of his affection and regard. And we must take it on the finding of the jury that irrespectively of the question of these dormant delusions, the testator was in possession of his faculties when the will was executed.”²⁰⁴

The case of *Banks v Goodfellow*, though not related to one’s capacity to decide on medical treatment, is nevertheless significant, as it is an early endorsement of the functional approach to capacity. It will be recalled that the Law Commission of England and Wales considered this to be the only appropriate approach for dealing with issues of capacity, as it requires an assessment of an individual’s decision-making capacity in relation to a particular decision, rather than allow an assumption of incapacity by virtue of the status of the individual as a sufferer of mental disorder

²⁰² Ibid at 554.

²⁰³ Ibid at 552.

²⁰⁴ Ibid at 571.

or impairment²⁰⁵. Similarly, the court in *Banks v Goodfellow* did not simply assume that the will created by Mr. Banks was automatically invalid because he suffered from delusions; the crux of the matter was whether these delusions were instrumental in the construction of the will, which they were not²⁰⁶.

The case of *Park v Park*²⁰⁷ similarly endorsed a functional approach in the context of capacity and marriage. In the case, the defendant, one Peter Park, sought to establish that his deceased father Robert Park was incapable of entering into a contract of marriage with the plaintiff, Mrs. Wyn Park, on the grounds that he did not appreciate the nature of the contract and the duties and responsibilities which it created. The deceased had made a will prior to marrying and the plaintiff sought to establish that the marriage was valid and the will thus revoked. The deceased suffered with heart problems which impaired blood flow to his brain, and thus on occasion hampered his decision-making faculties. It had been held at first instance that the deceased was capable of entering into the marriage with the plaintiff and thus died intestate, a decision which the defendant subsequently appealed. At appeal, the question arose as to whether the judge at first instance, Karminski J, had applied the correct test for capacity to enter into a marriage; namely, was the deceased, on the morning of his marriage, capable of understanding the nature of the contract into which he was entering, or was his condition such that he was incapable of understanding it?²⁰⁸ It was held on appeal that Karminski J had asked the right question and that there was therefore no reason why the decision should be overturned. The court confirmed that in order for a marriage to be valid, the parties must understand the nature of the marriage, understand the rights and responsibilities that the marriage creates and be able to take care of their own property and person. However, the court also confirmed that the marriage contract should not be difficult to comprehend, despite the requirements of the test²⁰⁹. In the case of the deceased, there was no evidence that he did not understand that he was about to embark upon a lifelong contract of marriage, nor was there any evidence to suggest that he **“thought himself to be other than he**

²⁰⁵ Law Commission Report No. 231 (1995) at Para 3.5.

²⁰⁶ See also *Scammell v Farmer* [2008] E.W.H.C 1100 (Ch).

²⁰⁷ [1954] P. 112.

²⁰⁸ *Ibid* at 128.

²⁰⁹ See also *Baldwin v Baldwin* [1919] *The Times*; *Durham v Durham* [1885] 10 P.D 80; *Park v Park* [1913] OH 19/12/1913; *Hunter v Edney* [1881] December 16th.

was; there was no confusion of identity of matters of that kind; and the position on the evidence of the medical men was really his.”²¹⁰

The case of *Park v Park* again illustrates the importance of a functional approach to capacity; in this case, was the deceased capable of understanding the nature of the marriage contract, along with the responsibilities that went along with it? It was not enough to simply assume that because the deceased had a condition which had the potential to affect his decision-making ability, he would automatically be incapable of understanding the contract of marriage²¹¹. The case was also important by virtue of the fact that it highlighted the usefulness of assessment criteria. This is particularly crucial to the issue of capacity assessment in the context of medical treatment, as will be seen below through discussion of the common law relating to the issues of capacity assessment and best interests.

An appropriate starting point for a discussion on the English common law is the case of *Re T (Adult: Refusal of Medical Treatment)*²¹². The case does not provide a working model for of assessment criteria as such, but is nevertheless important as it provides preliminary guidance on the definition of capacity.

The case concerned a heavily pregnant woman, T, who had become involved in a road traffic accident. The mother of T was a devout Jehovah’s Witness although T herself was not of the faith and upon receipt of the news that T required a blood transfusion (forbidden for Jehovah’s Witnesses under the tenets of the faith), T’s mother spent some time alone with her daughter. Following on from this meeting, T told the doctors in charge that she was refusing the transfusion. T maintained her stance on this issue, despite being told that an emergency Caesarean section would be necessary in order to deliver her baby. Upon deterioration of her condition, T was placed in an Intensive Care Unit, where the consultant anaesthetist was hesitant to administer a blood transfusion in the light of T’s previous statement. T’s father and boyfriend both took the matter to court where the judge granted a declaration authorising a blood transfusion on the basis that she had been unduly influenced by her mother, and that this had invalidated her refusal of the treatment. The same conclusion was

²¹⁰ *Park v Park* [1954] P. 112 per Birkett L.J at 130.

²¹¹ See also *Sheffield City Council v E* [2004] E.W.H.C 2808, which applies the judgment in *Park v Park*.

²¹² [1992] 4 All ER 649.

reached on a second hearing, after which T appealed. Dismissing the appeal, the court held that there were two main issues at the heart of the appeal: Did T have the requisite capacity to refuse the blood transfusion in the first place, and was this decision ultimately her own, or subject of influence from a third party? It was at the appeal that Lord Donaldson made his keynote statement on the issue of refusal of treatment:

“Every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death... it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent.”²¹³

On the issue of T’s ability to refuse the treatment, her assessment showed no signs of long-term mental incapacity at the time of her admission to hospital. It is therefore clear that the reason for the dismissal of T’s appeal centred on the conversation between T and her mother.

The judgment in *Re T* highlighted the complexities of capacity assessment. Lord Donaldson made the following statement on this point: **“What matters is whether at that time the patient’s capacity was reduced below the level needed in the case of a refusal of that importance.”**²¹⁴ Although it had been argued that T was not fully competent at the time of making the decision due to the drugs she had been given, this was still not the deciding factor in the case. The influence of T’s mother was considered to be significantly more prevalent. According to Lord Donaldson:

“...if at the time the decision is made, the patient has been subjected to the influence of some third party... this is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others... but the doctors have to consider whether the decision is really that of the patient.”²¹⁵

Ultimately, it is entirely possible that T was in such a vulnerable state that it was easy for the mother to override her daughter’s will and get her to refuse the transfusion. Therefore, it is submitted that an individual who is put under sufficient duress can lack the requisite capacity to make a treatment decision. As stated earlier, the

²¹³ per Donaldson M.R at 663. See also *St George’s Healthcare Trust v S* [1998] 3 W.L.R 936.

²¹⁴ *Ibid* at 643.

²¹⁵ *Ibid* at 661.

principle of autonomy is integral to the issue of treatment decisions. To give disproportionate weight to outside influence, even from a family member, is not to make an autonomous decision. Lord Donaldson was therefore correct in his assertion that undue influence is distinguishable from advice or assistance. However, the difficulty lies in proving the extent of the influence of the third party:

“...the real question in each case is ‘does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?’”²¹⁶

It is submitted the Court of Appeal in *Re T* was correct to rule that T had been unduly influenced by her mother. Crucial factors in this decision were the physical and mental state of T after the Caesarean operation (“... **One who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful.**”²¹⁷), and more importantly, the fact that the third party involved was a parent who happened to have strong religious views:

“Persuasion based upon religious beliefs can also be much more compelling, and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force, and should alert doctors to the possibility... that the patient’s capacity or will to decide has been overborne.”²¹⁸

It must be stressed however, that every case will be different on its facts. As Lord Donaldson stated, it would be incorrect to suggest that the existence of a parent with a dominant personality and/or strong religious views automatically means that undue influence will be present in a treatment decision. Kennedy and Grubb suggest that the Court of Appeal ruled that undue influence was present because of the gravity of the case²¹⁹ (T’s life was ultimately at risk). This position is entirely logical, and indeed, it is unclear as to whether a court would be so quick to rule on the presence of undue influence over a comparatively minor procedure such as a blood test. However, the issue in relation to procedures which may be deemed ‘simple’ must be considered

²¹⁶ Ibid at 666.

²¹⁷ Ibid at 661.

²¹⁸ Ibid.

²¹⁹ Kennedy and Grubb (2003) *Medical Law*; 3rd edition; Butterworths Press London at 757.

carefully, as there may be cases where the implications of a minor procedure may be more serious. Taking the above example of a blood test for example, the implications of consenting to or refusing such a procedure might ostensibly vary according to the purpose; a test intended to determine one's cholesterol level arguably has less serious implications than a blood test carried out to determine whether an individual carries the HIV virus. Therefore, one could argue that courts would consider whether an individual has been unduly influenced on the basis of the consequences of that decision. Therefore, it could be argued that the court applied the undue influence approach in *Re T* because the presence of strong religious views in the mother added considerable weight to this. Given the facts of the case, this is understandable:

“It is an irresistible inference that before 5pm the mother had discussed the question of blood transfusions with her daughter because Miss T ‘out of the blue’ according to the nurse raised the subject. The mother was also alone in the ambulance with her daughter when she was transferred about 11pm to the labour ward... the judge referred to the ‘mother’s fervent belief in the sin of blood transfusion’ and that Miss T had reached her decision under the influence of the mother.”²²⁰

The issue of undue influence is an important issue in the context of capacity, as it can ultimately invalidate a treatment decision irrespective of whether the individual is actually capable or not. However, the term has not been given a concrete definition as such²²¹. This makes undue influence hard to prove, since different judges would most likely have their own interpretations of what would constitute undue influence. The case of *Mrs U v Centre for Reproductive Medicine*²²² also concerned undue influence, but in a manner which contrasts sharply with *Re T*. In the case, Mrs U went with her husband to the Centre for Reproductive Medicine in Bristol in order to receive fertility treatment. The treatment involved the removal of Mr U's sperm which would be used to fertilise his wife's eggs. Mr U subsequently signed a consent form stating that he did not want his sperm to be destroyed upon his death, which would allow Mrs U to have a baby by him even if he should unexpectedly die at any time. However, the practice of posthumous insemination was contrary to the policy of the Centre, on the

²²⁰ *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649 at 665.

²²¹ See *Allcord v Skinner* [1887] 36 Ch D 145, in which Lindley J stated at 183 that **“as no court has ever attempted to define fraud, so no court has ever attempted to define undue influence.”**

²²² [2002] E.W.C.A Civ 565.

grounds that a child born in such circumstances would technically be fatherless. Following further consultation with a nurse, Mr U withdrew his consent for posthumous insemination and permitted his sperm to be destroyed upon his death. A few months later, Mr U died following an asthma attack. Subsequently, Mrs U wished to use her husband's sperm to achieve pregnancy and brought a case arguing that her husband's original consent should stand because he had been unduly influenced by the specialist training nurse. The court held that Mr U had not been unduly influenced, stating that although he had been pressurised to an extent, the pressure was not so great so as to override his will:

“when one stands back and looks at the facts of the case, it seems... that it is difficult to say that an able, intelligent educated man... could have his will overborne so that the act of altering the form and initialling the alterations was done in circumstances in which Mr U no longer thought and decided for himself... it is likely that he and his wife did not really think there was any likelihood that this part of the form would ever be necessary. He succumbed to the firmly expressed request of [specialist training nurse] Ms Hinks and under some pressure. But to prove undue influence, Mr U has to show something more than pressure...”²²³

The circumstances of Mr U are far removed from those of T in *Re T*. In the latter case, T was extremely unwell and was therefore in a significantly more vulnerable position than Mr U. In contrast, Mr U was in no such state, and though Ms Hinks is likely to have been emphatic in her opinions, it does not follow that Mr U would feel so overwhelmed by her testimony that he would feel compelled to alter the consent form. Furthermore, the fact that Ms Hinks was not a close relative meant that Mr U would not be compelled by any emotional factors such as those which T might have felt with her mother. It is submitted that the emotional link between T and her mother in *Re T* makes undue influence a more complicated issue in terms of application. On the one hand, it could be argued that the influence and opinions of a close family member can bring a fresh perspective to a particular decision, thus helping the individual to make a more autonomous decision. If for example, an individual is required to make an important decision on medical treatment and has a family member who is in the medical profession, it could be of great benefit to the individual to hear the opinions

²²³ Ibid at Para 15; quoting the President of the High Court of Justice Family Division at first instance.

of that family member to help make a more informed decision. The emotional ties with that family member may in many cases be helpful as the individual may be more likely to accept sound advice from somebody they trust. Conversely however, this emotional bond, as shown in *Re T*, can be detrimental if the outside party is using this to essentially manipulate a family member who is in a vulnerable state. In T's case, she herself was not a Jehovah's Witness although her mother was. If for the sake of argument T was also of the faith and this was the deciding factor in her decision to refuse treatment, it is submitted that the case would have been considerably more straight-forward²²⁴. The fact that T was seriously unwell, coupled with the fact that her final decision reflected the religious views of her mother, meant that the validity of her decision had to be questioned. These factors were of little relevance in Mr U's case. As stated earlier, undue influence has not been defined in the common law, but would a clear definition be practical? While *Re T* has shown that family members can be a barrier to making a fully autonomous decision, it would be untenable to suggest that this would always be the case. Similarly, it cannot always be assumed that those with whom one has no emotional connection will always provide advice from an entirely objective perspective. Therefore, guidance on the issue of undue influence is best approached on the facts of each individual case.

Having seen the potential impact of outside influence on decision-making capacity, it is also necessary to discuss existing guidance on assessment criteria. The implementation of the Mental Capacity Act 2005 means that statute can now be used as the source of this guidance. However, the assessment criteria laid down in sections 2 and 3 of the 2005 Act have been directly influenced by common law guidance on this issue, and it is thus necessary to examine the common law position on this issue.

In the case of *Re MB (Medical Treatment)*²²⁵, a 23-year-old woman, MB, was admitted to hospital whilst forty weeks pregnant with her baby in the breech position. Upon admission to hospital, MB signed a consent form allowing delivery of her baby by Caesarean section, but also refused consent to a number of procedures involving

²²⁴ Gunn makes this point in (1994) *The Meaning of Incapacity*; Medical Law Review, Vol. 2, 8-29 at 15. See also *Malette v Schulman* [1990] 67 D.L.R (4th) 321 (Ontario CA) and *R v Blaue* [1975] 1 W.L.R 1411, both of which concerned Jehovah's Witnesses and confirmed the right to refuse treatment on religious grounds.

²²⁵ [1997] 38 B.M.L.R 175.

needles, due to an intense phobia that she had of them. Having eventually agreed to anaesthesia via mask, MB subsequently refused this as well as delivery by C-section following a discussion of the potential risks involved. Upon going into labour, MB once more agreed to a C-section provided that she would not be able to feel the needle used to administer the anaesthetic. Later, MB again refused anaesthesia via mask which resulted in the cancellation of the operation. The Health Authority then sought a declaration allowing the C-section to take place. This was immediately granted and MB appealed the decision. Of greatest relevance to the decision was the first ground of appeal. It was argued that Lord Justice Hollis was wrong to rule that MB lacked the requisite capacity to refuse the operation. During her judgement, Lady Justice Butler-Sloss provided the following guidance on capacity assessment:

“A person lacks capacity if some impairment of disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment. That inability to make a decision will occur when;

- (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;**
- (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If... a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then that decision may not be a true one.”²²⁶**

MB’s appeal was dismissed on the grounds that she had been rendered temporarily incompetent by her needle phobia. Although she had undoubtedly understood the need for the operation and had consented to it, in the final moments, **“her fear dominated all.”²²⁷** As a result, MB was deemed to have failed the test laid down by Butler-Sloss L.J. The decision in *Re MB* has had its critics. Commentary of the case in *Medical Law Review* did not accept the decision, stating that

“Fear, without more, is far too loose a term to constitute a mental impairment. It cannot be the law that the moment fear enters the mind, capacity departs. Secondly, MB was not incapable of making a decision...

²²⁶ Ibid per Butler-Sloss L.J at 190.

²²⁷ Ibid at 181.

She refused the proposed operation, albeit for reasons others would reject. But, she does not have to give, not even have, reasons.”²²⁸

It is submitted that this criticism is ultimately without significant merit. The author criticises the notion that fear automatically results in a loss of capacity, and in a sense they are correct. However, MB’s fear of the operation was the instrumental factor in that case specifically. It does not necessarily follow from this that the presence of fear will always equate to a loss of capacity. Given the Law Commission’s endorsement of a functional approach to capacity assessment, the decision-making capacity of an individual in the light of factors such as fear and panic must be assessed in each individual case. *Re MB* highlights the fact that such factors can have a bearing on decision-making capacity at the material time. In addition, the commentator on the case states that MB need not have provided an acceptable reason for her refusal of the operation. Although not explicitly stated, it is clear that the commentator is referring to Lord Donaldson’s statement in *Re T*²²⁹ that reasons for refusal of treatment can be rational, irrational or even non-existent. Be this as it may, Lord Donaldson’s statement was intended to apply only to those who have the requisite capacity to make a treatment decision. Provided this capacity exists, the individual can make whatever decision they wish for whatever reason. In MB’s case, her capacity had been eroded to the extent that she lacked the capacity to make a valid refusal of the operation, as evidenced by her reasons for refusing the treatment. It is also worth remembering Grisso and Appelbaum’s four standards of decision-making capacity, one of which is the ability to appreciate the information given and to apply it realistically to one’s particular situation.²³⁰ Since MB’s fear of needles in effect took control over her decision, it could be argued that she was ultimately unable to appreciate the fact that the health of her unborn child was at risk without the operation. If she were able to appreciate this, MB might have better been able to put her fears aside and go ahead with the C-section²³¹.

²²⁸ Author unspecified [1997] *Consent: Adult, Refusal of Consent, Capacity*; Medical Law Review; Vol. 5, 317-325 at 324.

²²⁹ [1992] 4 All E.R 649 per Donaldson M.R at 663.

²³⁰ Appelbaum, P.S and Grisso, T (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2); 105-126 at 110.

²³¹ For further examples of cases relating to Caesarean sections, see also the cases of *L (Patient: Non – consensual treatment)* [1997] 2 F.L.R 837; *Norfolk and Norwich Healthcare NHS Trust v W* [1996] 2 F.L.R 613; *Rochdale Healthcare NHS Trust v C* [1997] 1 F.C.R 274. In addition, the judgment in *Re S (Refusal of Treatment)* [1993] Fam 123, represent the exception to the approach taken in the above cases inasmuch as a refusal of a Caesarean section on religious grounds was overridden. However, this

Butler-Sloss L.J's test of capacity was a development of an earlier test laid down by Thorpe L.J in the case of *Re C (Adult: Refusal of Medical Treatment)*²³². C was a sufferer of paranoid schizophrenia who developed a gangrenous foot whilst serving a term in Broadmoor. Without an amputation of the infected foot, C would have a mere 15% chance of survival. C continually refused the operation, and the issue at the heart of the case was whether C had the requisite capacity to validly refuse the operation. Thorpe L.J laid down a tripartite test for determining whether capacity is present:

“For the patient offered amputation to save life, there are three stages to the decision:

- 1. To take in and retain the treatment information;**
- 2. To believe it, and**
- 3. To weigh that information, balancing risks and needs.”**²³³

His Lordship held that C's capacity, whilst having been reduced due to his condition, had not diminished to such an extent so as to render his refusal of the treatment invalid. Evidence from C's doctor had stated that C suffered under the delusion that he had been a famous doctor, and that the proposed treatment was in fact intended to harm him. In the light of this evidence, it could be argued that the court's decision was wrong, since C appeared not have believed the information regarding the proposed amputation. In the light of this, C's capacity could be construed as having been reduced to the extent that he did not sufficiently understand the nature, purpose and effects of the treatment²³⁴. Despite this, Thorpe L.J confirmed his satisfaction that C had understood and retained the relevant information, and that he believed it in his own way, thus arriving at a clear choice²³⁵. It is submitted that this decision was likely to have been at least partially based upon what C had said to the consultant vascular surgeon, namely that he would prefer to die with two legs than live with one²³⁶. This suggested that C had acknowledged and accepted that his life was probably at stake if

case is not in any way representative of the legal position on treatment refusal as evidenced also in *St George's Healthcare Trust v S* [1998] 3 W.L.R 936. See also, Stern K (1993) *Court Ordered Caesarean sections: In Whose Interests?* Modern Law Review; Vol. 56, 238 and Thomson, M (1994) *After Re S*; Medical Law Review, Vol. 2(2), 127.

²³² [1994] 1 All E.R 819. See also the case of *Re W (Adult: Refusal of Medical Treatment)* [2002] EWHC 901.

²³³ per Thorpe LJ at 822.

²³⁴ *Ibid* at 824.

²³⁵ *Ibid*.

²³⁶ *Ibid* at 822.

he refused the operation, despite this being in contrast to the statement made to his doctor earlier. The case confirmed the importance placed upon the principle of autonomy and the right of the competent patient to make any treatment decision they wish even if death will result²³⁷. The functional approach dictates that the competence of an individual must be tested for the particular situation and cannot be assumed simply because of the presence of a mental disorder or impairment²³⁸. This stance has remained constant throughout the common law and can be seen in its starkest form through cases involving the refusal of lifesaving treatment, such as *Re B (Adult: Refusal of Medical Treatment)*²³⁹ and *Pretty v United Kingdom*²⁴⁰.

It can be seen that Butler-Sloss L.J's capacity test is in essence a reiteration of Thorpe L.J's *Re C* test. However, it can also be seen that the former test contains no reference to stage two of the *Re C* test, i.e. belief in the information given. Does this then represent derogation from Thorpe L.J's test? Kennedy and Grubb submit that this is not the case, since the court in *Re MB* did refer to the test on a number of occasions²⁴¹. Furthermore, her Ladyship stated that:

“Irrationality is here used to connote 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... it might be otherwise if a decision is based on a misperception of reality. Such a misperception will be more readily accepted to be a disorder of the mind.”²⁴²

In C's case, the nature of his condition meant that he had made a number of statements which were clearly indicative of a misperception of reality, most notably that he had at one time in his life been a famous doctor. However, central to the issue of C's capacity was the fact that he did ultimately believe that the proposed treatment

²³⁷ See also *Re W (Adult: Refusal of Medical Treatment)* [2002] EWHC 901 (Fam) which illustrates this in specific relation to those suffering with psychiatric disorder and is thus comparable to the decision in *Re C (Adult: Refusal of Medical Treatment)*.

²³⁸ See also *Re JT (Adult: Refusal of Medical Treatment)* [1998] 1 F.L.R 48, in which the patient suffered from severe learning disabilities and was deemed to be capable of refusing life-saving treatment for renal failure by virtue of having satisfied the *Re MB* test.

²³⁹ [2002] E.W.H.C 429. See also *Journal of Medical Ethics* (2002), Vol. 28, 232-243 for commentaries on this case.

²⁴⁰ [2002] 35 E.H.R.R 1. See also Boyd, K M (2002) *Mrs Pretty and Ms B*; *Journal of Medical Ethics*; Vol. 28, 211-212.

²⁴¹ Kennedy, I and Grubb, A (2003) *Medical Law*; 3rd edition; Butterworth's Press London at 626.

²⁴² *Re MB (Medical Treatment)* per Butler-Sloss LJ at 190.

would improve his condition. This was fully accepted by C, and his refusal of the treatment was not because he had any misperceptions about the nature treatment per se. The case of *NHS Trust v Ms T*²⁴³ illustrates further the issue of misperception of reality. Ms T was a sufferer of borderline personality disorder who self harmed on a regular basis. Eventually, this meant that Ms T would require a blood transfusion. Ms T had received a number of transfusions over the years which she had initially refused but had then accepted. On this occasion, Ms T refused the operation and provided an advance directive to that effect. The directive stated that Ms T was refusing further transfusions on the grounds that these would cause her greater stress in the long-term, and more importantly to the case, because she believed her blood to be a vessel of evil. Having a transfusion would not help as she believed that the blood would become corrupted once it entered her body. The court held that Ms T did not have the requisite capacity to refuse further treatment, and an interim declaration was made authorising a blood transfusion. The court interpreted Ms T's claim that her blood was evil as a misperception of reality attributable to a disorder of the mind²⁴⁴.

The case of Ms T further illustrates the justifiable reluctance of the courts to rule in favour of capacity when the reasons for refusing treatment are out of touch with reality. The court ultimately held that Ms T had failed to satisfy Butler-Sloss L.J's *Re MB* test inasmuch as she was unable to use and weigh the relevant information and in the process of arriving at her decision to refuse a blood transfusion, and this was held to have been the situation when she signed the advance directive²⁴⁵. As a result, the fact that Ms T had also made an advance directive outlining her delusional beliefs ultimately had no bearing upon the final decision. Whilst the making of such a directive would normally signify a well-thought out and consistent thought process which would give great weight to an individual's treatment refusal, this cannot apply when decisions are based upon a misperception of reality.

²⁴³ [2004] E.W.H.C 1279.

²⁴⁴ per Charles J at Para 62.

²⁴⁵ Ibid at Para 63.

3.1.2: CAPACITY ASSESSMENT IN ENGLISH LAW UNDER THE MENTAL CAPACITY ACT 2005.

As of October 2007, the Mental Capacity Act 2005 has been fully implemented in the law of England and Wales. The process which would eventually result in this is one that that began in earnest in 1991. In that year, the Law Commission of England and Wales published Consultation Paper 119, which was designed to provide a brief but concise overview of the then current legal position surrounding mental incapacity, as well as providing preliminary thoughts about which direction any proposed reforms should take. The Law Commission recognised that the law on capacity was in need of reform. As Parkin explains: **“The law was fragmented as a result of *ad hoc* developments in disparate fields. There were divergences between the treatment of people and then property; the division of responsibility between relatives and professionals was unclear; there was no formal method of resolving disputes.”**²⁴⁶

The approach taken on the issue of capacity assessment has been largely consistent throughout the discussion and consultation stages of the Mental Capacity Act 2005, and much of the common law guidance has now been enshrined in some form within the legislation. Section 1 of the Mental Capacity Act 2005 outlines the general principles of the Act, which show that there is a clear pro-autonomy ethos present throughout. Indeed, it should be noted that the emphasis upon empowerment and enablement of the individual resulted in a name change of the legislation from the originally proposed Mental Incapacity Act to the now used Mental Capacity Act 2005²⁴⁷.

From the outset, the Law Commission unequivocally stated that the individual must be presumed to have capacity unless this presumption can be accurately rebutted²⁴⁸. The presumption of capacity was accepted as being integral to the pro-autonomy ethos of the new legislation and was duly included in s. 1(2) of the Mental Capacity Act 2005:

²⁴⁶ Parkin, A (1996) *Where now on Mental Incapacity?* 2 Web J.C.L.I; accessed online on 19/04/2005; available at <http://www.ncl.ac.uk/~nlawwww/1996/issue2/parkin2.html>.

²⁴⁷ House of Commons Hansard Debates (11/10/2004) per Mr. David Lammy at Col. 22.

²⁴⁸ *Ibid* at Para 4.19.

“A person must be assumed to have capacity unless it is established that he lacks capacity.”

The remainder of section 1 of the Act similarly endorses the principle of autonomy, whilst also wholly rejecting a status approach to capacity in favour of a functional approach. The functional approach to capacity dictates that the decision-making capacity of an individual must be assessed for the particular decision, as opposed to the status approach to capacity which effectively allows for this to be assumed across the board based on the individual’s status as mentally disordered or impaired²⁴⁹. This approach is reflected in s.1(3) of the Mental Capacity Act 2005, which states that the individual must not be deemed as incapable of making a decision **“unless all practicable steps to help him to do so have been taken without success.”** The Mental Capacity Act Code of Practice 2007 confirms that this principle rejects the status approach in favour of the functional approach:

“People with an illness or disability affecting their ability to make a decision should receive support to help them make as many decisions as they can. This principle aims to stop people being automatically labelled as lacking capacity to make particular decisions. Because it encourages individuals to play as big a role as possible in decision-making, it also helps prevent unnecessary interventions in their lives.”²⁵⁰

In addition, the Code of Practice states that anyone who is supporting an incapable adult during the decision-making process should not use any coercion to unduly influence an individual’s decision. This is entirely consistent with the common law position on the issue of undue influence²⁵¹.

The third general principle which can be founding s.1(4) of the Act states that **“a person is not to be treated as unable to make a decision merely because he makes an unwise decision.”** Again, this principle is consistent with the common law approach, in particular Lord Donaldson’s statement in *Re T (Adult: Refusal of Medical Treatment)*, in which His Lordship stated that it was irrelevant if the reasons

²⁴⁹ Law Commission Report No. 231 (1995) at Para 3.5.

²⁵⁰ Mental Capacity Act Code of Practice 2007 at Para 2.6.

²⁵¹ *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R. 649.

behind an individual's decisions were rational, irrational or non-existent.²⁵² As long as the individual has the capacity to make a decision, he/she may do so without having to gain the approval of others. This principle also confirms the rejection of an outcome approach to capacity, in which any decision deemed inconsistent with traditional values or with the opinions of the one making the capacity assessment, will be classified as invalid²⁵³. Such an approach cannot sit alongside the pro-autonomy ethos of the Mental Capacity Act because according to the Law Commission, the outcome approach looks upon the individuality of the person as a negative quality and penalises such individuality accordingly²⁵⁴. However, the Code of Practice states that care should be taken when the individual continually makes unwise decisions that put themselves at risk of harm, or makes decisions that are obviously irrational or out of character²⁵⁵. Decisions made on either of these grounds should not automatically equate to a lack of decision-making capacity, but further investigation may be needed to ascertain whether any developments have taken place which could impair the individual's decision-making capacity. Gunn poses two questions which should be considered on this issue: **“Is there a sufficient impact upon decision-making abilities to warrant determining that this person is incapable of making the decision? And, does the apparent decision-maker hold a patently false belief that demonstrates an inability to make the decision?”**²⁵⁶ Gunn further states that the issue of a patently false belief is potentially complex because such beliefs must be distinguished from beliefs which are merely mistaken²⁵⁷. This point was originally raised by Saks who stated that it is often difficult to identify whether an individual's opinion of truth is mistaken and therefore, **“people should be free to pursue the truth as they see fit.”**²⁵⁸ If however a belief can be proven to be patently false as opposed to merely mistaken, it is then a matter of assessing whether these beliefs are a product of a mental disorder, and if they affect decision-making capacity to a

²⁵² Ibid per Donaldson M.R at 663.

²⁵³ Law Commission Report No. 231 (1995) at Para 3.3.

²⁵⁴ Ibid.

²⁵⁵ Mental Capacity Act Code of Practice 2007 at Para 2.11.

²⁵⁶ Gunn, M J (2005) *Decision-making Capacity and the Mental Capacity Act 2005: Some Difficult Issues and some Possible Means of Resolution*; Unpublished. See also, Saks, E R (1993) *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*; University of Miami Law Review 47: 689-761 and Saks, E R (1991) *Competency to Refuse Treatment*; North Carolina Law Review; Vol. 69; 945-999 at 962 and Chapter 1.1 of this thesis.

²⁵⁷ Ibid.

²⁵⁸ Saks, E R (1991) *Competency to Refuse Treatment*; North Carolina Law Review; Vol. 69; 945-999 at 964.

sufficient degree. If this is the case, then the provisions of the Mental Capacity Act 2005 become applicable, as will be explained below. In the context of s.1(4) of the Mental Capacity Act 2005, the Code of Practice alights on the fact that decisions made on the basis of values and beliefs cannot be deemed as invalid under this principle²⁵⁹.

The fourth general principle which is set out in s.1(5) of the Act reads as follows: **“An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.”** This is simply a restatement of the common law position which states that the best interests of the individual must form the basis for all actions done on behalf of the incapable adult.²⁶⁰ Although, as the common law confirmed, it is difficult to provide a single description of the best interests concept²⁶¹, the Mental Capacity Act 2005 does provide a set of criteria to be followed in order to make this determination. These will be discussed in Chapter 4 of this thesis²⁶², and as will be seen, it is through these criteria that derogation from the common law position on best interests can be seen.

The fifth and final general principle as laid down in s.1(6) of the Act states that before an act is done or a decision is made, **“regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.”** This is an explicit endorsement of the principle of least restrictive alternative and requires anybody intervening on behalf of the incapable adult to **“explore ways that would be less restrictive or allow the most freedom for a person who lacks capacity to make the decision in question.”**²⁶³ The Code of Practice also emphasises the fact that the principle of least restrictive alternative must not supersede the best interests of the individual i.e. in order to ensure that the best interests of the individual are being met, it may be necessary to choose an option which is not the least restrictive of the available options. However, from a practical point of view, it will often be possible to combine the process of selecting the least restrictive option and the action which will

²⁵⁹ See also *Ibid.*

²⁶⁰ *Re A (Medical Treatment: Male Sterilisation)* [2000] 53 B.M.L.R 66; *Re SL (Adult Patient: Medical Treatment)* [2000] 2 F.C.R 452; *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C 1.

²⁶¹ Mental Capacity Act Code of Practice 2007 at Para 2.13.

²⁶² See Chapter 4.1.2 of this thesis at 142.

²⁶³ *Ibid* at Para 2.16.

be in the best interests of the individual, making a conflict between the two possible but not likely²⁶⁴.

Once the principles which underpin the Mental Capacity Act 2005 have been established, the next question to be answered is how the Act deals with the issue of capacity assessment. This is covered in sections 2 and 3 of the Act. Section 2(1) provides a statement of the diagnostic threshold:

“For the purposes of this Act, a person lacks capacity in relation to a matter, if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain.”

As can be seen, it is not simply that an individual must suffer with some form of incapacity, but rather, that this incapacity must be attributable to a mental disorder or impairment. Section 2(2) states that this diagnostic threshold has been satisfied, the incapacity need not be permanent. The Code of Practice confirms once again that a functional approach must be taken when assessing an individual’s capacity: **“An assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.”**²⁶⁵ Following on from this, s.2(3) of the Act reiterates a rejection of the status approach by stating that a lack of capacity cannot be established merely by reference to **“a person’s age or appearance, a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.”** This statement also supports the principle of non-discrimination, which requires anybody acting for on behalf of an incapable adult to do so without acting negatively towards the individual on the basis of some aspect of their condition. A doctor for example, may not simply assume that an 80-year-old patient with dementia will be incapable of making any decisions simply by virtue of their condition. This must be assessed thoroughly²⁶⁶.

Section 3 arguably contains the most important provisions relating to assessment of capacity, and is worth quoting in full:

²⁶⁴ Ibid.

²⁶⁵ Ibid at Para 4.4.

²⁶⁶ see Mental Capacity Code of Practice 2007 at Paras 4.7-4.9

“3(1): For the purposes of section 2, a person is unable to make a decision for himself if he is 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 his decision (whether by talking, using sign language or any other means)**

(2): A person is not to be regarded as unable to understand the information relevant to a decision if he is unable to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –

- (a) deciding one way or another, or**
- (b) failing to make a decision.”**

It can be seen that section 3(1) in particular is in essence a restatement of the common law test of capacity as laid down in *Re MB (Medical Treatment)*²⁶⁷. It will be recalled that Butler-Sloss L.J.’s bipartite test states that an individual will be deemed incapable of making a treatment decision if he/she:

- “(a) ...is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;**
- (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.”**²⁶⁸

²⁶⁷ [1997] 38 B.M.L.R 175. See also *Local Authority X v MM and KM* [2007] E.W.H.C 2003 (Fam) per Munby J at Para 74, where His Lordship confirmed that the test of capacity as laid down in s.3(1) of the Mental Capacity Act 2005 was essentially the same as that which was laid down in *Re MB (Medical Treatment)*.

²⁶⁸ *Ibid* per Butler-Sloss L.J at 190.

Butler-Sloss L.J's test in essence restated Thorpe L.J's tripartite test in *Re C (Adult: Refusal of Medical Treatment)*²⁶⁹, except that Her Ladyship's test made no reference to belief in the information given. Similarly, the assessment criteria provided in s.3 of the Mental Capacity Act 2005 does not require the individual to believe the information given to them. This is unsurprising given that *Re MB* itself showed that belief is not necessarily a deciding factor in capacity assessment. In that case there was no issue as to whether MB believed that she needed the Caesarean operation to protect her unborn child. She believed this and fully accepted it. Nevertheless, she was deemed incapable of making a valid treatment decision on the basis that the fear and panic she experienced caused a temporary impairment of her mental functioning. However, Bellhouse et al make the point that although the issue of belief is not specifically tested through the Act's assessment criteria, a strong lack of belief or disbelief in relevant information given should be noted as it may invalidate the decision²⁷⁰. In the event of there being a strong lack of belief or disbelief in information given, the person making the capacity assessment should consider whether this sufficiently impinges upon an individual's decision-making capacity. However, under s.3 of the Mental Capacity Act, belief has not been deemed to be a cornerstone criterion of the assessment process.

That the individual must believe the information is not referred to specifically in the Mental Capacity Act 2005, nor was it referred to in the 1995 and 2003 versions of the Draft Bill. However, one could argue that belief in the information would be tied in to s.3(4) i.e. information which is relevant to a decision. While this could be argued to be a broad term, it is submitted that this might actually be advantageous. Different decisions involve different circumstances, and the inclusion of s.3(4) would allow for individual circumstances to be taken into account. With regards to s. 3(1), the Law Commission had gained substantial support for its assertion that testing for understanding of the information was a more realistic prospect than testing for understanding of the nature of a decision²⁷¹. The same applied to the express inclusion of 'foreseeable consequences', an issue which was of significant relevance in *Re C*. In addition, the inclusion of s.3(1)(c) was deemed to be important in order to

²⁶⁹ [1994] 1 All E.R 819.

²⁷⁰ Bellhouse, J et al (2003) *Capacity Based Mental Health Legislation and its Impact on Clinical Practice 2: Treatment in Hospital*; Journal of Mental Health Law; Vol. 24, 24-37 at 26.

²⁷¹ Law Commission Consultation Paper No. 128 (1993) at Para 3.22.

combat against the potential undue influence of third parties²⁷². Furthermore, the provision covers cases where an individual, whilst able to take in and retain the information, might, on account of mental disorder or impairment, arrive at a treatment decision that is entirely unrelated to the information given. The Commission stated that the object of this was to **“deflect the complications of asking whether a person needs to ‘appreciate’ the information as well as understand it.”**²⁷³ It is appropriate at this time to recall Grisso and Appelbaum’s four standards of capacity assessment. As well as the ability to express a choice and understand and process information, Grisso and Appelbaum state that the individual should be able to appreciate information given to them and apply it to their own situation²⁷⁴. The Law Commission appear not to have given much weight to the appreciation requirement, as it was ultimately left out of their recommendations. This is perhaps surprising given that Grisso and Appelbaum’s appreciation standard is arguably a better exposition of the functional approach to capacity, as it requires not just the ability to understand the information abstractly, but also the ability to apply that information directly to one’s own situation. However, one could argue that s.3(1)(c), which refers to the ability to use or weigh up the information in the decision-making process, in effect requires the ability to apply information to one’s situation, and thus makes reference to the functional approach that way. The functional approach is again endorsed in s.3(3), which states that a person can be deemed capacitous even if he/she is only able to retain the information for a short while. The crucial issue is whether the individual can retain the information long enough to make the decision at the material time, thus allowing for those with fluctuating capacity to make treatment decisions²⁷⁵.

Section 3(2) again signifies the pro-autonomy approach of the Act by stating that the individual must not be deemed incapable if they are able to understand an explanation of the treatment information given to him in a manner appropriate to their circumstances. According to the Code of Practice, section 3(2) **“stresses the importance of explaining information using the most effective form of**

²⁷² Law Commission Report No. 231 (1995) at Para 3.17.

²⁷³ Ibid.

²⁷⁴ Grisso, T and Appelbaum, P (1995) *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2), 105-126 at 110.

²⁷⁵ Mental Capacity Act Code of Practice 2007 at Para 4.20

communication for that person (such as simple language, sign language, visual representations, computer support or any other means).”²⁷⁶

Section 3(2) promotes autonomy by virtue of the fact that it requires the capacity assessor to consider the circumstances of the patient on an individual basis. This means that the patient is given the best possible chance of understanding relevant information to the degree that is necessary to be deemed capable.

3.2: CAPACITY ASSESSMENT IN SCOTTISH LAW UNDER THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

At the heart of the Scottish approach is a clear and unambiguous endorsement of the principle of autonomy: individuals were to be encouraged to participate in the decision making process as much as was practicable. This was highlighted in the Scottish Law Commission’s discussion paper *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*²⁷⁷:

“The philosophy that lies behind the new approach is one of minimum intervention in the lives of the mentally disabled consistent with providing proper care and protection and maximum help to enable individuals to realise their full potential and make the best use of the abilities they have.”²⁷⁸

The intention of the reforms was essentially to take the concept of autonomy and develop it as far as was possible. To this end, individuals would not only be encouraged to make decisions about treatment at the time the treatment is needed, but would also be encouraged to make decisions in advance, in the event of a loss of capacity in the future. This was laid down in the Scottish Law Commission’s 1995 *Report on Incapable Adults*: **“Incapacitated adults and their carers should be enabled and encouraged to do as much as possible for themselves and to make their own arrangements for possible future incapacity.”²⁷⁹**

The Scottish Law Commission stated in 1991 that the pro-autonomy approach to capacity law was greatly influenced by the United Nations *Declaration on the Rights*

²⁷⁶ Ibid at Para 4.17.

²⁷⁷ September 1991.

²⁷⁸ Scottish Law Commission Discussion Paper No. 94 (1991) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at Para 1.7.

²⁷⁹ at Para 1.27.

of *Mentally Retarded Persons*²⁸⁰, which fully endorsed a pro-autonomy approach in relation to potentially incapable individuals by stating that those suffering from mental retardation be given the same full rights as everybody else. Indeed, it is hard to disagree with the principle that those suffering with a mental disorder or impairment should be given the same rights as others²⁸¹, or that all potentially incapable individuals should be given full rights to proper medical care and a decent standard of living²⁸². However, although the Scottish Law Commission fully endorsed the approach outlined by the United Nations, it also highlighted the potential dichotomy between giving mentally retarded individuals full rights and full protection:

“There is an inherent conflict or tension between the principles of maximum freedom for mentally disabled people and their protection. Giving mentally disabled people exactly the same rights as mentally normal people would often result in the disabled harming themselves and others and becoming victims of exploitation and abuse. Protection from these consequences necessarily involves some curtailment of the rights that normal people enjoy. Indeed, a certain level of protection may enhance the ability of mentally disabled to enjoy their other rights to a greater extent.”²⁸³

The above statement by the Scottish Law Commission perhaps highlights the fact that the U.N Declaration is on occasion idealistic. The fact remains that giving incapable adults the same freedoms as capable adults may be counterproductive. It would be ignoring the fact that those suffering with a mental disorder or impairment are more vulnerable than healthy individuals; therefore, as the Scottish Law Commission stated, to bestow an identical set of rights upon a vulnerable group of people as a matter of principle may often result in harm coming to the individual or others. It is therefore not always possible to treat mentally disordered or impaired individuals the same as others across the board; the very fact that the U.N felt it necessary to state that mentally retarded persons had the right to full protection and due process confirms this. However, the fact that the U.N also used phrases such as ‘maximum degree of feasibility’ and ‘to the fullest possible extent of his capabilities’, suggests that it was aware of the fact that a mentally disabled individual’s ability to exercise

²⁸⁰ 1971 U.N General Assembly 26th Session, Resolution 2856.

²⁸¹ Ibid at Clause 1.

²⁸² Ibid at Clauses 2 and 3.

²⁸³ Scottish Law Commission Discussion Paper No. 94 (1991) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at Para 1.8.

these rights may often be hampered to some extent. This is evidenced by clause 3 of the Declaration, which confers upon the individual the right to economic security and the right to take up an occupation. This could be argued to be an endorsement of the principle that capacity is not necessarily an ‘all or nothing’ concept, and that it must not be assumed that mentally disabled individuals will always be incapable of handling some of their own affairs. However, as stated previously, a fully pro-autonomy approach may be unrealistic when dealing with mentally disabled individuals. That such individuals may often need some form of protection automatically necessitates at least a partially paternalistic approach. The fact that the Scottish Law Commission recognised the potential dichotomy between maximum freedom and maximum protection suggests that it was aware of this.

The Scottish Law Commission eventually recommended a functional approach to capacity. In the 1995 Report, the Commission made the following recommendations as to when it would be permissible to intervene on behalf of the individual:

“(1) an intervention should be capable of being made under our recommendation if the adult is:

(a) mentally disordered;

(b) unable to communicate due to physical or other disability and by reason of such mental disorder or inability to communicate, unable to take the decision or carry out the act in question;

(c) Mental disorder should mean mental illness or mental handicap however caused or manifested, but a person should not be regarded as mentally disordered by reason solely of promiscuity of other immoral conduct, sexual deviancy, dependence on alcohol or drugs or acting as no prudent person would act.”²⁸⁴

The above recommendations by the Scottish Law Commission first endorse a diagnostic threshold i.e. that a mental disorder must be present. In addition, the Commission clearly endorses a functional approach to capacity by referring to the inability to carry out the act in question. The individual’s incapacity must therefore be assessed in relation to a specific act, not generally. Finally, the Scottish Law

²⁸⁴ Scottish Law Commission Report No. 151 (1995) *Report on Incapable Adults* at Para 2.15.

Commission reject the status approach by stating that mental disorder should not be assumed simply from the presence of unorthodox actions. It can be seen from this that there is little difference in this approach from that which was adopted in English law. The Scottish Law Commission clearly endorsed a functional, pro-autonomy approach to capacity. It is therefore necessary to discuss how this approach was eventually utilised in the Adults with Incapacity (Scotland) Act 2000.

With regards to how one should assess an individual's capacity to make decisions on medical treatment, the Scottish Law Commission emphasised at the outset that the 2000 Act would not alter the common law position on this issue. The common law position was restated in the 1991 Discussion Paper:

“The capacity of a patient to give an effective consent depends on his or her ability to comprehend, from information supplied by the doctor or others, the nature of the proposed treatment and its effects and risks, to come to a decision and to communicate that decision to the doctor. The ability of individuals to carry out these steps varies enormously, even among the general adult population. For consent to be effective the patient does not need to have been given an exhaustive evaluation of the treatment. In particular, minimal risks need not be mentioned. What is required is that the patient is informed in broad terms of the nature of the proposed treatment.”²⁸⁵

The pro-autonomy approach is indirectly referred to in the above passage, by virtue of the fact that the individual need only be informed in broad terms of any proposed treatment. This illustrates the fact that the threshold of understanding for incapable adults should not be too high so as to enable a greater number of individuals to be ruled capable of making a treatment decision. This position remained unchanged and was restated in the 1995 *Report on Incapable Adults*²⁸⁶.

Little more on this issue was added or changed in the 1997 Scottish Executive Paper *Making the Right Moves*, which concentrated more on procedural issues rather than fundamental definitions. It is therefore clear that the Scottish Law Commission did not intend to change the common law position in relation to how capacity should be assessed. This approach would eventually find its way into the 2000 Act itself.

²⁸⁵ Scottish Law Commission Discussion Paper No. 94 (1991) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at Para 3.5; see also *Chatterton v Gerson* [1981] QB 432.

²⁸⁶ Scottish Law Commission Report No.151 (1995) *Report on Incapable Adults* at Para 5.2.

Section 1(2) of the Adults with Incapacity Act (Scotland) Act 2000 states that no intervention will be authorised on behalf of an individual unless the person authorising the intervention is satisfied that it will provide a benefit to the adult, and that the same benefit cannot reasonably be achieved without the proposed intervention. This confirms endorsement of the principle of autonomy. Following on from this, s.1(3) of the Act endorses the principle of least restrictive alternative in the event of an intervention being necessary.

Section 1(6) of the Adults with Incapacity (Scotland) Act 2000 provides the following guidance with respect to how incapacity should be defined:

“For the purposes of the Act, and unless the context otherwise requires:

‘adult’ means a person who has attained the age of 16 years;

‘incapable’ means incapable of:

- a) acting; or**
- b) making decisions; or**
- c) communicating decisions; or**
- d) understanding decisions; or**
- e) retaining the memory of decisions,**

as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretive nature or otherwise); and ‘incapacity’ shall be construed accordingly.”

Whilst the given definition of ‘adult’ is straightforward enough, criticism can be levelled at the Act’s definition of ‘incapacity’. On the positive side, it is perhaps commendable that the Scottish Parliament elected to define incapacity using a checklist, as opposed to a shorter, more generalised definition. As incapacity is the cornerstone of the 2000 Act, one might argue that legislation should contain as much guidance as possible, in order to provide doctors with as much information as is necessary to prevent an erroneous diagnosis of incapacity. However, the checklist of incapacity which was incorporated into the 2000 Act can still be argued as being inadequate. Indeed, while section 1(6) appears at first glance to be exhaustive, closer study of the provision in fact reveals a number of vagaries and generalisations.

First, the Act states that an individual will be deemed to lack capacity if he/she is incapable of 'acting'. It is submitted that this criterion is vague and ultimately unhelpful, since 'acting' in effect encompasses a number of aspects of the decision-making process. Simply referring to an inability to act without further qualification of the term is failing to take this into consideration. Indeed, the Code of Practice for Part 5 of the Act also fails to provide further guidance as to the provisions contained in s.1(6) of the legislation. Rather than issue guidance as to how doctors can assess accurately the failure of an individual to act, make, communicate, understand or retain the memory of decisions, the Code of Practice provides information on when an individual should not be deemed incapable of making decisions. Doctors and carers would perhaps benefit from more information in the legislation on when an individual is capable as opposed to incapable. Given that the emphasis of the 2000 legislation is upon presumption of capacity and empowerment of the individual wherever possible, this may explain the emphasis of the Code of Practice upon when an individual is capable, rather than the opposite. Nevertheless, it is submitted that failing to give adequate guidance on when a patient has satisfied the criteria of s.1(6) in effect defeats the purpose of the Act. What is also surprising about the generality of s.1(6) is that there appears to be no reference to the functional approach, despite it having been endorsed by the Law Commission during the discussion process. To illustrate this point, consider the wording of s.2(1) of the Mental Capacity Act 2005, which refers to the inability to make a decision **"at the material time"**. This phrase shows that one's decision-making capacity must be assessed in the context of a particular decision made at that particular time, rather than assessed in general terms. By contrast, s.1(6) of the Adults with Incapacity (Scotland) Act 2000 makes no such references, and although it would be inaccurate to suggest that a functional approach has not in fact been endorsed, this important point is not made remotely clear. Instead, the references to inability to act, making, communicating, understanding and retaining the memory of decisions are made as if a general assessment of these faculties will be acceptable. In 2002, the British Medical Association published suggested guidelines for capacity assessment in Scotland which included the following criteria to be considered when determining whether an individual is capable:

“Whether the adult:

- **is capable of making a choice;**
- **understands why a choice is needed;**
- **has memory abilities that allow the retention of information;**
- **is aware of any alternatives;**
- **has knowledge of the risks and benefits involved;**
- **is aware of the decision’s personal relevance to him or herself;**
- **is aware of his or her right to refuse, as well as the consequences of refusal;**
- **is aware of how to refuse;**
- **is capable of communicating his or her choice;**
- **has ever expressed wishes relevant to the issues when greater capacity existed, and;**
- **is expressing views consistent with previously preferred moral, cultural, family and experiential background.”²⁸⁷**

As can be seen, the B.M.A guidelines for assessing capacity are considerably more exhaustive than those which were included in the 2000 Act two years previously. In contrast to s.1(6), the B.M.A guidelines make no direct reference to ‘acting’, but instead focus upon one’s ability to make a choice, one’s awareness and communication of choices and opinions. It could be argued that these are ‘acts’ of sorts, although the 2000 Act appears not to consider them as such, since making, communicating and understanding decisions are considered separately to one’s inability to act. Another important difference between the Act’s provisions and the B.M.A guidelines is that the British Medical Association recognised the important difference between actually making a choice, and being capable of making a choice. Put another way, an individual may choose to somehow abdicate their decision-making rights, or make a decision in an entirely random or unorthodox manner (such as flipping a coin for example). This is of secondary importance provided the doctor is satisfied that the individual is at least capable of making a decision in the first place should they wish to. This is also in line with Grisso and Appelbaum’s exposition of capacity assessment, which states that an individual must display an ability to understand information, rather than actually be required to utilise this understanding

²⁸⁷ British Medical Association (June 2002) *Adults with Incapacity: Medical Treatment for Scotland* at 6.

directly²⁸⁸. Section 1(6) of the Adults with Incapacity (Scotland) Act 2000 and its Code of Practice do not include any such elaboration, referring only to acting, memory of decisions and making, communicating and understanding decisions.

The British Medical Association also suggested that as well as simply evidencing a choice, the patient should also demonstrate, or at least be capable of demonstrating, that they understand why a choice is necessary, that they are capable of retaining the information, and are aware of their right to refuse the treatment should they wish. One might argue these criteria to be essential aspects of informed decision-making, yet the 2000 Act has effectively ignored these aspects, electing instead to use all-encompassing terms such as ‘acting’ and ‘understanding’. As the B.M.A has shown, a term such as ‘understanding’ in reality encompasses a number of factors, such as retention of information and being able to balance up the risks and benefits. It is submitted that the guidelines laid down in s.1(6) of the Adults with Incapacity (Scotland) Act 2000 have failed to consider the possibility that many patients whose capacity is called into question are ‘borderline’ cases. In such cases, it is essential that healthcare professionals are given as much guidance as possible in how best to accurately determine a patient’s capacity. However, proponents of the set-up of the 2000 Act may equally argue that the provisions of the Act cannot realistically be too narrow, since the Act applies potentially to a variety of situations relating to personal welfare, finance and property. Capacity to consent to or refuse medical treatment may involve a different set of criteria to one’s testamentary capacity for instance, and it is therefore arguable that Parliament was simply attempting to take this into consideration. Adrian Ward explains thus:

“...the Act’s definitions of ‘incapable’ and ‘incapacity’, as with its other definitions, are only ‘for the purposes of this Act’. They will not necessarily be interpreted as coinciding with the tests of capacity for other purposes, such as determining whether a purported act or transaction is void. For example, the courts are unlikely to depart from their policy of reluctance to declare a person incapable of testamentary capacity, and might decline to apply – for that purpose – the element of ‘retaining the memory of decisions’ in the case of someone who is incapable of retaining memory of the decision

²⁸⁸ Appelbaum, P.S and Grisso, T (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2); 105-126 at 109.

as to appropriate testamentary provision, yet who consistently and repeatedly reaches the same decision in a manner otherwise satisfying all relevant tests of capacity.”²⁸⁹

Ward also highlights the fact that the Act does not in fact create a generalised category of incapable individuals²⁹⁰. Instead, the Act is designed to be applied to each individual case as the circumstances require. This would explain the fact that each of the criteria specified in s.1(6) of the 2000 Act are followed by ‘or’ as opposed to ‘and’. This effectively enables the decision-maker to choose which of the criteria they consider to be relevant to the particular decision they are required to make at the time. Furthermore, by phrasing s.1(6) in this manner, Parliament has arguably attempted to promote the concept of presumption of capacity –an individual will be presumed to have capacity unless proven otherwise. This is suggested by the fact that an individual whose capacity has been called into question is not required to satisfy all five of the criteria specified in s.1(6). To be required to do so would set the burden of proof at too high a level. By requiring the individual to satisfy at least one of the five criteria, they are given a better chance of being deemed capable of making decisions for him or herself. Despite this advantage, it is submitted that s.1(6) of the Scottish legislation ultimately fails to provide an adequate definition of incapacity. As stated above, this is largely due to the fact that the inability to act has been deemed to be a separate criterion to the remainder of the section, which refers to the inability to make, communicate, understand or retain the memory of decisions. It is submitted that the reference made to ‘incapacity to act’ in s.1(6)(a) is surplus to requirements, since the criteria provided in s.1(6)(b) – (e) could be interpreted as being ‘actions’ in the context of treatment decision-making. Possible exposition of what it means to be incapable of ‘acting’ may be found through reference to Gillon’s definition of autonomy²⁹¹. Gillon states that there are in essence three facets to autonomy: autonomy of thought i.e. the ability to think for oneself, make decisions and believe information that is conveyed; autonomy of will i.e. the freedom to make a particular decision on the basis of one’s deliberations; and autonomy of action, which correlates

²⁸⁹ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 4.27.

²⁹⁰ *Ibid* at Para 4.28.

²⁹¹ Gillon, R (1986) *Philosophical Medical Ethics*; Wiley Medical Publications Chichester.

to the notion that specific actions can be autonomous even if they are not the result of a thought process²⁹².

Another issue highlighted by the British Medical Association was the issue of awareness. The B.M.A stated that the individual should be **“aware of any alternatives [to the proposed treatment]... aware of the decision’s personal relevance to him or herself... aware of his or her right to refuse, as well as the consequence of refusal...[and] aware of how to refuse.”**²⁹³ The issue of awareness ties in with Grisso and Appelbaum’s four standards of capacity assessment, in particular their recommendation that the individual be able to appreciate the information. Grisso and Appelbaum state that for this criterion to be satisfied, the individual must show an ability to apply the information to one’s own situation²⁹⁴, which equates in essence to the B.M.A’s reference to the individual being aware of a decision’s relevance to themselves.

Section 1(6) of the Scottish legislation states that there are two gateways by which the provision of the Act may be invoked. First, the individual in question must be suffering from a mental disorder. Alternatively, the individual must be deemed incapable of communicating by virtue of a physical disability. Ward highlights the fact that Parliament elected to adopt the same definition of mental disorder as that which is contained in s.1(2) of the Mental Health (Scotland) Act 1984:

“...mental illness (including personality disorder) or mental handicap however caused or manifested; but an adult shall not be treated as suffering from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy, dependence on alcohol or drugs.”²⁹⁵

With respect to the second gateway definition, Ward states that this is the narrower of the two definitions²⁹⁶. Furthermore:

“It admits only those whose inability to communicate is a complete bar to exercise of capacity in a matter in which a decision cannot reasonably be

²⁹² Ibid at 61.

²⁹³ Ibid.

²⁹⁴ Appelbaum, P.S and Grisso, T (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2), 105-126 at 110.

²⁹⁵ Ibid at Para 4.27. See also Scottish Law Commission Report No. 151 (1995) *Report on Incapable Adults* at Para 2.15, which also recommended this definition.

²⁹⁶ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 4.26.

deferred, and whose inability to communicate results from physical disability. If the inability to communicate is the result of a mental rather than a physical disability, the first rather than the second gateway applies.”²⁹⁷

Once could infer from this that inability to communicate would only be deemed to be a barrier to exercising capacity if the physical disability is extremely severe i.e. a complete bar to exercise of capacity. Once again, Parliament’s intention to empower the patient as much as possible and thus promote the principle of autonomy is evident. However, the second gateway can only be invoked when the incapacity in question is physical rather than mental. Added to this, the Act’s provisions cannot be relied upon where the incapacity is due to the effects of alcohol or drug consumption. Intoxication has not been classed as a mental disorder. With this in mind, the second gateway definition in s.1(6) is potentially ambiguous. If an individual is incapacitated as a result of intoxication, could that be classified as a physical disability, and subsequently fall within the scope of s.1(6)? Ward suggests that if one were intoxicated to such an extent as to completely affect one’s capacity, the second gateway could then be relied upon²⁹⁸.

It is understandable that Parliament elected to approach the criteria of capacity assessment in the manner prescribed in s.1(6) of the 2000 Act. It is submitted that s.1(6) represents an attempt to be as inclusive as possible of all potential issues that may arise in relation to adult incapacity. This view was voiced during Stage 1 of the Parliamentary debates on the 2000 Act, where Mr Jim Wallace stated that the bill was based on **“strong and overarching principles”** and that there would be:

“...no labelling based on preconceived notions of what a person can or cannot do, nor will anyone be considered incapable just because they have a learning disability or a mental illness²⁹⁹. Doctors will make most assessments of incapacity, but we expect them to get advice from others who know the adult and who are aware of the nature of the decisions to be made on the adult’s behalf.”³⁰⁰

According to Mr. Wallace, the important aspect of assessing capacity is not from consultation of the legislation, but rather, from consultation with those who would be

²⁹⁷ Ibid.

²⁹⁸ Ibid.

²⁹⁹ A rejection of the status approach to capacity.

³⁰⁰ Ibid.

able to provide information as to how best to make decisions. If this was indeed intended to be the case, then this provides an explanation for the non-specific nature of the assessment criteria in s.1(6) of the Act. However, it is submitted that the criteria in s.1(6) are still too broad to be able to provide significant guidance on the issue. If legislation has been implemented to deal specifically with the issue of adult incapacity, it is obvious that an adequate explanation of how to assess this is essential to the correct working of that legislation. As seen earlier, the British Medical Association provided useful further guidance as to what factors are important when assessing an individual's capacity. The assessment criteria in the Mental Capacity Act 2005 far better encapsulate the important issues relating to capacity. The functional approach is clearly mentioned³⁰¹ and the assessment criteria reflect this approach³⁰². Despite the Scottish Law Commission having supported a functional approach to capacity, there is, as stated earlier, little to suggest this in the 2000 Act. While some of the criteria such as communicating, understanding and retaining the memory of decisions are well established and mirror the criteria specified by both Grisso and Appelbaum³⁰³ and the Mental Capacity Act 2005, the usefulness of these are countered by the presence of disconcertingly vague references to the ability to act and to make decisions. It is also perhaps telling that these issues were not discussed in any significant manner during the Parliamentary debates stage. As highlighted above, Jim Wallace makes the point that consultation with those close to the individual would aid the decision-maker when assessing capacity. This is a salient point. However, any consultation which takes place should be informed by the provisions of the Adults with Incapacity (Scotland) Act 2000. The vagaries of the assessment criteria make this more difficult than is necessary.

3.3: CAPACITY ASSESSMENT IN INDIAN LAW

There is currently no legal provision for capacity issues relating to medical treatment in Indian law. However, the law does cover the issue in relation to other areas, albeit briefly. The most notable of these is the law in relation to capacity to marry. Through an analysis of statutory and common law provisions in this area, it will then be

³⁰¹ Mental Capacity Act 2005 s.2(1).

³⁰² Ibid at s.3(1).

³⁰³ Appelbaum, P.S and Grisso, T (1995) *MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*; Law and Human Behaviour; Vol. 19(2), 105-126.

possible to discuss how the central provisions might extend to include matters of medical treatment.

Marriage is governed in Indian law primarily by the Hindu Marriage Act 1955. Section 5(2) is of particular relevance in relation to capacity:

“A marriage may be solemnised between any two Hindus, if... at the time of marriage, neither party

a) is incapable of giving a valid consent to it in consequence of unsoundness of mind; or

b) though capable of giving a valid consent, has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children; or

c) has been subject to recurrent attacks of insanity.”

The above provisions were introduced into the Hindu Marriage Act 1955 via an amendment to the Act made in 1976. Although the provisions of s.5(2) are broad, a rudimentary functional approach can be identified. Subsections (b) and (c) relate more to an individual's suitability as a marriage partner rather than one's ability to enter into the contract of marriage per se, and are therefore not wholly representative of a traditional functional approach. However, section 5(2)(a) refers more directly to a functional approach, as capacity is mentioned specifically. The terms of the section do not render a marriage voidable simply by virtue of the presence of a mental disorder or unsoundness of mind, but rather, requires an assessment of whether the mental disorder impacts sufficiently upon one's ability to cope with the responsibilities of marriage and parenting. However, one might argue that the provisions of s.5(2) give cause for concern due to the presence of the term 'unsoundness of mind'. This term has not been given further explanation, and it is submitted that its presence in legislation is unhelpful in the context of a pragmatic functional approach to capacity. Dhanda explains further:

“It is claimed that all persons with psychosocial disability are not viewed as incompetent by the law, and the legal provisions are meant to be only applicable to those who have been rendered incapable by their condition. However, studies of the litigation patterns show those efforts to obtain a legal determination of incompetence are made for all manners of persons from the

eccentric to the non-conforming to the deviant. These efforts (whether successful or not) are continually made because ‘unsoundness of mind’ is equated with incompetence in law and a legally incompetent person is required to live his or her life in accordance with the dictates of others, be it family, professional or state. The person’s own perceptions, wishes and aspirations are legislated out of existence.’³⁰⁴

As well as the Hindu Marriage Act 1955, other marriage laws in India make unsoundness of mind a potential factor in voiding marriage³⁰⁵. It is clear from Dhanda’s exposition of unsoundness of mind that without a more precise explanation of the term, there is a significant possibility that incapacity will be assumed across the board for anybody suffering from mental disorder or impairment. Put another way, a test for incapacity using the criterion of unsoundness of mind serves only to promote a status rather than a functional approach. It should be noted however that the provisions in s.5(2) of the Hindu Marriage Act 1955 pertaining to capacity to marry are markedly similar to the equivalent provisions in English law. Consider the relevant terms of s.12 of the Matrimonial Causes Act 1973:

“A marriage celebrated after 31st July 1971 shall be voidable on the following grounds only, that is to say –

(c) that either party to the marriage did not validly consent to it, whether in consequence of duress, mistake, unsoundness of mind or otherwise;

(d) that at the time of the marriage either party, though capable of giving a valid consent, was suffering (whether continuously or intermittently) from mental disorder within the meaning of the Mental Health Act 1983 of such a kind or to such an extent as to be unfit for marriage...”

As can be seen, there is little difference between the relevant provisions of both the Hindu Marriage Act 1955 and the Matrimonial Causes Act 1973, with the latter also referring to unsoundness of mind as a potential barrier to valid consent. In addition, the Matrimonial Causes Act 1973 stipulates that a marriage will be voidable if either

³⁰⁴ Dhanda, A [2002] *A Participative Evaluation of the Rights of Persons with Psychosocial Disability*; unpublished.

³⁰⁵ See Special Marriage Act 1954 s.4(b)(1-2). This legislation in essence permits any Indian national living either in India or abroad to marry irrespective of religion or faith. The specified provisions outline the conditions necessary for a valid marriage. The terms of s.5(2) of the Hindu Marriage Act 1955 are replicated in this legislation. In addition, it should be noted that under Islamic law, a person of unsound mind is deemed incapable of entering into a marriage unless consent of a guardian is given.

party was, at the time of the marriage, suffering with a mental disorder of such a kind so as to make that party unfit for maintaining a marriage. Both these provisions mirror the position in Indian law, and the fact that the terms of s.5(2) of the Hindu Marriage Act 1955 were the result of an amendment made in 1976 suggests that the provisions of the English law were of direct influence. The only difference between the terms of the two statutes is that the Hindu Marriage Act 1955 refers to either party being unfit for the procreation of children in addition to being unfit for marriage itself. This could be attributable to a cultural difference between the United Kingdom and India, in which the latter places equal emphasis upon procreation within marriage as well as the actual marriage itself.

The commonality between the relevant provisions of the Hindu Marriage Act 1955 of India and the Matrimonial Causes Act 1973 of England and Wales has been highlighted in order to illustrate the argument that any difference in approach between the jurisdictions on the issue of capacity is attributable to developmental issues. This is illustrated further by the common law guidance relating to capacity to marry in India.

The case of *Usha v Abraham*³⁰⁶ concerned two Christians who were parties in an arranged marriage. The respondent, a Mr. Abraham Jacob, sought dissolution of the marriage under s.19 of the Indian Divorce Act 1869³⁰⁷. He contended that, from as early as the marriage day itself, he had found what he believed to be symptoms of mental retardation in his wife the appellant. These symptoms allegedly included the appellant's inability to spell her own name. As time went on the appellant alleged that his wife was **“not merely dull intellectually, but deficient in intellect so as to be incapable of rational conduct expected of an adult woman”**. Therefore, **“the appellant's condition was such that she was incapable of any improvement and the normal married life was quite impossible”**³⁰⁸. The appellant denied that she suffered from any kind of mental retardation and stated that

³⁰⁶ [1988] A.I.R Ker 96.

³⁰⁷ Since the parties in the marriage were Christians rather than Hindus, the relevant provision for seeking a dissolution of the marriage is s.19 of the Indian Divorce Act 1869, which allows divorce on the grounds that either party was **“a lunatic or idiot at the time of marriage.”**

³⁰⁸ *Ibid* per Balakrishnan J at Para 2.

“the marriage was preceded by the usual house visits, and after the marriage the respondent and the appellant were living as husband and wife... By 1976 the petitioner went for a job to Gulf Country. The petitioner had been sending letters and gifts to the appellant and he also filed a declaration before the Indian Embassy at Sharjah to obtain a passport for the appellant. However, by 1980 the respondent showed some estrangement which culminated in the ultimate filing of the petition for declaration of nullity of marriage”³⁰⁹

At first instance, the court held that the appellant was in fact a lunatic or idiot at the time of marriage, and that subsequently she was incapable of consenting to marriage as she did not understand its objects and purpose. However, Balakrishnan J did not agree with this ruling. His Lordship first stated that the Indian Divorce Act 1869 did not contain any definition for the term ‘lunatic’. Therefore, it was deemed necessary to use the definition contained in section 3(5) of the Indian Lunacy Act 1912³¹⁰, as had been done previously in *Daniel v Sarla*³¹¹. Section 3(5) of the Indian Lunacy Act defines a lunatic as **“an idiot or person of unsound mind”**. In order to ascertain lunacy, the appellant had undergone a medical examination by a board consisting of three senior doctors working in Trivandrum Medical College. After a follow up appointment, the board stated that **“she [the appellant] is not a congenital idiot and... she does not suffer from lunacy... the intelligence quotient is 68. She is not congenitally impotent and there is no gynaecological anatomical defect”**³¹². The crux of the issue was not simply that the appellant was suffering from any form of retardation or mental disorder, but rather, whether the presence of such a condition resulted in incapacity to enter into a marriage³¹³. On this point, Balakrishnan J said the following:

“The marriage is a civil contract as well as a religious sacrament. The voluntary consent of both parties is necessary for a valid marriage. The contract of marriage is simple and it does not require a high degree of intelligence to comprehend. The test is whether a person in question is capable of understanding the nature of the contract, or whether his mental

³⁰⁹ Ibid at Para 3.

³¹⁰ This was the applicable mental health legislation at the time of the case, prior to the implementation of the Mental Health Act 1987.

³¹¹ [1976] ILR 2 Ker 357.

³¹² Supra note 88 at Para 7.

³¹³ Ibid at Para 10.

condition was such that he was incapable of understanding it. In order to ascertain the nature of the contract of marriage, a man must be mentally capable of appreciating that it involves responsibilities normally attaching to marriage. The parties to the marriage must be able to comprehend the significance of the promise and vows that flow from such a transaction. There is a strong presumption that such consent has been given. The burden of proof on the party attempting to impeach a marriage on the ground of want of consent is heavier than in the case of impeaching a commercial contract. The petitioner must show that because of the mental disorder, the other spouse was unable to know the nature and consequences of his/her act. A mere weakness of intellect, mild mental retardation or physical inability will not justify an annulment of marriage.”³¹⁴

The above statement by Balakrishnan J is important, in as much as it is arguably a clear endorsement of a functional approach towards capacity within the context of marriage. In stating that a mere presence of weak intellect, mental retardation or physical inability is not enough to justify nullity of a marriage, his Lordship appears to be explicitly rejecting a status approach in favour of a functional approach. It is submitted that his Lordship was correct to highlight the fact that different areas of one’s life will involve different thresholds that would need satisfying; marriage is one sphere that ultimately requires less understanding than others, and subsequently, the party that is seeking to end the marriage due to inability to consent and to understand, will need to produce significant evidence in support of his/her claim. Another important aspect of the case, in the context of the comparative study being undertaken in this thesis, was the clear influence of English law upon the decision. As can be seen in the above statement, Balakrishnan J stated that a contract of marriage was ultimately a simple one which did not require a high degree of intelligence to understand. This is an exact restatement of the law in England given by Sir Hannen J in the English case of *Durham v Durham*³¹⁵ in which His Lordship stated that the contract of marriage was **“a very simple one which did not require a high degree of intelligence to comprehend.”**³¹⁶ The case of *Durham v Durham* was cited in the

³¹⁴ Ibid at Para 11.

³¹⁵ [1885] L.R. 10 P.D 80.

³¹⁶ Ibid per Sir Hannen J at 82.

judgment in *Usha v Abraham* which, as with the statutory provisions relating to capacity to enter into a marriage, shows the influence of English law in Indian law.

In the judgment in *Usha v Abraham*, the court held that although the appellant did suffer from some form of arrested development, the evidence did not show that this affected her ability to manage her household duties. Furthermore,

“She was able to recall the date of her marriage and other details of personal importance. In the petition it has been alleged that she is an idiot and lunatic and that she did not know how to read or write... [However]... this is clearly belied by her evidence. During her examination she was asked to read a portion of the Bible and it has been recorded in the deposition that she had read the Bible”³¹⁷

Similarly, the appellant revealed during cross examination that she did not know who Christ was, and that cows would deliver calves once they were fed with straw. However, the court rejected this as sufficient evidence of her inability to appreciate the nature and consequences of her acts³¹⁸. Eventually, the court allowed the appeal and held that the appellant was quite capable of **“managing herself and all her affairs in her own simple way, and she would be able to cope with the obligation of marital life”**.³¹⁹

However, in *Pravati Mishra v Jagananda Mishra*³²⁰, it was held that the respondent, by virtue of having an I.Q below 50% of the normal level for a 21-year-old, would not be cured of her impairment and was thus incapable of marrying. The medical professional who conducted the I.Q test stated that **“a person, more particularly one belonging to the middle class, cannot manage with such a wife, as such a wife is not capable of rearing children”**³²¹. It is interesting that class would be mentioned as a relevant factor in determining capacity. This appears to be an endorsement of a status approach to capacity. It would be inaccurate to suggest that the legislation and the courts intended the status approach to be a determining factor in assessing capacity, however the court in *Pravati Mishra v Jagananda Mishra* appear to have supported just such a scenario. An inconsistency in approach is evident. Whilst the

³¹⁷ *Usha v Abraham* [1988] A.I.R Ker 96 at Para 12.

³¹⁸ *Ibid* at Para 16.

³¹⁹ *Ibid* at Para 22.

³²⁰ [1995] A.I.H.C 3434.

³²¹ *Ibid* at 3439.

court in *Usha v Abraham* were in essence endorsing a functional approach to capacity by requiring the capacity of Usha Abraham to be ascertained specifically in relation to the marriage contract rather than in general, the court in *Pravati Mishra* ultimately accepted the view of the medical professional who stated that the Pravati Mishra could not enter into a marriage contract because her condition was incurable and that she would thus not be capable of raising children or discharging her duties as the wife in a middle-class family. The fact that class was referred to raises the possibility that the result of disputes over capacity to marry may vary according to the class of the individual, thus in essence furthering a status approach to capacity. Such an approach would also contravene the substantive principle of non-discrimination, by virtue of emphasising the condition of the individual rather than the impact of the condition upon capacity³²². The inconsistency in approach towards the issue of capacity to marry is further illustrated by the decision in *Gurnam Singh v Chand Kaur*³²³, in which the Punjab High Court held that mere evidence of schizophrenia was not enough – it would be necessary to prove that the sufferer would not be able to marry or raise children as a consequence of the illness before a marriage would be considered voidable. This is yet another example of the preference of the functional approach to capacity over the status approach.

A theme that runs through a number of cases on marriage is the issue of capacity to bear children. As stated previously, in *Gurnam Singh* the court held that nullity would be granted if the respondent's mental disorder suffering rendered her incapable of both marriage and procreation. However, as Dhanda points out, **“the court held that ‘unfit for procreation of children’ did not connote the ability to bear children but the capacity to rear them”**³²⁴. One inference that could be drawn from this decision is that again, the effect of the respondent's illness on the other party is being prioritised. If an individual is unable to look after children as a consequence of their illness, and the marriage is voidable because of this, then by implication, the respondent is being potentially deprived of the right to a partner as well as the right to a family. The other party at least has the option of marrying again, whereas the respondent with the mental disorder will most likely not be able to get married until

³²² See Dhanda, A (2000) *Legal Order and Mental Disorder*, Sage Publications New Delhi at 189.

³²³ [1980] H.L.R 134.

³²⁴ Dhanda, A (2000) *Legal Order and Mental Disorder*; Sage Publications New Delhi at 190.

they are cured (if indeed this is possible), because each subsequent marriage would be avoidable on the same grounds. When one also considers the fact that the majority of child-rearing duties are considered to rest upon the wife, the court's decision again has the secondary effect of being more detrimental to women than to men. Consequently, the law has the effect of furthering a status approach to capacity. However, it must again be stressed that a blanket status approach has not been adopted by the courts in India. A functional approach is also present, As Dhanda explains:

“One set of decisions stress the fact of social recovery and hold that if a person can resume normal married life and management of herself and her affairs, she cannot be described as incurably of unsound mind merely because she has to take a drug once a week or once a day. However, if a person cannot manage herself or her affairs, lives an artificial existence protected from the normal incidents and problems of life, she will be termed incurable... In the other interpretative pattern, inability to predict for the period of recovery is viewed as determinative of the issue”³²⁵

Dhanda further highlights the fact that the standards of legal and medical incapacity are different. As stated previously, an individual could be ill but nevertheless maintain capacity to make decisions. Dhanda submits that of the two court approaches, the former standard of social recovery is the more appropriate. Simply because a person who has basically recovered but nevertheless needs maintenance therapy does not mean that a marriage need to be dissolved. What is integral to the issue of capacity here is not just the presence of mental disorder, but rather, the effect of the disorder upon the individual's capacity.

Further guidance on capacity in Indian law can be found in the law of contract. According to s.12 of the Indian Contract Act 1872, an individual will be deemed to be capable of making a contract, **“if at the time when he makes it, he is capable of understanding it and forming a rational judgment as to its effect upon its interests”**. This capacity has to be present at the time the contract is drawn up. In the case of a person with fluctuating capacity, the Act permits a contract to be made whilst the person is of sound mind, but not otherwise:

³²⁵ Ibid at 192.

“A person is said to be of sound mind for the purpose of making a contract, if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interest. A person, who is usually of unsound mind, but occasionally of sound mind, may not make a contract when he is of unsound mind.”

Dhanda explains:

“Section 12 requires that the cognitive faculties of understanding memory and judgment should be intact for the exercise of contractual capacity. These faculties are necessary for parties to comprehend an agreement, to remember their assets and liabilities and then to judge the effect of the contract on their interests. This standard encompasses both absolute and functional incapacity. Absolute incapacity would mean that the cognitive faculties of an individual are totally deranged or undeveloped. In functional incapacity however, the faculties, though present, are incapable of performing the specific functions of remembering, understanding and judging”³²⁶

Cases such as *Ram Sunder Saha v Kali Narain Choudhary*³²⁷ illustrate that symptoms ordinarily associated with old age such as forgetfulness, are not in themselves an indicator of lack of capacity. Ultimately, **“lack of capacity is inferred only if, due to old age, the mind has become vacuous and delusory”³²⁸**. In *Govindswami Naicker v K N Srinivasa Rao*³²⁹, an elderly gentleman gave a gift of some property to his daughter. The gentleman was under the delusion that he was in possession of thousands of acres of land. In reality, he owned approximately 120 acres in Myanmar and India. The court held that he did not have the requisite capacity to make the gift, because he could not have realised the impact of the gift on his own interests.

Upon analysis of the Indian law relating to capacity to contract, parallels with English law can be drawn. A functional approach can be identified which requires assessment of whether capacity existed at the time of entering into the contract, rather than simply require a generalised assessment of an individual’s capacity. In addition, the provisions of the legislation provide a potential starting point for development of the

³²⁶ Dhanda, A (2000) *Legal Order and Mental Disorder*; Sage Publications New Delhi at 249.

³²⁷ [1927] A.I.R Cal 889.

³²⁸ Dhanda, A (2000) *Legal Order and Mental Disorder*; Sage Publications New Delhi at 251.

³²⁹ [1940] A.I.R Mad 73.

law in India in relation to medical treatment. Section 12 provides embryonic information to begin a criteria specific test for medical treatment, which, if s.12 is used as a guide, would include the need to form a rational judgment as to the effect of accepting or refusing medical treatment upon the interests of the individual. There is thus some theoretical scope for adopting the same provisions to apply to medical treatment issues³³⁰.

The existing law that relates to capacity in India illustrates the fact that the central issues are recognised, albeit at a basic level. The statutory provisions in both the Hindu Marriage Act 1955 and the Indian Contract Act 1872 refer to a functional approach to capacity and recognise that capacity is necessary in order to enter into a marriage or a contract although guidance as to how this assessment is to be made is still extremely basic. However, this is in essence no different to the English position, with s.12 of the Matrimonial Causes Act 1973 specifying the same criteria as s.5 of the Hindu Marriage Act 1955 for example. In addition, common law guidance, particularly the judgment given in *Usha v Abraham*, has been clearly influenced by English law³³¹. However the use of the functional approach in some cases is counterbalanced by the use of the status approach in other cases. It is submitted that this inconsistency in approach is attributable to the fact that the law of capacity in India has simply yet to develop to the extent that a uniform approach can be recognised and adopted. The relevance of capacity in relation to medical treatment has not yet received any recognition in the law, but the fact that capacity is recognised in a nascent form suggests that this there is potential for this to happen. The position of capacity law in India currently is in essence the same as capacity law in England twenty years ago.

³³⁰ see *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R 649.

³³¹ See *Park v Park* [1954] P. 112; *Baldwin v Baldwin* [1919] The Times; *Durham v Durham* [1885] 10 P.D 80; *Park v Park* [1913] OH 19/12/1913; *Hunter v Edney* [1881] December 16th.

CHAPTER 4: DECISION-MAKING FOR THE INCAPABLE PATIENT IN ENGLISH, SCOTTISH AND INDIAN LAW

4.1: DECISION-MAKING FOR THE INCAPABLE PATIENT IN ENGLISH LAW

The concept of best interests is another cornerstone issue in the law of capacity. It becomes relevant only when the assessment of an individual's capacity has revealed conclusively that the individual is incapable of making treatment decisions without assistance. In such a case, the relevant healthcare professional must make a decision based on what they consider to be in the best interests of the individual. This concept has undergone significant development over the last two decades, more in terms of content than definition.

4.1.1: DECISION-MAKING FOR THE INCAPABLE PATIENT IN ENGLAND AND WALES PRIOR TO THE MENTAL CAPACITY ACT 2005 – THE CONCEPT OF BEST INTERESTS

As stated in Chapter 2 of this thesis, the concept of best interests becomes relevant in the law of capacity only once the assessment of an individual's capacity confirms that he/she lacks the capacity to make treatment decisions without assistance. As has been discussed, the common law position has provided actual criteria to assist with the assessment of decision-making capacity that has now been utilised in the Mental Capacity Act 2005. The common law position on the best interests concept has arguably harder to ascertain.

The case of *Re A (Mental Patient: Male Sterilisation)*³³² is an appropriate starting point for this discussion. A was a 28-year-old man who had Down's syndrome and whose intelligence levels had been assessed as being on the borderline between significant and severely impaired. A lived with his mother, who applied to the High Court for a declaration authorising a sterilisation operation. A's mother believed that his condition left him vulnerable to potential advances from women, which in turn might lead to A having casual sexual relations which might result in pregnancy for somebody. The declaration was refused at first instance and A's mother appealed. The judge at first instance had held that there was little chance of A entering into casual

³³² [2000] 53 B.M.L.R 66.

relationships whilst under the supervision of his mother. However A's mother stated that her health was deteriorating and that she would shortly be requiring hospital treatment. In her absence, the chances of A having sexual relations and making somebody pregnant increased. This would be particularly serious given that A would be unlikely to understand the implications of making somebody pregnant and would thus be unable to take proper responsibility. In the light of this, A's mother argued that a vasectomy would be in A's best interests. Contraception was not practical and A's application had been supported at first instance by a consultant psychiatrist who agreed with the mother's concerns. The appeal was also eventually dismissed. The President stated that carrying out the operation would not decrease the chances of A being exploited, nor would it help cope with any emotional fallout from any close relationship.

The court in *Re A* stated that the central issue relevant to any discussion on sterilisation operations must be whether the proposed operation would be in the best interests of the individual. This issue was first raised in the case of *Re F (Mental Patient: Sterilisation)*³³³, which concerned a 36-year-old mentally impaired woman who was a voluntary in-patient in hospital. F had formed a sexual relationship with a fellow patient, which had caused concern amongst the hospital staff. Since F had the mental capacity of a child and would never recover from her condition, both the hospital staff and both the hospital staff and F's mother believed that were F to become pregnant, she would be unable to cope with the responsibility of looking after a child as well as the stress of pregnancy in general. In the light of this, the hospital staff believed that a sterilisation operation would be in F's long term best interests. Since other less invasive forms of contraception had been ruled out as being unsuitable, F's mother sought a court declaration authorising a non-therapeutic sterilisation for F, which was duly granted. *Re F* was an important case inasmuch as it was the first case to examine the best interests concept³³⁴. The case has nevertheless been criticised on the grounds that the court declined to give an actual definition of the term, but instead provided guidelines designed to aid proxy decision-makers in

³³³ [1990] 2 A.C 1.

³³⁴ See Kennedy, I and Grubb, A (1994) *The Law Commission's Proposals: An Introduction*; Medical Law Review; Vol. 2, 1-7 at 2.

deciding whether a particular course of action would be in the best interests of the individual. Lord Justice Brandon gave his thoughts on the issue:

“In my opinion... a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, or consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health.”³³⁵

His Lordship’s exposition of best interests is useful as a starting point, but is still limited as a fully-rounded explanation of the concept. This is unsurprising given that *Re F* did not require broader considerations of the concept³³⁶. In *Re A*, the court sought to broaden the scope of best interests beyond what was stated in *Re F*. Butler-Sloss L.J referred back to the judgment in *Re MB (Medical Treatment)* in which she stated that best interests were not limited to best medical interests³³⁷. Her Ladyship expanded upon this point in *Re A* by stating that **“best interests encompasses medical, emotional and all other welfare issues.”**³³⁸ In A’s case however, the proposed sterilisation operation was deemed not to be sufficiently in A’s best interests. The central argument provided in favour of the operation was that A had clearly become sexually active but had no understanding of the link between sexual intercourse and pregnancy³³⁹. A sterilisation operation would therefore eliminate the possibility of pregnancy whilst allowing A to have an active sexual relationship should he wish to at any time. However, this evidence was countered on the grounds that A’s sexual activity had not as yet included sexual intercourse, and that in reality, the chances of A engaging in sexual intercourse was minimal³⁴⁰. In addition, Mr Francis QC submitted that there was a presumption against the non-therapeutic sterilisation of incapable adults, and that this can only be rebutted by sound evidence that the operation would be in the individual’s best interests³⁴¹. The case was also

³³⁵ Ibid per Brandon L.J at 55.

³³⁶ *Re A (Medical Treatment: Male Sterilisation)* per Butler-Sloss L.J at 73.

³³⁷ [1997] 38 B.M.L.R 175 at 189.

³³⁸ *Re A (Medical Treatment: Male Sterilisation)* per Butler-Sloss L.J at 72.

³³⁹ Ibid at 67.

³⁴⁰ Ibid at 69.

³⁴¹ Ibid at 70.

distinguishable from *Re F* on the grounds that A was a man and F was a woman. The issue of pregnancy would affect F far more directly than if A made another woman pregnant. On this basis, Butler-Sloss L.J stated that an application for the sterilisation of a man was not the direct equivalent of an application made on behalf of a woman. In addition, her Ladyship stated that **“In the case of a man who is mentally incapacitated, neither the fact of the birth of a child nor disapproval of his conduct is likely to impinge on him to a significant degree other than in exceptional circumstances.”**³⁴² The proposed operation was less about the best interests of A and more about the best interests of any woman that may become pregnant by him. Since the only issue of relevance was the best interests of A himself, the proposed operation was not justifiable.

Although the application for the sterilisation operation was dismissed, Thorpe L.J stated that the arguments in favour of the operation were entirely cogent and that a further application may be made on the basis of fresh evidence at a later time³⁴³. His Lordship accepted the view that A’s fertility was disadvantageous and that it was the duty of society to **“minimise the consequence of disability by vouchsafing for the disabled wherever possible the rights and freedoms vouchsafed to the majority who have been spared disability.”**³⁴⁴ On the issue of how to approach best interests, His Lordship stated that it was in essence a balancing exercise, with the factors that would provide benefit to the individual on one hand and any counterbalancing factors on the other³⁴⁵. Despite Thorpe L.J’s acceptance of the central arguments in favour of sterilisation, His Lordship too dismissed the appeal based on the evidence of A’s mother, who had stated that there would be no relaxation in the level of supervision even after the operation. In addition to this, there had been no evidence given by A’s carers that post-operation, A would be given the opportunity to develop his sexual experiences. Since this was one of the main arguments in favour of the operation, those arguing on behalf of A’s mother had failed to establish sufficiently that the operation would be in A’s best interests. This statement provided further guidance on

³⁴² Ibid at 74.

³⁴³ Ibid per Thorpe L.J at 78.

³⁴⁴ Ibid at 76.

³⁴⁵ Ibid at 77.

how to approach the issue of best interests, by highlighting the fact that the onus would be on the claimant to establish this³⁴⁶.

Re A is an important case in the context of best interests inasmuch as it develops the concept beyond the explanation of it given in *Re F*, in which it was stated that any proposed treatment will only be in the best interests of the individual if it is designed to preserve life or prevent a deterioration in the physical or mental well-being of the individual. *Re A* elaborates on this by confirming that best interests must encompass interests beyond mere medical ones to include emotional and other welfare issues. This central issue was further confirmed in the case of *Re SL (Adult Patient: Medical Treatment)*³⁴⁷.

The case concerned the proposed sterilisation of a 29-year-old woman, SL, for the purposes of eliminating her menstrual periods. SL had been born with severe learning difficulties and was unable to live without assistance from her mother. Her mother was concerned that as SL grew older and moved into separate accommodation, she would either form sexual relations of her own volition or be sexually assaulted, both of which may lead to pregnancy. Since SL would not be able to understand the implications or concept of pregnancy, SL's mother applied for a declaration authorising a sterilisation or partial hysterectomy to be performed on her daughter in order to avoid the risks of pregnancy. In addition, SL's mother stated that the operation would be therapeutic, since SL suffered from heavy menstrual bleeding which caused her considerable distress. Wall J oversaw the originating summons and authorised the operation for the latter reason. Leave to appeal was eventually granted and the appeal subsequently allowed on the grounds that major invasive treatment at the material time was on balance premature. There had been a failure to take the medical advice evidence into consideration, which had stated that SL's levels of menstrual bleeding were no higher than normal, and also the progress being made in medical research in that particular field, which may in the future provide more acceptable and less invasive methods of regulating menstrual periods³⁴⁸. In addition, the court also stated that best interests was wider in concept than medical

³⁴⁶ Ibid.

³⁴⁷ [2000] 2 F.C.R 452.

³⁴⁸ Ibid at 7.

consideration, and quoted *Re A* in support of this. Wall J was deemed at first instance to have insufficient note of these factors. He had dismissed the idea of SL having a Mirena coil inserted in lieu of surgery on the grounds that she would have to undergo a series of anaesthetics throughout her life³⁴⁹. This statement notwithstanding, the Court of Appeal overturned Wall J's judgment on the basis that he had misdirected himself in law. At first instance, Wall J stated that an appropriate standard for determining whether a particular course of action was in the best interests of the individual was the test laid down in *Bolam v Friern Hospital Management Committee*³⁵⁰. This test states that a doctor has a duty to act in accordance with a practice accepted at the time by a responsible body of medical opinion. Thorpe L.J highlighted the fact that the test had been developed so that the courts may determine appropriate boundaries of medical responsibility for treatment which had gone wrong³⁵¹. Consequently, its relevance to best interests existed **“only at the outset to ensure that the treatment proposed is recognised as proper by a responsible body of medical opinion skilled in delivering that particular treatment.”**³⁵² Therefore, this test merely provides the courts with a range of viable treatment options to choose from. Determining best interests however, is not about providing a variety of options, but about the courts declaring which single course of treatment is in the best interests of the patient³⁵³. Thorpe L.J stated that for this purpose, *Bolam* had no meaningful contribution to make³⁵⁴. However, Wall J's decision at first instance would ultimately have to be reversed on the grounds that he had provided possible alternatives to the proposed sterilisation, rather than decide whether the proposed treatment itself was in the best interests of SL.

It can be seen from the above discussion that the concept of best interests has undergone significant development in the common law. *Re F* provides a starting point, but it was through *Re A* and *Re SL* that the concept was given more detailed exposition. The facts of *Re F* and *Re SL* can be more readily compared with each other. Both cases concerned the proposed sterilisation of an incapable adult, both of whom were considered at risk of pregnancy which both F and SL would be unable to

³⁴⁹ *Ibid* at 6.

³⁵⁰ [1957] 2 All E.R 118.

³⁵¹ *Re SL (Adult Patient: Medical Treatment)* per Thorpe L.J at 466.

³⁵² *Ibid* at 468.

³⁵³ *Ibid*.

³⁵⁴ *Ibid* at 467.

cope with. However, the cases are also distinguishable in as much as both produced different judgments. The proposed sterilisation operation in *Re F* was wholly for non-therapeutic purposes³⁵⁵. It was held in the Australian case of *Secretary, Dept. of Health and Community Services v. JWB and SMB* (also referred to as *Marion's case*)³⁵⁶ that any treatment would be deemed to be therapeutic if it was

“administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychological disorder, provided that the treatment is appropriate for and proportionate to the purpose for which it is administered.”³⁵⁷

Put another way, treatment will be considered therapeutic if carried out to treat an underlying medical condition; a hysterectomy carried out to treat ovarian cancer is an example of this. Logically then, non-therapeutic medical treatment is that which is carried out for purposes other than for the treatment of an existing medical condition, such as the emotional well-being of the patient.

In F's case, the reasons for the proposed sterilisation fall clearly in to the non-therapeutic category i.e. there was no issue before the court of the operation being necessary to prevent excessive menstrual bleeding as was the case in *Re SL*, nor was there any other medical problem which could only be remedied through a sterilisation operation. The central issue was that F was at risk of becoming pregnant, which, due to the nature of her condition, she would be unable to appreciate or cope with. While this was also an issue brought before the court in *Re SL*, there was also a therapeutic element to the proposed treatment which makes it distinguishable from *Re F*. Phil Fennell, writing in 1990 just after the case had been heard, submits also that following *Re F*, the existing information on how to ascertain best interests was too broad to be able to resolve any **“ethical differences which may occur within care teams concerned with the treatment of incapable patients.”**³⁵⁸ In addition, Fennell suggests two possible ways in which the best interests test could be defined. First, the

³⁵⁵ As a useful point of comparison, see the Canadian case of *Re Eve* [1986] 2 S.C.R 388, which concerned the proposed non-therapeutic sterilisation of a mentally impaired woman for the purpose of preventing possible risks of pregnancy. Unlike the decision in *Re F* however, La Forest J rejected the argument that a sterilisation operation can ever be in the best interests of the individual unless it is for therapeutic purposes. This argument was however rejected in English common law in the case of *Re B (Minor)(Wardship: Sterilisation)* [1988] A.C 199. In that case, Lord Hailsham stated that it was wholly unconvincing to argue that a non-therapeutic sterilisation operation should never be authorised.

³⁵⁶ [1992] 175 C.L.R 218.

³⁵⁷ *Ibid* per Brennan J at 269.

³⁵⁸ Fennell, P (1990) *Inscribing Paternalism in the law: Consent to treatment and mental disorder*; *Journal of Law and Society*; Vol. 17(1), 29-51 at 43.

test could be defined so as to allow treatment to be given to incapable patients if it is in their best medical interests. Secondly, Fennell suggests that the test could be given a wider interpretation to take account of “**the welfare (in the broader sense) of the non-volitional patient.**”³⁵⁹ It is submitted that the second interpretation carries the most weight, and indeed, it was this approach which was subsequently adopted in cases such as *Re A* and *Re SL*. Without a more holistic approach to the issue of welfare and best interests, it is possible that *Re F* might have been decided differently. Although the procedure proposed was entirely medical, it could be argued that the reasons for authorising the operation were not related to best medical interests in the sense that there was no therapeutic benefit to be gained. However, despite the fact that this was not mentioned in great detail in the case, the courts did in effect give a wide interpretation of the best interests test to consider the impact on F’s welfare were she to become pregnant. Pregnancy would not have a detrimental impact on her health as such, but would more than likely be contrary to her emotional welfare, something which might not have been taken into consideration were the best interests given a narrower interpretation³⁶⁰.

The concept of best interests as developed through the common law has been held to encompass medical, emotional and other welfare interests in general. However, this is further complicated when the individual in question has been deemed by the law to have no interests of any kind. It was this precise issue which was at the heart of *Airedale NHS Trust v Bland*³⁶¹.

The case concerned Anthony Bland, who was severely injured in the Hillsborough disaster in 1989. As a result, Bland suffered irreversible brain damage and had subsequently lain in a Persistent Vegetative State (PVS) for three years. The doctors in charge unanimously stated that Anthony Bland would never recover and would never gain any form of awareness. With the approval of his parents, the Healthcare Trust applied for a declaration which would authorise the withdrawal of further life-prolonging treatment, which would result in Anthony Bland’s death. The declaration

³⁵⁹ Ibid at 44.

³⁶⁰ For other examples of cases relating to sterilisation of incapable adults, see the following: *Re GF (Medical Treatment)* [1992] 1 F.L.R 293; *Re LC (Medical Treatment: Sterilisation)* [1997] 2 F.L.R 258; *Re ZM and OS (Sterilisation: Patient’s Best Interests)* [2000] 1 F.L.R 523; *Re S (Adult Patient: Sterilisation)* [2001] Fam 15. In addition, see *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults Who Lack Capacity)* [2006] 2 F.L.R 373.

³⁶¹ [1993] 1 A.C 789.

was duly granted and the Official Solicitor appealed, although this appeal was subsequently dismissed. Lord Mustill's speech addressed the question as to whether treatment would provide any tangible benefit to Anthony Bland:

“He [Anthony Bland] feels no pain and suffers no mental anguish. Stress was laid in argument on the damage to his personal dignity by the continuation of the present medical regime, and on the progressive erosion of the family’s happy recollections month by month of distressing and hopeless care. Considerations of this kind will no doubt carry great weight when parliament comes to consider the whole question in the round. But it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of other’s distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family’s continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none. What other considerations could make it better for him to die now rather than later? The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no best interests of any kind.”³⁶²

Lord Mustill's speech is central to the issue of best interests in relation to PVS patients³⁶³. Of particular relevance is the final statement made by His Lordship in which he states that keeping Anthony Bland alive would not be in his best interests, because the nature of his condition meant that he effectively had no best interests. There is a certain logic to this statement, particularly given that in the case of Anthony Bland, continuing with life-prolonging treatment would do nothing to serve his well-being, but would only serve to delay the sad inevitability of his death. Lord Mustill further commented on the issue of best interests by stating that although ending Anthony Bland's life was not directly in his best interests, any potential interests in keeping him alive had long since evaporated. It would therefore not be a criminal

³⁶² Ibid per Lord Mustill at 897.

³⁶³ see also *Frenchay Healthcare NHS Trust v S* [1994] 1 W.L.R 601; *An NHS Trust v D and others* [2005] E.W.H.C 2439 (Fam); *NHS Trust B v H* [2001] 2 W.L.R 942; *An NHS Trust v J* [2006] E.W.H.C 3152 (Fam) for further examples of cases relating to P.V.S patients. See also, British Medical Association [2007] *Guidelines on Withdrawing and Withdrawing Life-prolonging Medical Treatment*; 3rd ed; Blackwell Publishing.

offence to stop the treatment, since the nature of the patient's condition meant that the doctors no longer had a duty to continue the treatment. It is also worth mentioning at this stage the European Convention on Human Rights, specifically Article 2 which guarantees the individual's right to life. It could be argued that doctors would be infringing Article 2 of the Convention because in ceasing all life prolonging treatment, they would effectively be bringing about Anthony Bland's death. However, this argument is ultimately untenable, As discussed in Chapter 1 of this thesis³⁶⁴, whilst Article 2 does not permit individuals to actively aid in the death of another, this is to be differentiated from a scenario such as that of Anthony Bland, whereby continuation of his treatment would have been, on balance, disproportionate to the benefit that it would have been achieved. Article 2 does not require life prolonging treatment to be continued indefinitely and to cease it would therefore not be a breach of Article 2.

Nevertheless, is it true to say that Anthony Bland no longer had any interests of any kind? In the Court of Appeal, Lord Hoffmann stressed the difficulty of cases such as that of Anthony Bland, stating that a conflict existed between the sanctity of life and the principle of self-determination. Speaking about the sanctity of life, His Lordship said the following:

“Our belief in the sanctity of life explains why we think it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless.”³⁶⁵

However, his Lordship continued by stating that the sanctity of life principle is only one of the relevant principles that must be considered. Anthony Bland, despite being in a vegetative state, was nonetheless still alive. Hoffmann L.J validly reminds us that human life has an intrinsic value to it which is given great importance by many individuals, both from a religious and a secular viewpoint³⁶⁶. In the case of those such as Anthony Bland who are incapable of expressing their wishes on medical treatment,

³⁶⁴ See Chapter 1 of this thesis at 15.

³⁶⁵ *Airedale NHS Trust v Bland* [1993] 1 A.C 789. per Lord Hoffman at 826.

³⁶⁶ *Ibid.*

the intrinsic value placed on human life nonetheless requires the individual to be treated with dignity. If for example the patient was a member of a religion such as Islam or Judaism that adhered to strict dietary codes. Respecting the patient's dignity would preclude the patient being fed with bacon, despite the fact that he/she would more than likely have no recollection of the hospital staff having done so. Certainly there is considerable validity in the statement that every human being has the right to be treated with dignity without fear of humiliation and indeed, this right is protected under Article 3 of the European Convention on Human Rights, which protects the individual against inhuman or degrading treatment. The fact remains however that to consider cases such as that of Anthony Bland exclusively in such terms is to do so in too idealistic a manner. Indeed, Butler-Sloss L.J stated that adhering unequivocally to the sanctity of life principle was failing to consider the reality of Mr. Bland's situation³⁶⁷. Her Ladyship referred to the fact that quality of life was an integral factor in determining whether a life should be preserved at all costs³⁶⁸. In the case of Anthony Bland, the Court of Appeal was entirely satisfied that he had been appropriately examined and that there was absolutely no possibility of him regaining consciousness having been in a permanent vegetative state for over one year³⁶⁹. It is here that the issue of dignity again becomes relevant. Hoffmann L.J rejected the idea that one retains interests only when conscious, and stated that this did not correspond to the intuitive feelings of many people on the issue of life and death³⁷⁰. In Anthony Bland's case, his dignity would be best respected by ensuring that he died in an appropriate manner:

“Most people would like an honourable and dignified death and we think it wrong to dishonour their deaths, even when they are unconscious that this is happening. We pay respect to their dead bodies and to their memory because we think it an offence against the dead themselves if we do not.”³⁷¹

His Lordship also rejected the notion that the principles of sanctity of life and self-determination were in conflict. Given the nature of Mr. Bland's condition, it was not possible for him to voice his opinions about whether he would wish to be kept alive or not. Therefore, the only realistic option for the Court of Appeal was to gather

³⁶⁷ *Airedale NHS Trust v Bland* [1993] 1 A.C 789. per Butler-Sloss L.J at 820.

³⁶⁸ *Ibid.*

³⁶⁹ *Ibid* per Hoffmann L.J at 828.

³⁷⁰ *Ibid* at 829.

³⁷¹ *Ibid.*

information about him from loved ones and decide accordingly; particularly given that the patient had made no advance statements outlining what he would wish to have done³⁷². Hoffmann L.J stated that in the circumstances surrounding Anthony Bland’s situation, the Court of Appeal had felt that it was on balance more likely that he would have chosen to die, and that it was therefore entirely lawful for any life-prolonging treatment to be withdrawn³⁷³. It should be noted however, that the ruling of the Court of Appeal in *Bland* was relevant to that particular case, and should not be taken as applying in all cases involving patients in a vegetative state. There was no chance of Anthony Bland regaining consciousness, but in other similar cases, the chances of recovery might be higher and so this must be taken into consideration when deciding whether life-prolonging treatment should be continued.

It could also be argued that individuals in a PVS retain interests because of the possibility that they may recover some degree of awareness –therefore, the argument that they have no interests cannot always be assumed. Lord Hoffman stated in his judgment in *Bland* that no individual had ever recovered consciousness after being in a persistent vegetative state for over one year³⁷⁴.

Existing literature has provided differing views as to whether PVS patients actually feel pain and whether this can be accurately determined. McCullagh refers to the testimonies of the American Medical Association, who stated that **“pain cannot be experienced by brains that no longer retain neural apparatus for suffering.”**³⁷⁵

Similarly, Cranford states that

“No conscious experience of pain and suffering is possible without the integrated functioning of the brainstem and cerebral cortex. Pain and suffering are attributes of consciousness, and PVS patients... do not experience them.”³⁷⁶

Certainly this was the conclusion reached by the U.K courts in *Airedale NHS Trust v Bland*. The medical staff were certain that Tony Bland was incapable of displaying any sentient response and that there was no hope of recovery. True though this may be however, the conclusion reached in *Bland* does not automatically apply to all PVS

³⁷² Ibid.

³⁷³ Ibid.

³⁷⁴ Ibid at 853.

³⁷⁵ Ibid at 88.

³⁷⁶ Ibid.

cases. The American Neurological Association stated in 1993 that the question as to whether PVS patients can feel pain **“may not be resolved scientifically to everyone’s complete satisfaction.”**³⁷⁷ This is illustrated in the U.K case of *Frenchay Healthcare NHS Trust v S*³⁷⁸, which also concerned an application by a health authority for a declaration allowing them to lawfully refrain from any further attempts to reinsert a gastrostomy tube into a PVS patient. Since this was the same position that Tony Bland was in, Frenchay NHS Trust argued that the same approach was justifiable in this case. The declaration was duly granted and the subsequent appeal dismissed. During the appeal, the Official Solicitor raised the question of whether the diagnosis of PVS was accurate, and whether S’s circumstances did in fact mirror those of Tony Bland. In particular, Sir Thomas Bingham M.R highlighted the following:

“More significantly, attention is drawn to suggestions in the medical reports of what might be interpreted as volitional behaviour: that is, not mere spasm or reflex reaction, but voluntary behaviour on the part of the patient. There is reference at one point to pulling out the nasogastric tube and indeed to the pulling out of the gastrostomy tube... There are references to the possibility that S may feel distress and may be suffering. Indeed, it is pointed out that one of the reasons why the nurses are so gravely distressed by S’s condition is that they are convinced that at times he seems to suffer.”³⁷⁹

Ultimately, the court was satisfied with the evidence of the consultant who had diagnosed S as a PVS patient who had no chance of recovery, particularly as this had been further confirmed by another consultant neuro-psychiatrist³⁸⁰. However the court also acknowledged that the circumstances of the Bland case could not be assumed as applying automatically to all PVS patients. In S’s case, the court stated that his condition was not as clear-cut as Tony Bland’s, and that it was still necessary for doctors to exhaust all treatment avenues before concluding that there is no hope of recovery for a patient in a persistent vegetative state³⁸¹.

Although not an example of a misdiagnosed PVS as such, the case of *Frenchay Healthcare NHS Trust v S* is useful as an illustration of the inherent difficulty in

³⁷⁷ Ibid.

³⁷⁸ [1994] 1 W.L.R 601.

³⁷⁹ Ibid per Sir Thomas Bingham M.R at 608.

³⁸⁰ Ibid at 604.

³⁸¹ Ibid at 608.

accurately determining awareness levels in PVS patients. Clearly, each case will be different and in the light of this, providing specific criteria for determining awareness is perhaps not practical. McCullagh has highlighted the fact that although much of the existing commentary confirms that PVS patients by definition are not capable of experiencing pain or any form of sentience, commentary also exists that would appear to challenge this.

The case of Anthony Bland illustrates the various complexities involved when dealing with patients in a persistent vegetative state. Lord Hoffman's assertion that patients in a persistent vegetative state still maintain critical interests, if not experiential ones, is entirely valid, but is also perhaps too idealistic to be of any real use when considering what to do regarding the continuation of treatment for patients such as Anthony Bland who have no chance of recovery. The question which must therefore be asked is whether continuation of life-prolonging treatment would benefit the patient in any way. However, would the same rules apply when the patient is not in a persistent vegetative state, but nonetheless finds their interests evaporating as a result of a serious illness? This was the central issue in *W Healthcare NHS Trust v KH and others*³⁸².

The case concerned a 59-year-old woman suffering with multiple sclerosis, who had been incapable of taking informed decisions for herself for at least 20 years. She lived in a nursing home and required round the clock care. Although the woman, KH, was conscious, her bodily functions had ceased and she could not speak more than one word at a time. KH had been fed through a tube for five years. On one occasion, the tube fell out and KH was admitted to hospital as a result. Although the hospital staff felt that it was in KH's best interests to have the tube reinserted, her family did not wish this to take place as they felt that under the circumstances, KH would prefer to die. However, the court held that there was insufficient evidence of KH's wishes prior to the loss of her capacity. Therefore, to permit the feeding tube to remain out would be tantamount to allowing the patient to die of starvation. This was deemed unacceptable for a patient who was not in a persistent vegetative state unless the patient's condition was so intolerable that death would unquestionably be in her best

³⁸² [2004] E.W.C.A Civ 1324.

interests. The subsequent appeal by KH's brother and daughter was dismissed for the same reasons.

W Healthcare NHS Trust v KH and others illustrates how complicated a best interests determination can be. At appeal, Brooke L.J referred to a statement made by the trial judge, stating how borderline the decision was, and how the family's case about KH's suffering was as strong as the arguments made to the contrary³⁸³. KH's condition was such that she did not recognise any of her family and received no visitors as a result. Why then, did the court rule against their wishes and order the feeding tube to be reinserted? The answer may lie in the nature of the treatment, namely artificial nutrition and hydration. As stated earlier, ceasing this was deemed tantamount to starving KH to death, which would have been extremely painful and undignified. Furthermore, Brooke L.J stated that there was no evidence to suggest that KH knew of the pain of starving to death, and that there was also no evidence to suggest that KH would explicitly prefer to die in this manner. The issue was therefore not whether it was in KH's best interests to die, but that it was not in her interests to die in such a painful undignified manner. This may not have been as important an issue were KH in a persistent vegetative state, but since she was mildly sentient, acceding to the family's wishes would have resulted in a painful death, which the courts were entirely correct not to authorise. In short, the issue of best interests must be considered not simply in terms of outcome, but in how that outcome is achieved.

4.1.2: DECISION MAKING FOR THE INCAPABLE PATIENT UNDER THE MENTAL CAPACITY ACT 2005: DEVELOPMENT OF THE BEST INTERESTS CONCEPT

Section 4(1) of the Mental Capacity Act 2005 states that when making a determination as to what is in an individual's best interests, the decision-maker must not do so based on the individual's age or appearance (4(1)(a)), or any condition which might lead others to make unjustified assumptions about what may be in the individual's best interests (4(1)(b)). This is an explicit endorsement of the principle of non-discrimination and the rejection of the status approach in favour of a functional approach to capacity, which is consistent with the Law Commission's earlier

³⁸³ Ibid at Para 10.

recommendations. Despite the fact that best interests has been interpreted in the common law as a predominantly paternalistic concept, the Law Commission's attempts to introduce a more autonomous aspect to it are also significantly represented in s.4 of the Mental Capacity Act. First, s.4(4) states that the decision-maker must permit and encourage the individual to participate in the decision-making process as far as is reasonably practicable. This is in contrast to a more traditional model of best interests, which places greater emphasis upon the decision-maker and what he/she deems to be the correct course of action to be taken on the individuals' behalf. Following on from this, s.4(6) states the following:

“He [the decision-maker] must consider, so far as is reasonably ascertainable-

(a) the person's past and present wishes and feelings (and, in particular any relevant written statements made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.”

This section has deviated very little from the Law Commission's proposals for the Draft Mental Incapacity Bill 1995³⁸⁴, which had originally included virtually identical provisions to the above. It is wholly in keeping with the Commission's main theme of empowerment of the individual, and illustrates further just how the best interests test as included in the Mental Capacity Act 2005 differs from the test as applied in the common law.

The issue of whether a particular course of treatment is in the best interests of the individual will be predominantly decided upon clinical factors. However, as can be seen above, Section 4(6) states that in addition to clinical factors, decision-makers must consider the past and present wishes and feelings of the individual as far as these can be ascertained³⁸⁵. This confirms the English common law position on the subject, which confirms that 'best interests' encompasses factors beyond mere medical

³⁸⁴ see Draft Mental Incapacity Bill 1995, clause 3(2).

³⁸⁵ See Mental Capacity Act 2005 Code of Practice 2007 Para 5.39, in which it is stated that 'reasonably ascertainable' means **“considering all possible information in the time available.”**

ones³⁸⁶. If an indication of the individual's preferences can be evidenced, this must take priority over the decision-maker's own opinions. The 2007 Code of Practice reiterates the importance of the individual's past and present wishes and feelings, in particular when an individual has made an advanced statement specifying a particular treatment decision³⁸⁷. Beyond this, the Code of Practice says little more on this issue which cannot be found in the Act itself. Section 4(6) also requires the decision-maker to consider any deeply held belief or value systems which may have an influence on a how an individual might make a particular decision. The Code of Practice states that these could include matters such as cultural background, religious beliefs, political convictions or past behaviour or habits³⁸⁸. If for instance, a Jehovah's Witness becomes incapable of making a decision following an accident and requires a blood transfusion, the doctor cannot simply rule that it is in the patient's best interests to have the treatment. Instead, the doctor must now consider the beliefs of the individual and decide accordingly. In this case, the treatment should not go ahead based upon the beliefs of Jehovah's Witnesses regarding blood products.

It is also worth noting that the presence of s.4(6)(c) provides further indication that certain elements of the substituted judgment test have been included within the best interests provisions in the Mental Capacity Act 2005. As well as the past and present wishes and feelings of the individual, s.4(7) of the Act requires the decision-maker to consider, as far as is practicable:

- “(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,**
- (b) anyone engaged in caring for the person or interested in his welfare,**
- (c) any donee of a lasting power of attorney granted by the person, and**
- (d) any deputy appointed for the person by the court.”**

Though not explicitly mentioned, the fact that the above provisions have been included directly below the references to the past and present wishes and feelings of the individual, suggests that consultation with others close to the individual should not

³⁸⁶ See Chapter 4.1.1 of this thesis.

³⁸⁷ Ibid at Para 5.42.

³⁸⁸ Ibid at Para 5.46.

take precedence over consulting with the individual themselves. In addition, s.7(a) refers to anybody who has been named by the person as somebody to be consulted. This is again emphasising the importance of the individual's involvement in the decision-making process; even when he/she may not be capable of contributing directly.

4.2: DECISION-MAKING FOR THE INCAPABLE PATIENT UNDER THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 – THE CONCEPT OF ‘BENEFIT’

The general principles of the Adults with Incapacity (Scotland) Act 2000 permits intervention in the affairs of the incapable adult provided that the person responsible for authorising or putting into effect the intervention is satisfied that the intervention will benefit the individual, and that this benefit cannot reasonably be achieved without the proposed intervention³⁸⁹. Where an intervention is necessary, the principle of least restrictive alternative must be applied in relation to the freedom of the adult³⁹⁰. It was further stated in *M, Applicant*³⁹¹ that the test for benefit should not include issues of primary or secondary benefit. The valid test was only that which adhered to the general principles of the 2000 Act³⁹².

The equivalent test to benefit in English law, namely the best interests test, is notable by its complete absence from the 2000 Act. The reason for this was explained in the 1995 Scottish Law Commission Report:

“We consider that ‘best interests’ by itself is too vague and would require to be supplemented by further factors which would have to be taken into account. We also consider that ‘best interests’ does not give due weight to the views of the adult, particularly to wishes and feelings which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child’s level of understanding

³⁸⁹ Adults with Incapacity (Scotland) Act 2000, s.1(2).

³⁹⁰ Ibid, s.1(3).

³⁹¹ [2007] S.L.T (Sh. Ct) 24.

³⁹² Ibid at 26. See also *B, Applicant* [2005] S.L.T (Sh. Ct) 95; *T, Applicant* [2005] S.L.T (Sh. Ct) 97; *B’s Guardian, Applicant* [2006] S.L.T (Sh. Ct) 23; *A’s Guardian, Applicant* [2006] G.W.D 417; *H, Applicant* [2007] S.L.T (Sh. Ct) 5.

may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles... are framed without express reference to best interests.”³⁹³

Although a definition of ‘benefit’ was not provided in the 2000 Act, s.1(4) of the 2000 Act provides further guidance:

“In determining if an intervention is to be made, and if so, what intervention is to be made, account shall be taken of –

- a) the past and present wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretive nature or otherwise) appropriate to the adult;**
- b) The views of the nearest relative and the primary carer of the adult, in so far as it is reasonable and practicable to do so;**
- c) The views of – any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention; and any person whom the Sheriff has directed to be consulted; in so far as it is reasonable and practicable to do so; and**
- d) The views of any other person appearing to the person responsible for authorising or effecting the intervention to have an interest in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible, in so far as it is reasonable and practicable to do so.”**

As can be seen, the past and present wishes and feelings of the individual have been placed at the top of the list of criteria. It has not been specifically stated that the above criteria have been listed in a hierarchical manner, but this notwithstanding, the emphasis placed upon patient autonomy suggests strongly that the ascertainable past

³⁹³ Scottish Law Commission Report No.151 (1995) *Report on Incapable Adults* at Para 2.50. See also, *Joint Committee on the Draft Mental Incapacity Bill Session 2002-2003* at p15, per memorandum from Donald Lyons which echoes this point.

and present wishes of the patient will be prioritised ahead of the views of relatives and carers.

It is unclear as to whether Parliament intended s.1(4) to be used specifically as criteria for determining whether a particular course of action benefits the individual. The fact that s.1(4) exists as a separate sub-clause from the ‘benefit’ clause (s.1(2)) suggests that s.1(4) is to be taken as a separate general principle. Nevertheless, the fact that ‘benefit’ was not defined also suggests that there is nothing to stop s.1(4) being used as guidance for determining what would constitute a benefit in a particular case. Ward suggests that the requirements to ascertain the individual’s own present or past wishes and feelings, and to consult the nearest relative and primary carer, would be particularly helpful in assessing benefit³⁹⁴. This is a valid submission worthy of consideration. The concept of benefit must be given construction beyond mere medical interpretation of the term. To explain this further, consider the example given above of the Jehovah’s Witness who has refused a much needed blood transfusion. If one were to give ‘benefit’ a strict medical interpretation, then one would arguably have to administer the blood transfusion in order that the patient might regain full health. However, an alternative interpretation might be that respecting the patient’s wishes and allowing them to refuse the blood transfusion is providing greater benefit to the patient. Also, the fact that such a great emphasis has placed upon autonomy in the 2000 legislation arguably gives greater weight to this interpretation. Following on from this, if the Act requires the ‘intervener’ to consider the present and past wishes of the individual, one could then link this to the ‘benefit’ requirement by prioritising the wishes of the individual, either from the present or the past. Ward provides extremely useful exposition on the issue of constructing decisions on behalf of an incapable individual. He states that there is in essence a hierarchy of twelve factors to be considered when making a decision, number one being the most important, and number twelve being the least important:

“The possible elements of the construct can be stated hierarchically as follows:

- 1) The adult’s present competent decision;**
- 2) The adult’s past competent decision;**

³⁹⁴ Ibid

- 3) **The adult's decisive present choice;**
- 4) **The adult's significant present choice;**
- 5) **The adult's present wishes and feelings;**
- 6) **The adult's past wishes and feelings;**
- 7) **Information about the adult from, and the views of, the persons closest to the adult;**
- 8) **Input of others with significant personal or professional knowledge of the adult, or specific appointments or roles in relation to the adult;**
- 9) **The shared views and ethos of the adult's family;**
- 10) **The shared views and ethos of any other grouping with which the adult is immediately and substantially associated.**
- 11) **The shared views and ethos of any religious, ethnic or other group of which the adult, or the adult's family, is a member;**
- 12) **The norms of the society of which the adult is a member.**³⁹⁵

In keeping with the pro-autonomy approach of the 2000 Act, Ward rightly considers the present competent decision of the adult to be the most significant factor in decision-making process. Put simply, if the individual is fully capable and makes a decision, then that decision must be respected by the doctor. Of secondary importance is any past decision the individual has made; if the individual has since become incapable, but has evidenced a decision made at a time when capacity had been retained i.e. through an advance statement, this must be followed. Elements three and four represent choices made by the individual who, though having some degree of incapacity, is nonetheless able to evidence some choice which may be decisive or significant in the final treatment decision. Elements three and four are very much in keeping with the Scottish Law Commission's earlier statement that capacity is not an 'all-or-nothing concept', and that incapacity in one aspect of life does not necessarily mean incapacity across the board. Elements five and six do not refer to actual choices made by the individual, but instead refer to any wishes and feelings expressed by the individual, either in the present or the past. These could be differentiated from actually making a choice in as much as the wishes and feelings expressed may not refer directly to the treatment decision in question, but rather to general opinions

³⁹⁵ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 15.9.

about issues such as the type of treatment offered, or about end-of-life issues in general for example. After consideration of the elements which are aimed at involving the individual in the decision-making process, the ‘intervener’, according to Ward, may then consider the opinions, wishes and feelings, be they past or present, of any persons who may be considered close to the adult. While this could ostensibly include nearest relatives, note also that Ward includes the ‘shared views of the adult’s family’ as a separate element. One might argue from this that information relating directly to the feelings and opinions of the individual are more to be considered ahead of the more general wishes and feelings of the individual’s family as a whole. Of lesser importance still are the opinions and feelings of any religious, ethnic or community group which may be connected to the individual. In this way, Ward appears to be giving only nominal importance to the principle of communitarianism, which in the context of treatment decision-making, places the needs and wishes of any community of which the individual is a member above the wishes and feelings of the individual themselves. The fact that the views of any religious, ethnic or any other group have been placed at the bottom of Ward’s list along with the norms of society shows that Ward considers these factors to be insignificant when compared to the wishes and feelings of the individual.

The concept of benefit bears strong similarity to the best interests test contained in the Mental Capacity Act 2005. Both concepts prioritise what is best for the individual, and both concepts emphasise the need to consider past and present wishes and feelings of the individual and persons close to the individual. Given these apparent similarities, it is perhaps useful to examine whether the concepts of ‘benefit’ and ‘best interests’ are in reality all that different.

First, consider the definition of benefit as espoused by Adrian Ward. Ward states that the concept of benefit could, with due caution, be used to describe anything which attempts to overcome the limitations that incapacity may create for an individual. This would in turn permit a course of action to be taken which the individual could reasonably be expected to have chosen to do if they had capacity. It appears from this definition that the concept of ‘benefit’ contains elements of another test used during cases of incapacity, namely, the substituted judgment test. According to Ward, the substituted judgment test means **“ascertaining and applying the choice or decision**

which, it is believed, the adult would have arrived at if able to make and communicate a choice or decision in the matter in question.”³⁹⁶ There is a great similarity between Ward’s definition of substituted judgment and his definition of ‘benefit’. As stated earlier, the lack of statutory definition for the concept of ‘benefit’ means that one could theoretically use the provisions of s.1(4) of the 2000 Act; in particular, the need for the decision-maker to take account of the past and present wishes and feelings of the individual so far as they can be ascertained. It is submitted that the inclusion of this requirement within statute suggests government endorsement of some form of substituted judgment. Endorsement of a pure best interests model would arguably not require consideration of the past and present wishes and feelings of the individual, as the deciding factor in a treatment decision would be what the decision-maker considers to be in the individual’s best interests, irrespective of what the individual might have decided had he/she had the requisite capacity. It is unsurprising that the 2000 legislation makes it necessary for decision-makers to consider the past and present wishes and feelings of the individual; it is after all in keeping with the pro-autonomy approach of the legislation. What is particularly interesting however, is the fact that the best interests test as laid down in the English Mental Capacity Act 2005 also states that decision makers must have regard to the past and present wishes and feelings of the individual. One might conclude from this that the test for proxy decision-making in both U.K jurisdictions is undergoing an evolution of sorts and that this evolution is represented by the inclusion of a hybrid test which consists of elements from both the best interests test and the substituted judgment test. Indeed, it is perhaps too obtuse to proponents of both tests to insist upon a pure model of either test. Adrian Ward highlights some potential deficiencies in a pure best interests model, whilst endorsing the approach eventually favoured by the Scottish Law Commission:

“The approach of the Scottish Law Commission is to be preferred both on its merits and because Scots law in this regard now implements the Commission’s recommendations. [The best interests test] is an inherently subjective and paternalistic approach. Except where the choice of decision is beyond doubt, it entails a choice by someone other than the adult. If that choice is in any way reflective of the personal views and background of

³⁹⁶ Ibid at Para 15.27. See also *D’s Curator Bonis, Noter*, [1998] S.L.T 2.

whoever makes it, it is to that extent flawed; but even if the person making the choice is rigorously objective, that choice will inevitably be a reflection of level 12 of the list.³⁹⁷ In other words it will be a contribution from the lowest level of the list, and should be accorded no higher status than that. If inconsistent even with level 11³⁹⁸ or with the preponderant view to be derived from higher levels, then usually it should not prevail. It is worthy of repetition that the requirement of modern Scots law is that any judge, safeguarder, curator ad litem... or appointee, or any other authority or person exercising functions under the Incapacity Act, should proceed in all respects in accordance with the general principles of the Incapacity Act, and not by simply interjecting their personal views as to the adult's 'best interests'."³⁹⁹

Ward makes a number of points which are central to the issue of decision-making for incapable adults. In the light of Ward's twelve point checklist, it is submitted that the application of the 'benefit' requirement necessitates prioritisation of the substituted judgment approach i.e. acting on the basis of the past and present wishes of the individual. If the past and present wishes, feelings or choices of the individual are unascertainable, it would then be acceptable for the decision-maker to adopt a more paternalistic approach i.e. act on the basis of what he/she feels would be beneficial to the individual. The fact that the best interests test as laid down in the English Mental Capacity Act 2005 also contains the requirement that decision-makers consider the past and present wishes, feelings and beliefs of the individual⁴⁰⁰, shows that even the English approach to best interests has evolved so as to now include a degree of substituted judgment. One could therefore infer that the concept of benefit is not particularly far removed from best interests as laid down in the 2005 English Act. Furthermore, the fact that the Scottish Act was passed five years before the English legislation suggests that England might in fact have been influenced by the Scottish approach.

³⁹⁷ **"The norms of the society of which the adult is a member"** see earlier in this chapter at 144-145 for Ward's complete list.

³⁹⁸ **"The shared views and ethos of any religious, ethnic or other group of which the adult or the adult's family, is a member"**.

³⁹⁹ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 15.27.

⁴⁰⁰ Mental Capacity Act 2005 s.4(6).

It is submitted that despite the rejection of the best interests concept by the Scottish Law Commission in 1995, there is ultimately little substantive difference between this concept and the concept of benefit as laid down in the Adults with Incapacity (Scotland) Act 2000. The Scottish Law Commission stated that the best interests test was unsuitable in the context of incapable adults because it was developed in the context of childcare law and it was this inappropriate to equate incapable adults with children⁴⁰¹. It is submitted however, that this distinction is wholly unconvincing, given the way that both concepts have been laid down in both English and Scottish legislation. Both concepts require the person making the determination to prioritise the past and present wishes and feelings of the individual and take account of the wishes and feelings of those closely connected to the individual. Therefore, the Scottish Law Commission's assertion in 1995 that the best interests test does not give adequate weight to the wishes and feelings of the adult⁴⁰² no longer has any validity. Furthermore, English common law application of best interests has highlighted the fact that for some incapable adults, incapacity will have existed from birth and it would therefore not be possible in such cases to ascertain what the past wishes of an individual would be with regard to a particular situation⁴⁰³. However, this has been taken into account by both the English and Scottish legislations by allowing for the view of relatives and carers to be considered by the person making an intervention on behalf of an incapable adult.

4.3: DECISION-MAKING FOR THE INCAPABLE PATIENT IN INDIAN LAW

Indian law currently does not recognise the concepts of best interests or benefit and their relevance in determining how to act on behalf of an incapable adult. However, a review of the literature has revealed that recognition of the underlying issues is slowly developing, in particular to the important issues of sterilisation for the incapable adult and issues relating to end-of-life care. Thus far, one case relating to sterilisation of the incapable adult has been reported in India, and is worthy of discussion here.

⁴⁰¹ Scottish Law Commission Report No. 151 (1995) *Report on Incapable Adults* at Para 2.50.

⁴⁰² *Ibid.*

⁴⁰³ See *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C 1; *Re A (Mental Patient: Sterilisation)* [2000] 53 B.M.L.R 66; *Re SL (Adult Patient: Medical Treatment)* [2000] 2 F.C.R 452. In each case, the condition present in the individual which resulted in incapacity had been present since birth.

On February 5th 1994, The Indian Express Newspaper published an article concerning the proposed removal of the uterus from several mentally impaired women by a doctor working at Sassoon General Hospital in Pune. There were two reasons given to justify the operation:

“a) these women, whose mental age was between two and three years, were unable to attend to their personal hygiene and often smeared themselves and their surroundings with menstrual fluid.

b) They were subject to rape and unwanted pregnancy. Removal of the uterus would stop menstruation and prevent pregnancy. Ms. Vandana Khullar, Director in charge of the welfare of women, children and the handicapped in Maharashtra pointed out that the guardians of such women were often unwilling to attend them or children born to them. She claimed that removal of the uterus did not eliminate femininity”⁴⁰⁴

PARYAY, a group promoting alternatives to hysterectomy operations for the mentally impaired, published an article denouncing the proposed operations for the following reasons:

“Menstruation, even in the mentally handicapped, is not a disease to be eliminated. Hysterectomy has been carried out for the convenience of the caretaker institutions and not for the health of the mentally handicapped women. Would a ‘normal’ woman undergo this operation just to get rid of the ‘trouble of menstruation’ even after the completion of childbearing?

... Hysterectomy is major surgery with a mortality rate of 1-2 per 1000 operations and an even higher complication rate.

... Such hysterectomy is not recommended by any standard textbook of gynaecology or psychiatry. An extensive search... shows that it is not an accepted practice in developed countries.

...The human rights of persons in State custody need to be strengthened, not weakened. Removal of a healthy organ without even providing basic care and facilities erodes their human rights”⁴⁰⁵

⁴⁰⁴ Author unspecified (1994) *Removing the Uterus from Mentally Handicapped Women: Some Ethical Considerations*; Indian Journal of Medical Ethics; Feb-Apr 1994(3); accessed on 18/01/2006; available online at <http://www.issuesinmedicalethics.org/013mi010.html>.

⁴⁰⁵ PARYAY (1994) *Hysterectomy in the Mentally Handicapped*; Indian Journal of Medical Ethics; Aug-Oct Vol.2(1); accessed online at <http://www.issuesinmedicalethics.org/021mi006.html>.

Following outrage amongst women's rights groups, the Chief Minister of Maharashtra ordered an immediate ban on the proposed operations. The protesters felt that removal of the uterus for the sake of menstrual hygiene was too extreme a measure, since **"...keeping these women clean during the three of four days when they were menstruating each month was not an insurmountable problem."**⁴⁰⁶. Furthermore, it was not accepted that removing the uterus would not affect the patient's femininity: **"The statement that removal of the womb does not deprive a woman of her femininity smacks of insensitivity. There is ample documentation of the deep sense of despair experienced by women who have been deprived of this organ"**⁴⁰⁷. However, the ban on the proposed operation was subsequently lifted, thus permitting hysterectomy operations on handicapped women to continue, provided that such procedures were not carried out in surgical 'camps', which presumably invoked images of the Third Reich.

The Pune hysterectomies scandal further raises questions about the status of women in certain sections of Indian society. Rajan comments on this through reference to the practice of female infanticide that has been reported in certain areas of India:

"Son-preference is a widespread attitude in India, but its degree, and the consequential degree of discrimination against girl children, varies in different regions. Neither the preference nor the discrimination is much camouflaged. The abhorrence of female children is intense enough to affect their chances and rates of survival."⁴⁰⁸

Bandewar comments further on this issue:

"...it is argued that if women do not produce sons, they will be victimised by their families and communities. This, women should have the right to sex-selective abortion, exercising their right to autonomy and preventing victimisation. However, while individual women might escape abuse this way, it actually reinforces gender inequities and accepts social injustice. Women's right to abortion should emancipate them from sex-based subordination. Sex-

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid.

⁴⁰⁸ Rajan, R S (2003) *The Scandal of the State: Women, Law and Citizenship in Postcolonial India*; Duke University Press, Durham and London at 177-178.

selectives practices perpetuate the oppressive and sexist society which promotes this practice.”⁴⁰⁹

One of the central reasons for female infanticide is the existence of the dowry system, whereby the families of women, when they reach marriageable age, are required to provide money, goods or property to the family of their daughter’s would-be groom. For families who live near to or below the poverty line, this will be impractical yet compulsory if they wish their daughter to be married. Therefore, the birth of a daughter could be seen by some as a burdensome prospect from the outset, where infanticide is the preferred option. If women are vulnerable by virtue of their gender, this vulnerability is arguably increased for women who are affected with some form of disability.

Rajan suggests that women, who are destitute or suffering from some form of disability, are extremely vulnerable because the State welfare system effectively fails to distinguish between those who need to be placed in correctional institutions and those who require protection or rehabilitation:

“Formally, a distinction exists between ‘protective homes’ and ‘corrective institutions’, but actually they are put to use interchangeably. Destitute or sick women for whom the first is intended are placed along with women accused of ‘victimless crimes’ like vagrancy or solicitation identified for the occupation of the latter, and all of them are indistinguishable from criminals.”⁴¹⁰

Rajan highlights the fact that the stigma of mental illness still prevalent in India, often results in individuals being committed to institutions by family members who are unable to cope with this stigma. In addition to this, women are arguably more prone to being taken into custody under charges of prostitution, vagrancy or begging; according to a 1995 Report by the Joint Women’s Program, the status of being **“a single and especially poor woman, without any male support, must either be already be working in prostitution or will soon be corrupted into joining it.”⁴¹¹** It would therefore appear that the notion still exists in India of women being incapable by virtue of their gender, essentially rendered incapable without the support of a

⁴⁰⁹ Bandewar, S (2005) *Exploring the Ethics of Induced Abortion*; Indian Journal of Medical Ethics; Vol. 13(1), accessed online on 23/01/09, available online at <http://www.issuesinmedicalethics.org/131di018.html>.

⁴¹⁰ Ibid at 88.

⁴¹¹ Ibid.

male⁴¹². Women who are placed in institutions will therefore often not be released unless they have families to be released to⁴¹³, an unlikely scenario if the individual has been admitted by family members in the first place. Rajan explains further:

“It is the ‘ideology of the family’ – the conviction that women’s sexuality must be both protected and controlled – that underpins the ideology of institutional confinement, making a vicious circle of the passage of women from family of community to the institution and back. The processes of discharge/exit are highly bureaucratic. Women are released only if they have a family to receive them, but families... are either reluctant or unfit to receive them.”⁴¹⁴

Rajan links the above analysis back to the Pune hysterectomies scandal by highlighting both the ideological conflict that was at the heart of the dispute, coupled with the unofficial but definite endorsement of the status approach:

“It will be clear that in the debate over the hysterectomies, the government’s most elevated defence of the practice was based on the ‘alleviation of suffering’ argument, while the activist’s opposition to it drew from the human rights defence of the women’s autonomy, liberty, integrity and privacy... In a single stroke, the sterilisation procedure wholly and comprehensively defined the identity of the inmates of the welfare home as ‘mentally retarded women’: as *women*, in terms of the ‘problems’ of female sexuality; and as *mentally retarded* in terms of their incapacity to make rational choices. The individual’s spaces of selfhood, subjectivity and citizenship are thus entirely usurped by the state and the exigencies of institutional care.”⁴¹⁵

The Pune hysterectomies scandal effectively brings together a number of key ethical concepts and thus is essential for any discussion of capacity issues in India. On a more general level, state intervention, it would seem, has yet to recognise the possibility that women who are mentally disordered or impaired can be encouraged and empowered to live at least partly independently; they must either be released into the care of the family or remain institutionalised, without any middle ground available to

⁴¹² See also Ramanathan, U (1996) *Women, Law and Institutionalisation: A Manifestation of State Power*; Indian Journal of Gender Studies; Vol. 3(2); 199-224 at 200.

⁴¹³ Rajan, R S (2003) *The Scandal of the State: Women, Law and Citizenship in Postcolonial India*; Duke University Press, Durham and London at 89.

⁴¹⁴ Ibid.

⁴¹⁵ Ibid at 94; italicised emphasis in original extract.

the individual that takes into account the varying degrees of incapacity that exist. Such an analysis also means that the ability of women to exercise their right to autonomy is effectively being disputed by the state, thus giving way to the principle of paternalism. With specific reference to the Pune case, Rajan suggests that the issues surrounding the sexuality of women are particularly contentious in the context of Indian society:

“The anxieties produced by women’s sexuality – real and imagined fears about promiscuity, commercial sex, sexually transmitted diseases, unregulated fertility, infertility, deviant sexuality – are widely recognised as coexisting with the exploitation and regulation of aspects of women’s sexuality by social, religious, legal, communal and state sanctions.”⁴¹⁶

The above statement suggests a meeting of both cultural and developmental issues. From a developmental perspective, state handling of mentally disordered and impaired women arguably illustrates a lack of awareness of fundamental capacity issues. However, given that it was only after *Re F (Mental Patient: Sterilisation)* in 1990 that U.K capacity law developed significantly, the present situation in India is arguably comparable to the U.K situation twenty years previously. Cultural differences however can be identified, particularly in the degree to which the status approach is applied to women in both jurisdictions. It would be inaccurate to suggest that women are not, or never have been perceived as being somehow ‘lesser’ than men in the United Kingdom. They were not granted the vote until 1928, and marital rape was not criminalised until 1991⁴¹⁷. However, the manner and degree that male preference is shown in India, e.g. through female infanticide and the reasoning behind it, arguably sets it apart from the United Kingdom.

Pursuant to this, the Forum for Medical Ethics drew up draft guidelines for dealing with hysterectomy cases in mentally impaired women.

“Rationale for hysterectomy:

1) Inability to maintain personal hygiene during menstruation a) this must be documented on the case sheets. The effects of such documented lack of hygiene on the mentally handicapped woman must be clearly stated. Reference must be made in writing to the state of personal hygiene on other

⁴¹⁶ Ibid at 89.

⁴¹⁷ See *R v R* (1992) 1 A.C 599.

days when she is not menstruating, especially with regard to excretion of urine and faeces. It must be evident to an objective observer scrutinising the case sheets and inspecting the woman's surroundings that despite all available care and assistance, there is breach of hygiene from menstruation hazardous to the woman's health and well-being.

b) Where available care and assistance are less than what can be reasonably expected, the shortcomings must be corrected before a decision is made on hazard to the woman from breach of hygiene.

c) Hysterectomy in the absence of a conscientious effort at helping the woman to maintain personal hygiene cannot be justified.

...Whilst improvement in facilities for maintenance of personal hygiene to the state where it would be unnecessary to consider such options as hysterectomy would be ideal, given the circumstances in most institutions for the mentally handicapped in India, this is likely to remain infeasible for quite some time. Whilst every effort should be made to reach this ideal, in the interim the above guidelines appear practical.

It must be emphasised that all concerned... should ensure that recourse to hysterectomy does not become the refuge of the inefficient, corrupt or unconcerned. Public institutions running on subsidies from society cannot evade their responsibilities towards these women or consider the promotion of personal hygiene amongst them as 'extraordinary care'.

2) ...Hysterectomy is not permitted solely to prevent unwanted pregnancy. Laparoscopic tubal ligation is the procedure of choice for this purpose.

3) For medical indications such as menorrhagia... the decision by a qualified gynaecologist to perform hysterectomy as therapy for such indications documented on the patient's case sheets cannot be challenged.

4) To avoid the consequences of rape: This is an untenable reason for hysterectomy. Prevention of rape is the responsibility of the legal guardian of the mentally handicapped woman. When such a woman is in a state institution, the onus for preventing such assault lies squarely on the

administrators of the institution. The very nature of the handicap necessitates special protection.”⁴¹⁸

It can be seen that there is, to at least some extent, a convergence of approach between India and the U.K. It was held in the English case of *Re SL (Adult: Medical Treatment)*⁴¹⁹ that hysterectomy of mentally impaired women for the purpose of stopping menstrual periods can only be done where the lack of menstrual hygiene is of such a level as to be potentially or actually hazardous to the health and well-being of the patient. Although a hysterectomy operation was not authorised in SL’s case, this was because the court were not satisfied that less invasive alternatives were not available. Had a hysterectomy operation been the only viable method of treatment available to SL, it would have been authorised if in her best interests, and indeed, it was only at appeal that the operation was rejected. Similarly, the Forum for Medical Ethics in India expressly stated that such operations were unjustifiable unless all measures had been taken to maintain menstrual hygiene via less invasive measures; in other words, a hysterectomy cannot be performed simply for the convenience of the carers. However, the Forum also correctly emphasised that the state of India’s health service may mean that maintenance of acceptable standards in this area may not always be possible. Though it is commendable that this was recognised, it remains to be seen whether this will translate into actual improvements in healthcare provision.

The Forum for Medical Ethics further stated that a hysterectomy for the purposes of preventing unwanted pregnancy was not justifiable. The Forum for Medical Ethics recommended a laparoscopic tubal ligation as an alternative which is a considerably less invasive sterilisation procedure. The Forum for Medical Ethics was rightly adamant that an already vulnerable group of individuals should not be subjected to potentially distressing and invasive procedures when the same effect could be achieved via simpler means. This is an endorsement of the principle of least restrictive alternative and mirrors the U.K position. Cases such as *Re A (Medical Treatment: Male Sterilisation)*⁴²⁰, *Re SL (Adult Patient: Medical Treatment)*⁴²¹ and *Re F (Mental*

⁴¹⁸ Author unspecified (1994) *Suggested Guidelines for Hysterectomy in Mentally Handicapped Women*; Indian Journal of Medical Ethics; Vol. 1(4). Accessed online on 18/01/2006; available at <http://www.issuesinmedicalethics.org/014mi002.html>.

⁴¹⁹ [2000] 2 F.C.R 452. See also Chapter 4 of this thesis for discussion of this case at 135.

⁴²⁰ [2000] 53 B.M.L.R 66.

Patient: Sterilisation)⁴²² have in the past confirmed that sterilisation operations will not be authorised unless they are in the best interests of the individual and provided that no less restrictive means of achieving the same result are feasible.

A further incident which is worthy of discussion was reported in the Indian Journal of Medical Ethics in 1993. The incident in question took place in Mumbai and involved a group of individuals who went on hunger strike in order to protest the construction of a new dam. On the second day of the fasting, two protesters, Medha Patkar and Devram Kanera were arrested and taken to hospital. Despite continuous refusal, both Patkar and Kanera were fed intravenously and released two days later. However, both were subsequently rearrested nine days later when again, attempts were made to force feed both of them. Jesani and Pilgaokar highlighted in the article the fact that the medical profession remained completely silent about the treatment of the two protesters. This suggests that the medical profession saw very little that was wrong with the actions of the hospital staff in force feeding the two protesters. Jesani and Pilgaokar suggested the following reasons why there was little reaction:

- “1) Some of us may be ignorant of the ethical requirement that we must respect the autonomy of such patients as regards choice of therapy, especially when they are competent to exercise such a choice.**
- 2) Some may feel that once a person is legally ‘arrested’, her/his rights as a patient are restricted.**
- 3) Many might be unwilling to allow a person’s health to deteriorate when ‘simple therapy’ such as an infusion will restore fluid and electrolyte balance.**
- 4) There may be a feeling that when superiors ‘order’ subordinates to carry out actions that might contravene ethics, the onus shifts to the superiors”⁴²³**

Jesani and Pilgaokar regard the above reasons as being insufficient justification for force-feeding. They highlight the fact that the Tokyo Declaration (1975) of the World Medical Association states that:

“Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the

⁴²¹ [2000] 2 F.C.R 452.

⁴²² [1990] 2 A.C 1.

⁴²³ Jesani A & Pilgaokar A (1993) *Patient’s Autonomy: Throwing it to the Winds?* ; Indian Journal of Medical Ethics; Aug-Oct Vol.1(1). Accessed on 18/01/2006; available online at <http://www.issuesinmedicalethics.org/011mi006.html> .

consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.”⁴²⁴

Jesani and Pilgaokar also state that if the doctors in charge of the two protesters felt an ethical dilemma about force-feeding, the appropriate measure would have been to hand the case over to another doctor⁴²⁵.

The treatment of the two protesters in Mumbai can be compared with the manner in which force-feeding cases are dealt with in England. In *Secretary of State for the Home Department v Robb*⁴²⁶, an adult prisoner began refusing all forms of nutrition. Upon medical examination, it was confirmed that Robb was of sound mind and understood entirely that the refusal of nutrition and hydration would result in his death. The Home Office subsequently sought a declaration stating that all relevant prison and medical staff should abide by Robb’s decision to fast, provided that he retained the capacity to continue it. The declaration was duly granted, with the court stating that an adult with capacity had the right to refuse food and water and that this right should not be eroded simply by virtue of the fact that the individual was a prisoner. His Lordship rejected the judgement in the case of *Leigh v Gladstone*⁴²⁷, which provided authority for the premise that it was the duty of the prison to safeguard the welfare of prisoners, even if this included force-feeding. Lord Thorpe stated that the judgement of Lord Keith of Kinkel in *Airedale N.H.S Trust v Bland* was more relevant for modern times. In the *Bland* case, Lord Keith stated that the principle of the sanctity of life did not compel a doctor to treat a patient contrary to his/her wishes, irrespective of whether refusal would lead to death. It was ultimately this authority which prevailed in *Secretary of State for the Home Department v Robb*.

It is evident that the approach taken by the Mumbai police and the medical staff was in stark contrast to the approach taken in the English common law. Despite a complete lack of evidence to suggest that Medha Patkar and Devram Kanera were

⁴²⁴ Tokyo Declaration of the World Medical Association (1975) Article 5.

⁴²⁵ Supra note 110.

⁴²⁶ [1995] 2 W.L.R 722.

⁴²⁷ [1909] 26 T.L.R 139.

incapable of refusing food, this decision was not respected in any way. Indeed, the fact that the refusal of food was in protest to what Patkar and Kanera perceived to be a social injustice, suggest strongly that the attempts to force-feed them were made not in order to safeguard the welfare of the protesters, but rather as a form of social control in order to avoid a difficult political situation. Jesani and Pilgaokar submitted that one of the reasons why the medical profession were silent on the protester's treatment was that it was perhaps deemed acceptable for a patient's rights to be restricted once they had been arrested⁴²⁸. If this is true, then it is stark contrast to the approach now followed in England, as evidenced by the judgement in *Secretary of State for the Home Department v Robb*. However, it may be premature to suggest that this difference could be attributed to cultural difference between England and India. As stated above, Lord Thorpe in *Robb* highlighted the fact that Lord Alverstone in *Leigh v Gladstone* held that the duty of prison officials to preserve the health of prisoners could extend to force-feeding. *Leigh v Gladstone* provides an interesting comparison to the case of the Mumbai protesters, in as much as the former case also concerned a protester, a suffragette, who had been force-fed in prison. It was held that force-feeding was acceptable, since fasting technically constituted a suicide attempt which was illegal at that time. In India, attempts to commit suicide are still illegal under s.309 of the Indian Penal Code 1860. It is therefore apparent that the facts of *Leigh v Gladstone* bear some similarity with the Mumbai protesters case, albeit the former took place almost 100 years earlier, suggesting that the difference between England and India in this case are due to developmental, rather than cultural or ideological differences.

Commentary has also been given in a number of articles regarding end-of-life issues. Adhikary and Raviraj comment on the status of the Do Not Resuscitate order in India, and highlight the fact that such issues are not recognised in the law as yet:

“The Do Not Resuscitate order is still not documented legal practice in India. It is a verbal communication between the clinician and the patient's relative or caregiver. The autonomy of the patient also remains a weak concept. Even the right to live a dignified life or die a dignified death has not been

⁴²⁸ Jesani, A & Pilgaokar, A (1993) *Patient's Autonomy: Throwing it to the Winds?*; Indian Journal of Medical Ethics; Aug-Oct, Vol. 1(1). Accessed on 18/01/2006; available online at <http://www.issuesinmedicalethics.org/011mi006.html>.

extensively discussed. The law is silent or ambiguous on most issues related to end-of-life care.”⁴²⁹

Adhikary and Raviraj also highlight one important aspect of proxy decision-making which provides a useful contrast to the U.K position:

“When the patient is not in a position to give consent, the consent given or obtained in such circumstances is called proxy consent. Ideally the patient’s relative or caregiver gives proxy consent... Ideally, a person with the most accurate and intimate knowledge of the patient’s recent wishes and lifestyle should give proxy consent. He/she should have a maximum stake in the decision and should be responsible for the consequences... In developed countries people’s daily needs and medical care at the end of life are usually looked after by government agencies or insurance companies. This is not the case in India. Caregivers here may feel that the death of the person they care for will relieve them of a burden. This can lead to a conflict of interests arising from the treatment decision.”⁴³⁰

Adhikary and Raviraj’s commentary highlights the fact that there are no mechanisms in place to govern the issue of decision-making on behalf of the incapable adult. The authors state that a family member or carer may fulfil this role; this contrasts sharply with the position in U.K capacity law, in which it is the doctor who makes healthcare decisions for the incapable adult, with the views of family members and carers being only providing information for the doctor when making a best interests or benefit determination⁴³¹. The fact that the authors state that the proxy should “ideally” be one who has intimate knowledge of the individual shows further that there is no concrete guidance on the issue in either statute or common law. If such guidance did exist, Adhikary and Raviraj would have been able to definitively state what the position was as opposed to what an ideal scenario would be. In addition to this, commentary on end-of-life issues in India suggests that it will be sometime before the right of the individual to have life-sustaining treatment terminated is fully acknowledged:

“There are several impediments to end-of-life practices in India: the approach of the physician is generally paternalistic, as the concept of patient

⁴²⁹ Adhikary, S D and Raviraj, R (2006) *Do Not Resuscitate orders*; Indian Journal of Medical Ethics; Vol. 3(3), 100-101 at 100.

⁴³⁰ Ibid at 101.

⁴³¹ See Mental Capacity Act 2005, s. 4(7) and Adults with Incapacity (Scotland) Act 2000, s.1(4).

autonomy is weak in the prevailing cultural ethos... Self-determination of patients relating to medical decisions is not well articulated in our Constitution...⁴³²

The above statement by Mani et al suggests that culture is of relevance in the context of end-of-life issues. Reference is made to the paternalistic attitude of the physician. This attitude would ostensibly manifest itself via the physician's refusal to terminate life-prolonging treatment. Rastogi highlights this in the context of how his dying mother was treated in an Indian hospital: **"The attending physician said that he was obliged to keep her alive with machines even if this was against the family's wishes..."**⁴³³ Rastogi's comment identifies a strongly paternalistic approach to medical treatment, which manifests itself through a desire to preserve life as far as is practicable. Although cultural attitudes may play a part in this approach, Jindal opines that the central problem is the lack of clear protocol for doctors to act upon, and that until such protocol is introduced, doctors are in essence bound to follow local cultural medical practices⁴³⁴. Furthermore, Indian law currently makes no provision for ways in which the individual can take control of what happens in the event of incapacity, such as advance statements or welfare powers of attorney. This means that there is realistically little that the patient can do to have their wishes and feelings heard, and thus have their autonomy respected. However, it is not beyond possibility that this situation may change. Although the law has yet to recognise the issues relating to treatment for incapable adults, journal articles have been published highlighting the practices of western medicine and how these should influence Indian guidance on the issue. Jagannadha Rao highlights the importance of *Airedale NHS Trust v Bland* upon end-of-life issues. Mamdani for example discusses the possible implications of the American cases of Karen Quinlan, Nancy Cruzan and Terry Schiavo, all of which concerned the termination of life-support for patients in a persistent vegetative state. Mamdani concludes by emphasising the importance of designating a health-care proxy and the need to respect the wishes of the patient: **"When called upon to act as proxies, we must remember that it is the patient's likely choice that we have to**

⁴³² Mani, R K et al (2005) *Limiting Life-Prolonging Interventions and Providing Palliative Care Towards the End-of-life in Indian Intensive Care Units*; Indian Journal of Critical Care Medicine; Vol. 9(2), 96-107 at 97.

⁴³³ Rastogi, A K (2005) *End-of-life- Issues Neglected in India*; Indian Journal of Medical Ethics; July-Sept 2005(3), accessed on 9/01/2008; available online at <http://www.ijme.in/133di03.html>.

⁴³⁴ Jindal, S K (2005) *Issues in the Care of the Dying*; Indian Journal of Medical Ethics; July-September 2005(3); accessed on 9/01/2008; available online at <http://www.ijme.in/133di01.html>.

express, not our own wishes.”⁴³⁵ One could argue that advance decision-making on end-of-life issues may not be utilised even if provided for in Indian law. Deshpande, writing about the attitude of Hindus living in the United States of America towards end-of-life care, writes the following:

“...there have been no published reports concerning the use of specific life-sustaining or life-prolonging procedures in Hindu patients, and these issues are not covered in the scriptures. However, there have been a few small population-based studies examining the beliefs and use of advance directives and hospice care in Asian-Indian Hindu immigrants. These studies found that only approximately 9% of Hindus have advance directives, well below the national average of 15% to 20%. A familial decision-making tradition or strong beliefs in the importance of religion and rituals were negatively correlated with having an advance directive.”⁴³⁶

Deshpande’s commentary highlights the potential importance of the principle of communitarianism in relation to advance decision-making, and suggests that the importance placed upon communal decision-making within Hindu families may negate the need for an advance directive; after all, the individual has a family to make decisions. It cannot of course be assumed that a strong belief in communal decision-making and religious ritual will always equate to a lesser emphasis on advance directives; it is possible for example that an individual may not have strong ties to their families and in such a case, collaborative decision-making with family may not be of such importance. However, the individual may nevertheless place great importance upon religion and ritual, and may therefore want to express these wishes through advance directives. India currently has no legal recognition of advance directives, and it is submitted that whether they are used or not, mechanisms must be in place to allow the individual the option of taking control over medical decisions for a time when they may no longer have the capacity to do so. If it is necessary for decisions to be made on behalf of an incapable adult, India’s healthcare system has no protocol in place to govern who is permitted to make such decisions and who is not; all that has been ascertained from literature on the subject is that there is nothing to

⁴³⁵ Mamdani, B (2005) *The Terry Schiavo Case: Possible Implications for India*; Indian Journal of Medical Ethics; July-September 2005(3); accessed on 9/01/2008; available online at <http://www.ijme.in/133ss01.html>.

⁴³⁶ Deshpande, O (2005) *Attitudes of Asian-Indian Hindus Toward End-of-Life Care*; Journal of the American Geriatric Society; Vol. 53, 131-135 at 133.

stop family members from taking decisions on behalf of an incapable adult. However, even this has not been specified in law, which ultimately means that there is no consistency in approach. Whereas Adhikary and Raviraj refer to the family as decision-makers, Rastogi's experience involving his mother suggested that the wishes of the family were subordinate to the doctor's duty to keep patients alive whatever the cost. It is difficult to tell which the correct approach is. What this means, in the context of the best interests of the individual, is that there are no real safeguards in place to ensure that those who are making decisions on behalf of the incapable adult are considering the best interests of the patient, and also whether they are acting in accordance with their wishes and feelings.

Ultimately no system is perfect, but it is submitted that the best way to safeguard the best interests of the individual whilst considering their wishes, feelings, beliefs and values is to follow the route taken by the English and Scottish legislations, where the wishes and feelings of the individual must be considered by the healthcare professional wherever practicable, followed by the views of anybody named by the individual or those closely connected to them. However, the views of others must merely be considered by the healthcare professional making the decision; this is distinguishable from a scenario where others named or connected to the individual, such as family members, actually make the final decision as to what is in an individual's best interests, which is not permitted under U.K capacity law. In specifying the healthcare professional as the one who is permitted to make determinations on what is in the best interests or to the benefit of the individual, there is less chance of a decision being made for less than genuine motives. It should also be noted however, that in the context of a communitarian approach to decision-making, an individual choosing specifically to defer future treatment decisions to family members is no less of an autonomous decision than if the individual made the decision entirely by themselves. If evidence can be ascertained that part of an individual's value system includes deferring to or collaborating with family members for important decisions, this could be used as evidence of the past wishes, feelings, beliefs or values of the individual⁴³⁷. Therefore, if Indian capacity develops to the extent that the individual's right to take control of treatment decisions is recognised to

⁴³⁷ See Chapter 1 and 6 of this thesis. Also, see Mental Capacity Act 2005, s.4(6).

a greater extent, there is no reason why a communitarian approach to decision-making should not continue to be viable. The crux of the matter, it is submitted, is to increase awareness amongst health professionals that the wishes, feelings, beliefs and values of the individual need to be ascertained wherever practicable, and not simply assumed on the basis of local cultural practice or the word of others. The fact that articles have been published highlighting these issues using Western practices as a guide, suggests that there is a possibility of this awareness increasing in future.

CHAPTER 5: PROCEDURAL JUSTICE IN ENGLISH, SCOTTISH AND INDIAN CAPACITY LAW

5.1: PROCEDURAL JUSTICE UNDER THE MENTAL CAPACITY ACT 2005

As stated in Chapter 2 of this thesis, the primary purpose of procedural justice is to ensure, as far as is practicable, that the substantive principles which underpin the law are adhered to and protected. To this end, the Mental Capacity Act 2005 contains a set of procedural mechanisms which are designed to safeguard the interests of the incapable adult.

The starting point for any discussion on procedural justice begins with section 5 of the Mental Capacity Act 2005, which provides for a general authority to treat. The section relates to acts which are carried out in connection with care or treatment and reads as follows:

- “(1) If a person (D) does an act in connection with the care or treatment of another person (P), the act is done to which this section applies if –**
- (a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and**
 - (b) when doing the act, D reasonable believes –**
 - (i) that P lacks capacity in relation to the matter, and**
 - (ii) that it will be in P’s best interests for the act to be done.**
- (2) D does not incur any liability in relation to the act that he would not have incurred if P –**
- (a) had had the capacity to consent in relation to the matter, and**
 - (b) had consented to D’s doing the act.”**

The Mental Capacity Act Code of Practice 2007 states that the purpose of section 5 is to protect family and carers from liability for actions which may otherwise be classed as civil wrongs or crimes. In allowing this, **“the Act allows necessary caring acts or treatment to take place as if a person who lacks capacity to consent had consented to them.”**⁴³⁸ Peter Bartlett commends the decision to include a general authority to treat within the legislation, stating that it has considerable advantages: **“It**

⁴³⁸ Mental Capacity Act Code of Practice 2007 at Para 6.2.

is designed to apply to all and only those decisions the client is unable to make himself or herself, thus addressing the issue of least restrictive alternative and the consequent variations in difficulty and category of decision.”⁴³⁹ However, Phil Fennell highlights the fact that under the pro-autonomy ethos of the legislation, the general authority to treat can be overridden when the proposed treatment is contrary to a valid anticipatory refusal, a refusal of consent by a person with the authority to do so, or prohibition via judicial forum⁴⁴⁰. Consequently there are a number of mechanisms in place to allow the individual to control what may happen to them in the event of the onset of incapacity. This is integral to the pro-autonomy ethos of the legislation inasmuch as the mechanisms which are in place allow the wishes and choices of the individual to be prioritised and carried out even when he/she is no longer capable of making decisions.

Under sections 24 to 26, the Mental Capacity Act 2005 allows an individual to refuse in advance specified medical treatment for a time in the future when they may no longer have the capacity to make a treatment decision⁴⁴¹. The terms of the Mental Capacity Act 2005 only permits treatment to be refused in advance; the Act cannot be used to insist upon a specific form of treatment that the individual feels is in their best interests⁴⁴². If the advance refusal of treatment is valid, it will have the same effect as a decision made by a person with capacity⁴⁴³. Under the terms of the Act, an advance decision to refuse life-sustaining treatment will be applicable only if it is in writing and is signed by the individual or by someone else in the presence of the individual at his/her behest⁴⁴⁴. In keeping with the pro-autonomy ethos of the Act, an advance refusal can be withdrawn or altered at any time by the individual provided that he/she has the capacity to do so, and this need not be in writing.⁴⁴⁵ It will no longer be valid under the following circumstances: If the individual has withdrawn the decision when he/she was capable; if the individual has created a lasting power of attorney subsequent to making the advance refusal and conferred authority upon the donee to

⁴³⁹ Bartlett, P (1997) *The Consequences of Incapacity*; 4 Web JCLI; accessed online on 19/03/2005; available at <http://webjcli.ncl.ac.uk/1997/issue4/bartle4.html>.

⁴⁴⁰ Fennell, P (1994) *Statutory Authority to Treat, Relatives and Treatment Proxies*; Medical Law Review; Vol. 2, 30-56 at 45.

⁴⁴¹ Mental Capacity Act 2005 s. 24(1).

⁴⁴² See *R (On the Application of Burke) v General Medical Council* [2005] E.W.C.A Civ 1003.

⁴⁴³ *Ibid* at s.26(1).

⁴⁴⁴ *Ibid* at s.25(6).

⁴⁴⁵ *Ibid* at s.24(4-5).

give or refuse consent to the treatment specified in the advance statement; or if the individual has done anything else which is clearly inconsistent with the advance decision remaining his fixed decision.⁴⁴⁶ An advance refusal will not be applicable if: the treatment in question is not the treatment which is specified in the refusal; the circumstances specified in the advance decision are absent; or if there are reasonable grounds for believing that circumstances exist which the individual had not anticipated at the time of making the advance decision and which would have affected the decision had they been anticipated⁴⁴⁷.

In terms of the essential principles which underpin the procedural mechanisms contained in the Act, advance decisions to refuse treatment are entirely in keeping with the principle of participation. It will be recalled that this principle requires that the individual should be able to participate in any proceedings relating to them as far as is practicable. In this case, advance decisions in essence enable the individual to participate in all areas relating to specific medical treatment even when the individual no longer has the capacity to make such decisions directly. In this way, the procedural principle of participation is being utilised to promote the substantive principle of autonomy, by ensuring that even when capacity is no longer present, the wishes of the individual are paramount above those of the family or carer. The need to specify the details of any treatment to be refused also helps to satisfy the procedural principle of accuracy. If the exact terms of the individual's refusal of treatment is specified precisely, there is no chance of the wishes and feelings of the individual being misunderstood and not being adhered to accurately.

As an alternative to making an advance decision to refuse treatment, the individual may also ensure control over future events by making a Lasting Power of Attorney (L.P.A). L.P.As may be set up in order to oversee issues relating to health and personal welfare or property and affairs⁴⁴⁸. All L.P.As must be registered with the Public Guardian who is responsible for making sure that they comply fully with the provisions of the Mental Capacity Act 2005⁴⁴⁹. The attorney must carry out their

⁴⁴⁶ Ibid at s. 25(2).

⁴⁴⁷ Ibid at s.25 (4).

⁴⁴⁸ Mental Capacity Act 2005, s.9(1).

⁴⁴⁹ Mental Capacity Act Code of Practice 2007 at Para 7.14. See also Para. 7.58- 7.68 which provides details of the duties which the attorney has towards the donor.

duties whilst always following the statutory principles contained in s.1 of the Mental Capacity Act 2005. In keeping with the pro-autonomy ethos, the individual may select anybody they wish to act as a donee for the L.P.A, but must name a specific individual rather than a job title⁴⁵⁰. Under s.10(4) of the Mental Capacity Act 2005, two or more attorneys may be appointed and the donor may decide whether they should act jointly or independently of each other. The scope of the attorney's powers is ultimately at the discretion of the donor. As the Code of Practice explains, **“the standard form for personal welfare L.P.As allows attorneys to make decisions about anything that relates to the donor's personal welfare. But donors can add restrictions or conditions to areas where they would not wish the attorney to have power to act.”**⁴⁵¹ The attorney must be sure that the donor does in fact lack the capacity to make relevant decisions, and only then will the L.P.A be valid and the attorney permitted to discharge his/her duties⁴⁵². In addition, an L.P.A will never override an advance decision unless the L.P.A has been made last⁴⁵³, nor can the attorney make any decision relating to life-saving treatment unless the donor has specifically authorised this in the L.P.A document⁴⁵⁴.

The provisions relating to Lasting Powers of Attorney are entirely in keeping with the theme of empowerment and autonomy which is prevalent throughout the Mental Capacity Act 2005. The ultimate objective of the attorney is to act as an agent for the donor, and as a result, the donor is entitled to specify precisely which areas the attorney is and is not permitted to make decisions upon. Whilst providing the donor with full autonomy, the provisions contained in the Act also take into account fully the need to safeguard the best interests of the individual against any potentially conflicting interests, which is why the attorney is not permitted to make any decisions on life-saving treatment without express permission from the donor. As with the provisions relating to advance refusal of treatment, the provisions relating to L.P.As also endorse the principle of participation by virtue of the fact that the individual is provided with the opportunity to have all his/her wishes and feelings adhered to through the construction of the L.P.A document. In addition, the principle of accuracy

⁴⁵⁰ Ibid at Para 7.10.

⁴⁵¹ Ibid at Para 7.22.

⁴⁵² Mental Capacity Act 2005, s. 11(7)(a).

⁴⁵³ Ibid at s.11(7)(b).

⁴⁵⁴ Ibid at s.11(7)(c).

would also be satisfied because, as with advance refusals of treatment, the individual must specify in great detail precisely what the attorney is entitled to do or not do on behalf of the individual. If this is done correctly, there is little chance of the wishes of the individual being incorrectly carried out.

Despite the existence of provisions to create an advance refusal of treatment and a Lasting Power of Attorney, disputes may still arise concerning issues dealt with by the Mental Capacity Act 2005. In such cases, it may be necessary to apply to the Court of Protection.

The Court of Protection in its pre-2005 Act form was established under s.94(2) of the Mental Health Act 1983. This incarnation was not a court as such, but an administrative body which dealt with matters of property and finance on behalf of incapable adults. This incarnation of the Court of Protection has now been abolished under the Mental Capacity Act 2005⁴⁵⁵. In accordance with s.47(1) of the Mental Capacity Act 2005, the new Court of Protection has the same powers, right, privileges and authority as the High Court, which retains its inherent jurisdiction to make declarations on issues of medical treatment when there is a serious justiciable issue⁴⁵⁶. The Court of Protection thus also has the power to make declarations on specific issues including the capacity of an individual and the lawfulness of any act done in furtherance of the individual's best interests⁴⁵⁷. Gunn makes the point that the power of the Court of Protection to make declarations on an individual's capacity achieves compliance with Article 6 of the European Convention on Human Rights⁴⁵⁸. In addition, issues involving serious healthcare and treatment decisions must be brought before the Court of Protection without exception. Such decisions will predominantly relate to: the proposed withholding of artificial nutrition and hydration from patients in a permanent vegetative state⁴⁵⁹; organ or bone marrow donation⁴⁶⁰; non-therapeutic

⁴⁵⁵ see: Lush, D (2005) *The Mental Capacity Act 2005 and the New Court of Protection*; Journal of Mental Health Law; May 2005 31-40 at 35; Leason, B (23/07/2004) *Worth Waiting For*; New Law Journal Vol. 7138(1122); Ashton, G (2006) *Mental Capacity: The New Law*; Legal Executive; Vol. April 14-16 at 15; Ward, O (2005) *The Mental Capacity Act 2005 (England and Wales) – A New Legal Framework for Decision-Making*; Northern Ireland Legal Quarterly; Vol. 56(2) 275-279 at 278.

⁴⁵⁶ *Re F (Adult: Court's Jurisdiction)* [2001] Fam 38.

⁴⁵⁷ Mental Capacity Act 2005, s.15. See also Mental Capacity Act Code of Practice 2007 at Para 8.17.

⁴⁵⁸ Gunn, M.J (2005) *Decision-Making Capacity and the Mental Capacity Act 2005: Some Difficult Issues and Some Possible Means of Resolution*; Unpublished.

⁴⁵⁹ See *Airedale NHS Trust v Bland* [1993] AC 789.

⁴⁶⁰ See *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1996] 2 F.L.R 787.

sterilisation of an incapable adult⁴⁶¹ and any other cases where there is dispute about whether a particular course of treatment is in the individual's best interests⁴⁶². This mirrors the position on declarations prior to the Mental Capacity Act 2005. The 2006 Practice Note by the Official Solicitor on declaratory proceedings states that court applications must be made wherever the proposed treatment relates to: withdrawal of artificial nutrition and hydration for patients in permanent vegetative state; the sterilisation for contraceptive purposes of a person who cannot consent; and certain termination of pregnancy cases⁴⁶³.

Whenever the central issue before the court is serious medical treatment, the body responsible for the treatment i.e. the N.H.S, must instruct an Independent Mental Capacity Advocate (I.M.C.A) to support and represent the individual provided that there is no-one else available to fulfil this role. According to rule 4 of the I.M.C.A Rules 2006, an I.M.C.A must be appointed where the treatment in question: involves a fine balance between benefits and risks to the patient; a fine balance as to which from an available choice is to be used or where the proposed treatment would be likely to have serious consequences for the patient. Section 36 of the 2005 Act details the functions of an I.M.C.A, who will be expected to fulfil the following duties:

- provide support to the incapable adult in order that he/she may be able to fully participate in the decision-making process as much as is practicable;
- obtain and evaluate all relevant information;
- ascertain what the individual's wishes, beliefs and values would be likely to be, and how these might influence a decision;
- ascertain any alternative courses of action available to the individual;
- obtain further medical opinion where treatment is proposed and the advocate believes that one should be obtained.

As the name suggests, Independent Mental Capacity Advocates are entirely independent, and are available for appointment when there is no other representative

⁴⁶¹ See *Re A (Medical Treatment: Male Sterilisation)* [2000] 53 B.M.L.R 66.

⁴⁶² Mental Capacity Act Code of Practice 2007 at Para 8.18.

⁴⁶³ *Practice Note; Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults Who Lack Capacity* [2006] 2 F.L.R 373 at Para 5.

available for consultation⁴⁶⁴. Their presence in theory satisfies a number of important principles both substantive and procedural. First, the fact that I.M.C.As are an available option to help the individual participate in the decision-making process in the absence of any other representative is essential to upholding the principle of autonomy. In addition, the principle of non-discrimination would be satisfied as I.M.C.As would ensure that the individual would be able to have his/her interests taken care of in the same way that a capable adult would. In terms of procedural principles, I.M.C.As would help to satisfy the principles of participation in as much as the individual would be provided with impartial help in communicating their needs, and would thus be able to directly participate in any dispute resolution.

Whenever possible, the Court of Protection is expected to resolve disputes on its own. In the event that this is difficult however, further safeguards have been put in place to ensure that the best interests of the individual are safeguarded at all times. Under s.16 of the Mental Capacity Act 2005, a deputy may be appointed to help the incapable adult make decisions on personal welfare or property matters. Section 17 details the powers of the deputy in relation to personal welfare; these powers include giving or refusing consent to the carrying out or continuation of treatment by a healthcare provider and giving directions that a particular person responsible for the individual's healthcare should be replaced⁴⁶⁵. The Court of Protection has the power to appoint a deputy if there is the need for an ongoing process of decision-making powers and a Lasting Power of Attorney has not been set up. An additional safeguard for the supervision of deputies comes in the form of the Public Guardian, which derives the power to supervise deputies from s.57 of the Mental Capacity Act 2005. Given that it is the Court of Protection, rather than the incapable adult who selects the deputy, the presence of the Public Guardian is extremely important to ensure that the deputy appointed is appropriate and that they do not misuse their position⁴⁶⁶. Dhanda criticises the manner in which deputies are subject to supervision, stating that rather than foster an ethos of trust, the Mental Capacity Act 2005 **“legislates for conflict**

⁴⁶⁴ Mental Capacity Act Code of Practice 2007 at Para 10.0.

⁴⁶⁵ Ibid at s.17(1)(d-e).

⁴⁶⁶ Mental Capacity Act Code of Practice 2007 at Para 14.15.

and suspicion.”⁴⁶⁷ It is submitted however, that this is not the case. The fact remains that incapable adults are potentially vulnerable and need to be safeguarded as well as empowered. As stated above, deputies, when necessary, are appointed by the Court of Protection and the incapable adult has no say in who is appointed to this position. It is therefore essential that court-appointed deputies are adequately supervised as they lack the endorsement of the incapable adult themselves. According to the Code of Practice, deputies will only be necessary in extremely difficult cases where the court’s authority is essential and there is no other way of resolving a particular issue in relation to the individual’s best interests⁴⁶⁸. Section 20 of the Act highlights some restrictions on the powers of a deputy. The most important of these is to be found in s.20(1): **“A deputy does not have power to make a decision on behalf of P [the incapable adult] in relation to a matter if he knows or has reasonable grounds for believing that P has capacity in relation to the matter.”** This is perhaps an obvious inclusion given the continuous emphasis that has been placed upon the autonomy of the individual being paramount, but it is nevertheless important that it has been mentioned in relation to the powers of a deputy. It must be made clear that the appointment of a deputy does not mean that the capacity of an individual should not be assessed regularly in order to ascertain whether his/her capacity has returned, since in the event of this, the individual would no longer require any formal help in making decisions. In essence, s.20(1) is a restatement of the functional approach to capacity which had been endorsed and applied from the early stages of the Act’s consultation process.

In order to apply to the Court of Protection, permission must first be sought. However, s.50(1) of the Mental Capacity Act and rule 51 of the Court of Protection Rules 2007 provide a list of persons who do not require permission to apply to the Court. These are: the person who lacks or is alleged to lack capacity; anybody with parental responsibility for the individual should he/she be under the age of 18; the donor or donee of a Lasting Power of Attorney to which the application relates; a person named in an existing order of the court, if the application relates to the order;

⁴⁶⁷ Dhanda, A (2007) *Support Capacity instead of Managing Incapacity: A Critique of the Mental Capacity Act 2005*; article sent as part of personal correspondence.

⁴⁶⁸ Code of Practice 2007 at Para 8.38. see Para 8.39 for examples of this, which include when someone needs to make a series of linked welfare decisions over time and it would not be beneficial or appropriate to require all of those decisions to be made by the court.

the Official Solicitor and the Public Guardian⁴⁶⁹. This means that any other persons who have an interest in the individual will require permission to apply, i.e. family members who are not attorneys or named in an existing order of the court, but who still have an active interest in the welfare of the individual. The purpose of the permission requirement is ultimately to safeguard the welfare and best interests of the individual. According to the Code of Practice, the Court of Protection must consider the following criteria when deciding whether to give permission for an application: **“The applicant’s connection to the person the application is about; the reasons for the application; whether a proposed order or direction of the court will benefit the person the application is about, and whether it is possible to get that benefit another way.”**⁴⁷⁰ This protects the individual against any other party who may wish to promote their own interests rather than the best interests of the individual.

Section 50 of the Mental Capacity Act 2005 plays an important role in upholding the ethos of the Mental Capacity Act. It is essential to a pro-autonomy, non-discriminatory approach that the incapable adult does not require permission to apply to the court, because having in place a complicated applications process is likely to discourage individuals from seeking help from the Court of Protection, which would entirely defeat the purpose of the Court. In addition, encouraging the incapable adult to apply to the Court by making the process easier is likely to better satisfy the principle of participation, which stipulates that the individual must have the opportunity to be present and participate in any proceedings relating to them. This is less likely to happen if the individual is required to jump through a number of procedural hoops. Furthermore, allowing the incapable individual to apply to the Court of Protection without permission will help to satisfy the provisions of Principle 13 of the Council of Europe’s Recommendation (99)4, which highlights the right of the individual to be heard in person. If it is not practical for the incapable adult to make an application to the Court of Protection, s.50(1) allows for persons representing the individual, such as parents or guardians and Lasting Powers of Attorney. This is

⁴⁶⁹ See also Practice Direction 8A relating to permission to apply to the Court of Protection.; available online at <http://www.publicguardian.gov.uk/forms/practice-directions.htm>.

⁴⁷⁰ Mental Capacity Act 2005, s.50(3). See also Mental Capacity Act Code of Practice 2007 at Para 8.12.

also important as it represents a pragmatic approach; the incapable adult may be entirely unable to make applications to the Court of Protection, in which case it is correct that their interests should be represented by a third party for whom the applications process should be as straight-forward as it would have been for the incapable adult themselves. The provisions of s.50 should also ensure compliance with Article 6 of the European Convention on Human Rights, which states that everyone is entitled to a fair and public hearing within a reasonable amount of time. The chances of this happening increase if the individual is able to apply to the Court of Protection without first having to ask permission.

The new Court of Protection is a superior court of record and is able to establish judicial precedent⁴⁷¹. However, it is intended to be accessed as an option of last resort. The Department of Constitutional Affairs stated that any application made to the Court of Protection should be resolved as smoothly and as expeditiously as possible⁴⁷². In order to achieve this, the Draft Court of Protection Rules 2006 made extensive reference to pre-action protocols, which were designed to specify the action that must be taken prior to the making of an application to the Court of Protection. In addition, it had been envisaged that the presence of pre-action protocols would encourage co-operation between the parties and promote an early exchange of information that would ideally resolve any disputes without having to apply to the Court of Protection⁴⁷³. Despite a positive response during the consultation process⁴⁷⁴, the final Court of Protection Rules 2007 contain no reference to pre-action protocols. This is a surprising omission. It is submitted that the presence of pre-action protocols would have greatly helped the provisions relating to the Court of Protection to satisfy the principle of conciliation, which requires any proceedings to be less adversarial when the parties involved do not necessarily have competing interests⁴⁷⁵. Including pre-action protocols in the final Court of Protection Rules would have helped to emphasise dispute resolution through compromise and ensuring that all parties, including the incapable adult, were given opportunity to have opinions and feelings

⁴⁷¹ Mental Capacity Act Code of Practice 2007 at Para 8.1.

⁴⁷² Department of Constitutional Affairs (17/07/2006) *Draft Court Rules: Mental Capacity Act 2005 Court of Protection Rules Consultation Paper* at Para 4.2.

⁴⁷³ Draft Court of Protection Rules 2006, Draft Rule 12.

⁴⁷⁴ Department of Constitutional Affairs (17/07/2006) *Draft Court Rules: Mental Capacity Act 2005 Court of Protection Rules – Response to Consultation* at 8.

⁴⁷⁵ See Chapter 2.2.3 of this thesis.

heard. It is submitted that encouraging individuals to deal with issues in such a manner would also help to uphold the substantive principle of non-discrimination, inasmuch as the individuals who may find it difficult to go through the process of applying to the Court of Protection would not be made to feel uncomfortable or stigmatised because of the difficulties that may be faced in making an application to the Court of Protection. The Court of Protection emphasises that it is best for those in dispute to utilise less formal methods of dispute resolution, such as mediations, before applying to the Court of Protection⁴⁷⁶. Discouraging individuals from applying directly to the Court of Protection is a salient suggestion, since otherwise, there is a risk of the Court being over-burdened with applications. As well as the potential for increased costs, such a scenario carries with it the risk of challenge under Article 6 of the E.C.H.R on the grounds of the court being inaccessible within a reasonable time. Whether this happens currently remains to be seen given that the Mental Capacity Act has been in force for only fifteen months at the time of writing, but it is submitted that the decision to drop pre-action protocols from the Court of Protection Rules is confusing given the awareness shown during the consultation process of their potential benefits.

5.2: PROCEDURAL JUSTICE UNDER THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

As with the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 has in place a number of procedural mechanisms which are designed to safeguard the welfare of the incapable adult. In addition, mechanisms are in place which allow the incapable adult to control what may happen in relation to medical treatment once he/she is no longer capable of making such decision directly.

Section 47 of the 2000 Act provides a general authority to treat patients who are incapable of making a decision on the proposed treatment. It provides details on the procedure which must be followed by those responsible for the administration of medical treatment upon an incapable adult. Section 47(2) outlines this authority:

⁴⁷⁶ Mental Capacity Act Code of Practice 2007 at Para 15.7.

“Without prejudice to any authority conferred by any other enactment or rule of law, and subject to sections 49 and 50 and to the following provisions of this section, the medical practitioner primarily responsible for the medical treatment of the adult shall have, during the period specified in the certificate, authority to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult.”

Certain forms of treatment have been excluded from this general authority to treat. These are specified in Schedule 1 of the Specified Medical Treatment Regulations 2002 as being: neurosurgery for mental disorder; sterilisation where there is no serious malfunction or disease of the reproductive organs and surgical implantation of hormones for reducing sex drive. In order for these treatments to be carried out, permission will always be required from the Court of Session, a stipulation which is comparable to the position under the Mental Capacity Act 2005 where permission will be required from the Court of Protection for issues regarding any serious medical treatment⁴⁷⁷.

In order to ensure further that a finding of incapacity is genuine, a certificate of incapacity must be completed by the responsible medical practitioner. This duty is laid down in s.47(5) of the 2000 Act:

“A certificate for the purposes of subsection (1) shall be in the prescribed form and shall specify the period during which the authority conferred by subsection (2) shall subsist, being a period which –

- (a) the medical practitioner primarily responsible for the medical treatment of the adult considers appropriate to the condition or circumstances of the adult; but**
- (b) does not exceed one year from the date of the examination on which the certificate is based.**⁴⁷⁸”

⁴⁷⁷ Mental Capacity Act Code of Practice 2007 at Para 8.18.

⁴⁷⁸ With respect to this provision, the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Treatment Certificates) (Scotland) Regulations 2007 allow for a certificate to be made out for three years if the incapable adult suffers with severe or profound learning disability, but only if the condition is unlikely to improve.

When completing the certificate, any proposed treatment must adhere to the general principles of the Adults with Incapacity (Scotland) Act 2000. In addition, the relevant medical practitioner must be satisfied that the individual lacks capacity in relation to a decision regarding the treatment in question.⁴⁷⁹ This is clear endorsement of a functional approach to capacity, as evidenced by reference to the treatment in question, rather than ability to make treatment decisions in general. This mirrors the approach taken in the Mental Capacity Act 2005. Section 47 certificates are useful for ensuring that an assessment of capacity is made thoroughly. It also potentially removes any possible ambiguity over a decision made by a particular doctor. In addition, the presence of a specific time limit allows for the individual's capacity to be reassessed after a time, ensuring that their autonomy is not interfered with for any longer than is absolutely necessary. This also helps to uphold the procedural principle of accuracy by ensuring that an individual is not erroneously deprived of their fundamental right to decision-making when they have since regained the capacity to make treatment decisions themselves.

In the context of procedural justice, certificates issued under s.47(5) are important as they serve as concrete evidence that the doctors in charge are permitted to make treatment decisions on behalf of the individual. Formal proxy decision-making should only be triggered in the event of the individual's incapacity. Therefore, s.47(5) certificates are in keeping with Principle 12 of Recommendation (99)4 by the Council of Europe, which states that appropriate procedures must be in place to facilitate the investigation and assessment of the individual's personal faculties. This has been accounted for in s.47(5) via the stipulation that any certificate issued must be of a limited duration. This is order to ensure that an individual suffering from temporary incapacity is not subject to proxy decision-making any longer than is necessary. This is also in line with Principle 14 of Recommendation (99)4, which stipulates that all measures of protection must be of a limited duration and reviewed to take account of any change in circumstances.

Although incapacity certificates clearly have their advantages, they could also be considered impractical if overused. It is submitted that incapacity certificates are more

⁴⁷⁹ Adults with Incapacity (Scotland) Act 2000 Code of Practice for Part 5 at Para 2.17.

useful when dealing with borderline or fluctuating capacity cases. An individual may for instance lack capacity in a specific area of life which may be pertinent to a particular requirement for treatment. In such cases, a certificate detailing the exact nature of incapacity could be considered necessary. However, one could argue that a certificate would be surplus to requirements when an individual's incapacity is so pronounced as to be beyond doubt. The Code of Practice suggests that certificates may not be necessary when treatment is required for multiple ailments, but would almost certainly be needed when just a single course of treatment is required:

“It would be unreasonable and impractical to issue a certificate of incapacity for every healthcare intervention in some people... On the other hand, a single certificate of incapacity is entirely appropriate when a person requires a single procedure e.g. an operation. The Act specifies, under s.47(2), that ‘the medical practitioner primarily responsible for the medical treatment of the adult shall have... authority to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult’. This could cover not only the operation but also post-operative medical care and pain relief. It is therefore clear that the certificate of incapacity, as designed, will provide an effective and workable means for managing single healthcare interventions, but requires careful completion for a person who needs multiple interventions.”⁴⁸⁰

The Code of Practice makes a salient point regarding the practicalities of issuing certificates for multiple ailments. In such a case, it is possible that the certificate will become more complicated to fill in, which in turn could lead to mistakes being made, effectively voiding the certificate because of a failure to follow procedure correctly. One possible solution might be to allow the completion of one certificate for a condition such as dementia, which then permits the doctors to make interventions for any subsequent ailments relating to the main condition which the individual is not capable of making decisions over. In the case of dementia for example, the certificate could be made to cover healthcare decisions relating to feeding if the individual is no longer able to do this themselves. This in itself is not an ideal solution, since in the case of an individual who has a large number of problems, complications may still

⁴⁸⁰ Ibid at Para 2.18.

arise over whether a particular issue is directly attributable to the main condition. However, if one wishes to formalise the need for proxy-decision making in such a manner, there may be no other solution that does not contain disadvantages. Completing a s.47 certificate is the way in which the general authority to treat may be accessed. However, under s.47(7), the general authority does not authorise the use of any force or detention unless absolutely necessary, nor does it authorise the admission to hospital for mental disorder against the will of the individual. In this way, s.47(7) upholds the principles of least restrictive alternative and autonomy. In keeping with the pro-autonomy ethos, the general authority to treat may be disapplied if the individual has a proxy-decision maker in place to aid in the decision-making process⁴⁸¹. In order that the individual may exercise control over welfare issues, including medical treatment, following the onset of incapacity, the 2000 Act allows for the creation of a Welfare Power of Attorney (W.P.A). The creation of a Welfare Power of Attorney is authorised under s.16 of the 2000 Act and may only be exercised once the granter has become incapable in relations to matters specified in the document⁴⁸². To ensure complete clarity, the Welfare Power of Attorney document must be in writing, signed by the granter and include a certificate by a solicitor or another member of a prescribed class which confirms that the granter has been interviewed prior to the document being signed and that he/she understands the nature and extent of it without having been unduly influenced⁴⁸³. As a further safeguard, the document must be registered with the Public Guardian under s.19 of the 2000 Act. The Code of Practice states that the attorney, once appointed, must apply the general principles contained in the 2000 Act i.e. ensure that all interventions benefit the individual utilising the least restrictive alternative whilst taking account of the wishes and feelings of the individual and relevant others. In addition to this, s.1(5) of the Adults with Incapacity (Scotland) Act 2000 states that any Welfare Power of Attorney must encourage the individual to exercise whatever skills might be present relating to relevant issues. This is a clear endorsement of the substantive principle of autonomy and the procedural principle of participation, which states that the individual must be able to participate in proceedings relating to him/herself as much as is practicable.

⁴⁸¹ Adults with Incapacity (Scotland) Act 2000, s.50(2).

⁴⁸² Ibid at s.16(5)(b). See also Code of Practice for Continuing and Welfare Powers of Attorney 2002 at Para 3.1.

⁴⁸³ Ibid at s.16(3)(b). See also Code of Practice for Continuing and Welfare Powers of Attorney 2002 at Para 3.4.

It is clear that the ability to create a welfare power of attorney is important in the context of the pro-autonomy ethos of the Act. The ability to create a Lasting Power of Attorney under the Mental Capacity Act 2005 is comparable to this mechanism. In the light of this, it worth mentioning briefly the position of the Act with regards to advance statements. The Draft Adults with Incapacity (Scotland) Bill 1995 had originally made provision for the inclusion of advance statements which would allow either consent or refusal of treatment in advance⁴⁸⁴ (this is in contrast to the position of advance statements in the Mental Capacity Act 2005, which relate only to advance refusals of treatment). Advance statements were deemed to be in keeping with respect for patient autonomy inasmuch as they would allow an incapable adult to have their wishes on treatment carried out in the same way as that of a capable patient.⁴⁸⁵ In the light of this, advance statements were ultimately excluded from the Adults with Incapacity (Scotland) Act 2000. No significant reason given for this at any time during the Parliamentary debate stages, although Patrick suggests that there was dispute over whether advance statements should be persuasive or legally binding⁴⁸⁶. Given that the 2000 Act makes clear an absolute obligation to consider the past and present wishes and feelings of the individual, this exclusion is baffling. What renders the scenario regarding advance statements yet more confusing is the fact that they would eventually gain statutory recognition in the Mental Health (Care and Treatment) Scotland Act 2003⁴⁸⁷. This suggests that the advance statements were excluded from the 2000 Act either by design or by mistake, although the former reason can effectively be discounted on the grounds that an intention to introduce advance statements into legislation at a later stage would more than likely have been expressed during the Parliamentary debates stage for the Mental Health (Care and Treatment) Scotland Act⁴⁸⁸. As a result, one can only conclude that the failure to include advance statements in the Adults with Incapacity (Scotland) Act 2000 represents a missed opportunity for legislators to further respect the wishes and

⁴⁸⁴ See Draft Adults with Incapacity (Scotland) Bill 1995 at Clause 40.

⁴⁸⁵ Scottish Law Commission Report No. 151 (1995) Report on Incapable Adults at Para 5.41.

⁴⁸⁶ Patrick, H (2000) *Reviewing Scottish Mental Health Law: Any Lessons for England and Wales?* Journal of Mental Health Law; December 2000; 147-156 at 155.

⁴⁸⁷ Mental Health (Care and Treatment) Scotland Act 2003, s.275-276.

⁴⁸⁸ Indeed, Scott Barrie stated during Stage 1 of the debates that an opportunity had been missed with regards to advance statements being included within the Adults with Incapacity (Scotland) Act 2000.

feelings of the individual. Given that this is one of the cornerstone criteria of the 2000 Act, the exclusion of advance statements from the legislation is hard to defend.

The powers of the Sheriff and the Sheriff court were set up via s.3 of the Adults with Incapacity (Scotland) Act 2000. The purpose of the Sheriff court is to hear applications relating to guardianship and intervention orders. The court also retains a supervisory role with regards to certain issues relating to adult incapacity. Sections 3(1) – (3) outline the powers of the Sheriff and read as follows:

“(1) In an application or any other proceedings under this Act, the Sheriff may make such consequential or ancillary order, provision or direction as he considers appropriate.

(2) Without prejudice to the generality of subsection (1) or to any other powers conferred by this Act, the Sheriff may –

a) make any order granted by him subject to such conditions and restrictions as appear to him to be appropriate;

b) order that any reports relating to the person who is the subject of the application or proceedings be lodged with the court or that the person be assessed or interviewed and that a report of such assessment or interview be lodged;

c) make such further inquiry or call for such further information as appears to him to be appropriate;

d) make such interim order as appears to him to be appropriate pending the disposal of the application or proceedings.

(3) On an application by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult, the Sheriff may give such directions to any person exercising –

a) functions conferred by this Act; or

b) functions of a like nature conferred by the law of any country.”

As can be seen, the powers of the Sheriff are relatively exhaustive. He/she has the authority to **“make any order or direction he/she considers necessary when**

considering an application or hearing other proceedings under the Adults with Incapacity Act.”⁴⁸⁹

In their 1991 Discussion Paper, the Scottish Law Commission discussed the issue of which decision-making body would be most appropriate for making decisions relating to mental incapacity. Part of the discussions involved the issue of whether a tribunal system should be utilised for this purpose. The Scottish Law Commission stated that a tribunal system had its advantages, in as much as tribunals themselves were informal and less adversarial than the more traditional court system. Furthermore:

“Informality in conducting proceedings and in the atmosphere and layout of the places where hearings take place is very important if people other than lawyers are to participate in the proceedings. Party litigants feel more at ease with tribunals and hearings than with courts. The surroundings and procedures ought not to be unwelcoming and unintelligible.”⁴⁹⁰

However, the Scottish Law Commission ultimately decided that the most appropriate body to handle issues of incapacity would be the Sheriff Court. The Commission stated that despite the undoubted advantages of the tribunal system, there were also flaws which could not be ignored:

“Tribunals however, have disadvantages. Using professionals as tribunal members could blur the distinction between professional assessments or opinions and judicial or quasi-judicial decision making. Moreover, members of one profession may dominate the others who lack the expertise to question their opinions or assessments. The volume of mental disability cases would make the job a part-time one. It may prove difficult to get and train suitable members.”⁴⁹¹

The Commission’s rejection of the tribunal system was interesting inasmuch as the system might be better suited characteristically to dealing with issues of capacity. First, a tribunal system, as stated above, is less adversarial and more informal in nature. This would theoretically be a more effective system for promoting the principle of conciliation, which requires proceedings to be conducted in a manner which promotes and emphasises compromise. This is better for the incapable

⁴⁸⁹ Patrick, H (2006) *Mental Health, Incapacity and the Law in Scotland*; Tottel Publishing West Sussex and Edinburgh at Para 24.19.

⁴⁹⁰ Scottish Law Commission Discussion Paper No. 94 (1991) at Para 6.5.

⁴⁹¹ *Ibid* at Para 6.6.

individual at the centre of proceedings, who may feel unduly pressured by formal proceedings in which the individual's condition will be focused on heavily. A tribunal system can be classified as being more inquisitorial and conciliatory, rather than adversarial. Rather than have each side arguing its case and then being cross-examined by the opposition, a tribunal system allows for the tribunal itself to question both parties in order to establish the relevant facts of the proceedings. This is considerably more appropriate for cases relating to capacity, as the notion of there being two opposing sides does not apply as such. Both sides are likely to be arguing for the same thing; the welfare of the incapable adult. The conflict more than likely will arise from disagreement as to how to promote the welfare of the individual.

Hilary Patrick highlights the fact that although a tribunal system places greater emphasis upon an inquisitorial process, the nature of procedural justice dictates the need for some elements of an adversarial system to be present⁴⁹². This is in order to ensure that a fair hearing takes place. A mental health tribunal system is utilised in Scotland under s.18 of the Mental Health (Care and Treatment)(Scotland) Act 2003, which does not deal with any issues of capacity, but is nonetheless useful as a point of comparison here. The rules for the Tribunal are provided for in the Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005. Rule 63(3) highlights the fact that the system still retains an adversarial flavour:

“The relevant persons shall be entitled to give evidence, to call witnesses, to question any witness and to address the Tribunal both on the evidence and generally on the subject matter of the case.”

As can be seen, this procedure is very much in keeping with a traditional adversarial system, where evidence is given and witnesses called. However, the Tribunal Rules also provide for more inquisitorial procedure in rule 63(5), so as to achieve an appropriate balance:

“Having considered the circumstances of the relevant persons and whether (and to what extent) they are represented, the Convener–
(a) may, in order to assist resolution of any disputed fact, put questions to the relevant persons and to witnesses or may allow another member of the Tribunal to put such questions; and

⁴⁹² Patrick, H (2006) *Mental Health, Incapacity and the Law in Scotland*; Tottel Publishing West Sussex and Edinburgh at Para 23.31.

(b) shall, to the extent the Convener considers it necessary for the just conduct of the hearing, explain any legal terms or expressions which are used.”

It is submitted that the Tribunal Rules illustrate further that the system could have been beneficial in relation to Scottish capacity law. As well as promoting the principle of conciliation, the fact that any relevant individuals should be questioned in order to assist the resolution process, means that if practicable, the incapable adult themselves would theoretically be given the opportunity to voice any wishes opinions or feelings, thus satisfying the procedural principle of participation. If evidence from all relevant individuals is heard within a tribunal system, this would also in theory help to satisfy the procedural principle of accuracy. As long as all relevant information is heard, and the best interests of the individual emphasised at all times, systemic accuracy is present, which in turn increases the likelihood of an accurate outcome being produced, which, in the context of capacity law, should always be that which safeguards the welfare of the individual.

Despite its perceived advantages, the tribunal system, as stated above, was rejected by the Scottish Law Commission on the grounds that its presence could blur the distinction between professional medical assessment and judicial decision-making. As well as this, the Commission stated that there were issues of accommodation for tribunal hearings:

“Accommodation for the hearings and the tribunal staff would also be a problem. The cost of having separate premises would seem unjustifiable so that the tribunal would have to share with another appropriate organisation.”⁴⁹³

Unsurprisingly, much of the procedure surrounding applications to the Sheriff court adhere, at least in theory, to the philosophical underpinnings of the Adults with Incapacity (Scotland) Act 2000. First, Adrian Ward highlights an important aspect of this:

⁴⁹³ Ibid

“In relation to any intervention under the Act the Sheriff is required to apply the general principles. These include the absolute obligation to take account of the adult’s present and past wishes and feelings so far as ascertainable by any means. In discharging the responsibility, the Sheriff may be assisted by a safeguarder or by someone else appointed specifically to convey the adult’s views... Where there is doubt about whether relevant views are ascertainable, or specialist skills may be required to ascertain them, the Sheriff’s powers under s.3(1) and (2) may be of assistance. By whomever the adult’s views are ascertained and conveyed, there must be a clear distinction between that function, on the one hand, and any other wider assistance to the court in seeking to arrive at an appropriate decision, on the other.”⁴⁹⁴

As can be seen, it is essential that the Sheriff adhere to the general principles of the 2000 Act at all times during hearings. Of particular importance is the requirement that the past and present wishes and feelings of the individual be given paramount importance. However, for some individuals, communication of those wishes and feelings may be problematic. In order to address this problem, s.3(4) of the 2000 Act allows the Sheriff to appoint a safeguarder:

“In an application or any other proceedings under this Act, the Sheriff –

- (a) shall consider whether it is necessary to appoint a person for the purpose of safeguarding the interests of the person who is the subject of the application or proceedings; and**
- (b) without prejudice to any existing power to appoint a person to represent the interests of the person who is the subject of the application or proceedings may, if he thinks fit, appoint a person to act for the purpose specified in paragraph (a).”**

As stated, the main function of a safeguarder is to oversee the interests of the individual. Part of this duty involves communicating the wishes, feelings and needs of the individual to the Sheriff, should he/she be incapable of doing these themselves. This process could be argued to be essential in promoting the autonomy of the individual, in as much as inability to communicate does not necessarily equate to inability to make a decision. Furthermore, the appointment of a safeguarder for the purposes of easier communication is in accordance with s.1(6) of the 2000 Act, in

⁴⁹⁴ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 5.8.

which it is stated that although inability to communicate decisions could be indicative of incapacity, this could be made good via either **“human or mechanical aid (whether of an interpretive nature or otherwise).”** The appointment of an individual for the purposes of conveying an individual’s views could certainly be construed as a communicative deficiency being made good via human aid.

Another important factor in the Sheriff Court procedures is the intimation, or notification of proceedings, to the individual from the Sheriff. Adrian Ward describes this aspect of procedure as **“central to the philosophy and principles of the Act...”**⁴⁹⁵ Put simply, the individual at the centre of proceedings and has the right to be kept up-to-date of all proceedings and progress regarding his/her case. Ward highlights the fact that there may on occasion be circumstances where such notification could be detrimental to the health of the individual. In such a case s.11(1) of the 2000 Act allows for the duty of intimation to be waived:

“Where, apart from this subsection, intimation of any application or other proceedings under this Act, or notification of any interlocutor relating to such application or other proceedings, would be given to an adult and the court considers that the intimation or notification would be likely to pose a serious risk to the health of the adult, the court may direct that such intimation or notification shall not be given.”

As stated above, intimation to the individual is an essential part of the proceedings of the Sheriff court. However, it is also essential to consider the welfare of the individual. As every case is potentially different, it is submitted that the government was wise to include provision for bypassing the intimations process should it be necessary. Rule 3.16.5 of the 2001 Rules provides further details of the procedure that the Sheriff must follow before the intimations process can be legally bypassed. It is not enough to convince the Sheriff to bypass the process. It will also be necessary to convince two independent medical practitioners that this is the most appropriate course of action. This is as it should be; it is submitted that dispensing with the intimations process is something which should be done only when absolutely necessary, and not simply out of convenience to any of the relevant parties. Indeed, Ward validly states that if an individual feels that an application made to the Sheriff

⁴⁹⁵ Ibid at Para 5.9.

court is unjust, it would be more beneficial for the individual to be kept informed of all proceedings in order that he/she might argue their case more effectively. However, the fact remains that the individual at the centre of proceedings is likely to be vulnerable to some extent, and it is therefore essential that their interests and welfare are safeguarded at all times. The inclusion of provisions which allow for dispensation of intimation in extreme circumstances contribute towards providing this protection by providing a pragmatic approach which considers the welfare of the individual and the potential impact of the intimations process upon this.

The right to appeal to the Sheriff court is also provided for under the Adults with Incapacity (Scotland) Act 2000. First, s.14 allows for appeal against any decision made as to the incapacity of an adult which is made by anybody other than the Sheriff. This is particularly important in the context of Article 6 of the European Convention on Human Rights, which guarantees the right to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Ward states that the right of the individual to make one's own personal welfare decisions is a fundamental civil right, and any imposition of a determination that one is in fact incapable of exercising this right without a fair hearing will be a breach of Article 6. The right to appeal against a finding of incapacity is therefore important in this respect.

With regards to an appeal against decisions relating to medical treatment, this is predominantly governed by s.52 of the 2000 Act (the only exception is for appeals under s.50 of the Act):

“Any decision taken for the purposes of this Part [5], other than a decision by a medical practitioner under section 50, as to the medical treatment of the adult may be appealed by any person having an interest in the personal welfare of the adult to the Sheriff and thence, with the leave of the court, to the Court of Session.”

When the appeal concerns a treatment decision, this must be made by a person who has an interest in the personal welfare of the individual. In such an appeal, it is quite possible for the person having the interest to appeal either against the provision or the non-provision of treatment. If for example, an appeal is lodged against the provision of artificial nutrition and hydration, and the appeal is successful, the end result will

ultimately be the death of the individual. This may well be the best course of action in some cases, however the fact remains that the potential outcome of such an appeal carries potential risks to the individual's health. For this reason, it is arguably essential that those wishing to lodge an appeal must not simply claim to have an interest, but must prove that they have an interest. This is comparable in some respects to the law of childcare in England, in particular the law dealing with wardship. According to family law, wardship proceedings can be started by any individual with sufficient interest, including the child him/herself⁴⁹⁶. Cretney, Masson and Bailey-Harris also highlight the fact that professional carers are also entitled to start wardship proceedings, although the application will be considered in a personal rather than professional capacity. Therefore, professionals normally do not start proceedings unless supported by their particular organisation⁴⁹⁷. The Code of Practice for Part 5 of the 2000 Act provides guidance on this point in relation to s.50 of the 2000 Act:

“The procedure applies only in cases where a proxy decision-maker has been appointed, but it gives rights not only to the proxy, but also in certain circumstances to ‘any person having an interest in the personal welfare of the adult’. Such a person may be a close relation of the adult, or a person who has lived with, or cared for or about them, over a significant period. The term does not extend to those whose interest is that of an onlooker, such as interested pressure groups, uninvolved neighbours, or those seeking to achieve objectives which are of wider import than the welfare of the particular adult. It should be noted that, while proxies can legitimately object to particular courses of medical treatment, they may not act unreasonably by, for example, refusing fundamental care procedures. Proxy decision-makers have a duty of care to the adult on whose behalf they act, and a duty to abide by the general principles set out in section 1 of the Act.”⁴⁹⁸

The above guidance shows that anybody wishing to appeal against a treatment decision must demonstrate that they have a significant interest in the welfare of the individual. This is comparable to the terms of s.50 of the Mental Capacity Act 2005, which stipulates that permission must be sought in order to make an application to the

⁴⁹⁶ see *Re T (A Minor) Wardship: Representation* [1994] Fam. 49.

⁴⁹⁷ Cretney S.M, Masson J.M and Bailey-Harris R (2003) *Principles of Family Law* 7th Ed; Sweet & Maxwell London at 625.

⁴⁹⁸ Adults with Incapacity (Scotland) Act 2000 Part 5 Code of Practice at Para 3.2.

Court of Protection unless that person falls under the exceptions listed in the Act⁴⁹⁹. In both cases, the overriding purpose is to protect the individual against those who do not have the welfare of the individual at heart.

Section 50 of the 2000 Act allows for appeal against a medical decision made by a medical practitioner in particular circumstances. Section 50(3) provides for one such circumstance:

“Where the medical practitioner primarily responsible for the medical treatment of the adult has consulted the guardian, welfare attorney or person authorised under the intervention order and there is no disagreement as to the medical treatment of the adult, any person having an interest in the personal welfare of the adult may appeal the decision as to the medical treatment to the Court of Session.”

As can be seen, section 50(3) ensures that any other persons having an interest, such as relatives, will be given an opportunity to get their voice heard with regards to any medical treatment decision. In this way, the Act does not simply confer all the power upon medical practitioners and the appointees that they select.

Section 50(6) also provides for appeal against a treatment decision and reads as follows:

“Where the nominated medical practitioner certifies that, in his opinion, having regard to all the circumstances and having consulted the guardian, welfare attorney or person authorised under the intervention order as the case may be and, if it is reasonable and practicable to do so, a person nominated by such guardian, welfare attorney or person authorised under the intervention order as the case may be, the proposed medical treatment should or, as the case may be, should not be given, the medical practitioner primarily responsible for the medical treatment of the adult, or any person having an interest in the personal welfare of the adult, may apply to the Court of Session for a determination as to whether the proposed treatment should be given or not.”

⁴⁹⁹ These are: the person who lacks or is alleged to lack capacity; anybody with parental responsibility for the individual should he/she be under the age of 18; the donor or donee of a Lasting Power of Attorney to which the application relates; a person named in an existing order of the court, if the application relates to the order; the Official Solicitor and the Public Guardian.

Adrian Ward states that ‘persons having an interest’ is also intended to include appointees⁵⁰⁰.

In addition to the Sheriff Court, the Court of Session acts as an additional safeguard. Under the 2000 Act, the Court of Session exists as an appellate jurisdiction, particularly in relation to issues of medical treatment. As stated above, appeals must first go through the Sheriff Principal, and then, subject to permission, may then be referred to the Sheriff Court. However, in the case of s.52 appeals, the Sheriff principal is not involved, and appeals go first to the Sheriff and then to the Court of Session subject to permission. The process varies further with regards to s.50 appeals, which go directly to the Court of Session, presumably due to the Court’s expertise in dealing with medical issues. Furthermore, certain treatments always require the permission of the Court of Session. These are specified in Schedule 1 of the Specified Medical Treatments Regulations 2002 as being: neurosurgery for mental disorder; sterilisation where there is no serious malfunction or disease of the reproductive organs; and surgical implantation of hormones for the purpose of reducing sex drive⁵⁰¹. It is imperative that the Court of Session adhere to the principles of the Act at all times when hearing cases relating to special medical treatments, as stated regulation 3 of the Specified Treatments Regulations:

“(1) Subject to regulations 5 and 6 below, a treatment of a kind set out in Part 1 of Schedule 1 to these Regulations may be carried out in relation to an adult who is incapable in relation to a decision about that treatment if –

(a) the Court of Session is satisfied, on application to it by the medical practitioner primarily responsible for the medical treatment, that the treatment will safeguard or promote the physical or mental health of the adult and that the adult does not oppose the treatment; and

(b) the adult does not resist the carrying out of the treatment

(2) The Court of Session shall, in considering such an application afford an opportunity to any person having an interest in the personal welfare of the adult to make representations in respect of it.”

⁵⁰⁰ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 14.61.

⁵⁰¹ Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (SSI 2002/275).

In addition, the Court of Session has the power to appoint a safeguarder for the purpose of protecting the interests of the individual who is the subject of appeal⁵⁰².

It can be seen that the Adults with Incapacity (Scotland) Act 2000 contains an exhaustive amount of procedure, all of which are designed to ensure that the welfare of the individual is given the highest priority. Opportunity is also given for the individual to exercise control over decisions relating to medical treatment and welfare decisions in general through the creation of a Welfare Power of Attorney document. Given the effort that has clearly been placed in creating an effective system of procedural justice, this is certainly to be commended. However, it could also be argued that the Act places too much emphasis upon procedure. Following on from this, there is a risk that the complexity of the procedural mechanisms in place may deter individuals from accessing these mechanisms. Hilary Patrick states for example that although a large number of people are creating powers of attorney, the figures are still comparatively low in comparison to the estimated number of people in Scotland with some form of incapacity⁵⁰³. Patrick argues for a more simplified approach to procedure under the 2000 Act and this is a salient point⁵⁰⁴. In addition, it is submitted that in some areas, the Act does not go far enough to adhere to its own general principles. This is most evident by the fact that advance statements have not been provided for in the Act, despite evidence that shows they are an effective way of ascertaining the wishes and feelings of an individual; a cornerstone principle of the legislation. It is therefore submitted that the procedural mechanisms of the 2000 Act are worthy in intention, but nevertheless deficient in some key areas.

⁵⁰² Adults with Incapacity (Scotland) Act 2000 s.5.

⁵⁰³ see the Mental Welfare Commission for Scotland Report (2004) *Authorising Significant Interventions for adults who lack capacity* at 31. Here, Patrick explains that over 30,000 powers of attorney have been registered since 2001. However, this is in comparison to the estimated 100,000 adults with incapacity in Scotland.

⁵⁰⁴ *Ibid* at 32.

5.3: PROCEDURAL JUSTICE IN INDIAN LAW AND ITS POSSIBLE APPLICATION TO CAPACITY ISSUES

In the light of the fact that Indian capacity law is still in its embryonic stages, it is unsurprising that recognition of the importance of procedural justice in the same context is practically non-existent. However, procedural mechanisms do exist which could theoretically be used to resolve matters of capacity. The most relevant of these is the power to seek declaratory relief. The scope of declaratory decrees in Indian law can be found in section 34-35 of the Specific Relief Act 1963. Section 34 of the Act reads as follows:

“Any person entitled to any legal character, or to any right as to any property, may institute a suit against any person denying, or interested to deny, his title to such character or right, and the court may in its discretion make therein a declaration that he is so entitled, and the plaintiff need not in such suit ask for any further relief.”

Dr Abul Fazal explains the significance of the term ‘legal character’: **“The expression ‘legal character has been equated with the status or the position which a person occupies in the eyes of the law. The concept of legal character, stretched to its furthest point, can invest the court with the widest jurisdiction to grant a declaration in a variety of cases.”**⁵⁰⁵ Dr Fazal then quotes the work of Holland who wrote the following on the issue:

“The chief varieties or status amongst natural persons may be referred to the following cases: sex, minority... celibacy, mental defect, bodily defect, rank, caste and official position, race and colour... All of the facts included in the list which may be extended, have been held at one time or another to differentiate the legal position of persons one time or another to differentiate the legal position of persons affected by them from that of persons of the normal type.”⁵⁰⁶

One of the statuses contained in the above list is that of the ‘mental defect’, which could be interpreted in modern vernacular as referring to those suffering from mental

⁵⁰⁵ Fazal, M A (2000) *Judicial Control of Administrative Action in India, Pakistan and Bangladesh* 3rd Ed; Butterworths India, New Delhi at 530.

⁵⁰⁶ Ibid quoting Holland (1924) *Elements of Jurisprudence*; Clarendon Press 14th edition at 351.

disorder or impairment. Dr Fazal states further that declarations under the Specific Relief Act 1963 can be used to positively determine the rights of the individual and have the appropriate relief granted⁵⁰⁷. In the context of capacity law, this suggests that in theory, an incapable adult would be entitled to apply for a declaration as they have the requisite legal character to be able to commence proceedings.

As can be seen, Indian law does allow for declaratory relief to be sought by anybody with legal character. This requirement could theoretically be used to include those suffering with mental disorder or impairment. However, awareness of capacity issues in India has not yet developed to the extent that they are deemed worthy of attention from the courts. That an individual with a mental disorder or impairment will be eligible to apply for a declaration is only a theoretical right at this stage; there is no evidence in Indian law to show that this has actually been done. However, the system of declaratory relief, despite always having existed in English law, only begun to be used in the context of medical treatment after the common law had begun to recognise the significance of capacity issues in the early 1990s.⁵⁰⁸ In order for declaratory proceedings to be used to obtain rulings on matters of capacity, it is first necessary for individuals to want to avail themselves of this option. This has evidently not yet happened in India, although this does not mean that it will not happen. Fazal highlights the fact that under the Specific Relief Act 1877, any civil court in India may be applied to for a declaration. Prior to the implementation of the Mental Capacity Act 2005, only the High Court had an inherent jurisdiction to hear declarations in England. This was confirmed in *Re F (Adult: Court's Jurisdiction)*⁵⁰⁹ in which the court stated that the High Court's jurisdiction could be invoked if there was a serious justiciable issue. The court also confirmed the decision in *Re S (Hospital Patient: Court's Jurisdiction)*⁵¹⁰ that the High Court would treat as justiciable any issues relating to the best interests of the individual. Following implementation of the Act, the High Court has maintained its jurisdiction, with the

⁵⁰⁷ Ibid at 530.

⁵⁰⁸ See *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C.1; *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All E.R. 819; *Airedale NHS Trust v Bland* [1993] 1 All E.R. 821. These cases serve as evidence of the fact that capacity issues began to significantly permeate the English common law from 1990 onwards.

⁵⁰⁹ [2001] Fam 38.

⁵¹⁰ [1996] Fam 1 per Sir Thomas Bingham M.R at 18.

Court of Protection also having the power to grant declarations⁵¹¹. Since the common law jurisdiction still prevails in India, the case of *Re F (Adult: Court's Jurisdiction)* provides useful guidance as to how the courts might decide whether to grant a declaration in matters of capacity and medical treatment.

As discussed in Chapter 2 of this thesis, an important principle in the context of capacity law is the principle of conciliation, which states that any proceedings relating to the incapable adult should be conducted in a way that promoted compromise and conciliation between disputing parties. India's legal system recognises the importance of alternative means of dispute resolution, and it is worth briefly analysing this issue to assess its relevance to capacity law.

A review of the literature suggests that the need for alternative dispute resolution was triggered primarily by the significant strain on the Indian courts. In a speech made on the 5th Bhilwara Oration in March 2000, Central Vigilance Commissioner Vittal stated that as of the year 2000, there were approximately 30 million cases which were pending before the various courts in India, with a dispute taking an average of twenty years to resolve. As a result, **“litigation has become a convenient method for avoiding prompt retribution by many people on the wrong side of the law.”**⁵¹² As of 2007, the figures quoted by Vittal do not appear to have improved greatly, with 25,900,000 cases pending throughout India. K.G Balakrishnan, Chief Justice of India, quoted this figure and stated also that this figure would be likely to increase with even a small amendment in legislation, but despite this, no new courts had been created⁵¹³. Given these figures, it is clear that were matters of capacity to ever become a matter worthy of pursuing in the courts, they would more than likely be swallowed up in the system along with the millions of other cases still pending.

The Arbitration and Conciliation Act 1996 aims to provide resolution of commercial disputes, by means of a private arbitration process. The two main methods of dispute resolution dealt with in the act are arbitration and conciliation, as the title of the Act suggests.

⁵¹¹ Mental Capacity Act 2005, s.15.

⁵¹² Ibid at Para 10.

⁵¹³ The Hindu (12/08/2007) *Backlog of Cases a Matter of Concern, says CJI*; accessed on 20/09/2007; available online at <http://www.hindu.com/2007/08/12/stories/2007081254500500.htm>.

In recognition of the need for alternative dispute resolution, the Code of Civil Procedure 1908 was amended in 2002 to include a section on settlement of disputes outside the court. Section 89 reads as follows:

“(1) Where it appears to the Court that there exists elements of a settlement which may be acceptable to the parties, the Court shall formulate the terms of settlement and give them to the parties for their observations and after receiving the observations of the parties, the Court may reformulate the terms of a possible settlement and refer the same for –

(a) arbitration;

(b) conciliation;

(c) judicial settlement including settlement through Lok Adalat; or

(d) mediation”

Note the reference in (1) to Lok Adalats. According to Nariman, these are currently the only alternative means of dispute resolution in India. Meaning ‘Court of the people’, the purpose of a Lok Adalat is to settle matters which have yet to reach or are pending in the court. In 1980, the Committee for Implementing Legal Aid Schemes began monitoring the manner in which legal aid was administered across India⁵¹⁴. Consequently, Lok Adalats were set up and officially recognised in statute law in 1987 via sections Chapter VI (section 19- 22) of the Legal Services Authorities Act 1987, with the Act gaining implementation in 1995. Robert Moog describes the primary objective of Lok Adalats:

“LA’s [Lok Adalats] can be considered a recent expression of a trend in judicial populism which has continued in India since independence. Its primary characteristic is an overriding concern with the delivery of affordable legal services to the ordinary person.”⁵¹⁵

The Legal Services Authorities Act 1987 emphasises the need for Lok Adalats to arrive at a compromise or settlement between the two parties whilst upholding the principles of justice and equality⁵¹⁶. Any court may send a case to the Lok Adalat if it

⁵¹⁴ Mukhija et al (07/05/2007) *Lok Adalats: A Move Towards More Effective Dispute Resolution*; accessed online on 22/08/2007; available at SSRN: <http://ssrn.com/abstract=998537>.

⁵¹⁵ Moog, R.S (1991) *Conflict and Compromise: The Politics of Lok Adalats in Varanasi District*; Law and Society Review, Vol. 25(3), 545-570 at 552.

⁵¹⁶ Legal Services Authorities Act 1987, ss. 20(3)-(4).

is felt that the case will be resolved more effectively⁵¹⁷, and perhaps most importantly, any decision handed down is legally binding and cannot be appealed unless a fraud has taken place. No court or legal fees are required to be paid by either party, providing a significant incentive for individuals to seek some form of formal redress.

Figures have shown that Lok Adalats have gained in popularity, predominantly in cases relating to financial matters. According to the Press Information Bureau of India, as of 2002, approximately 15 million cases had been resolved by Lok Adalats across India, with a total payout of approximately Rs. 3600 crores⁵¹⁸.

As stated previously, Lok Adalats have been utilised predominantly for the resolution of financial disputes. Review of the literature has shown that at no time have they been used for the resolution of capacity matters. However, the emphasis placed upon issues such as conciliation and mediation suggests that the system may be usable in some form to resolve matters relating to capacity. Given the importance of the procedural principle of conciliation, using an alternative system such as Lok Adalats might ultimately be beneficial for dealing with capacity issues for two reasons: firstly, it may be helpful for disputes to be dealt with away from the traditional court setting, which for many, is more associated with adversariality and conflict, with both parties in effect taking opposite sides. This is inappropriate in the context of disputes over capacity issues, as both parties are in effect after the same outcome i.e. the best interests of the incapable individual who is at the centre of proceedings. Secondly, the provision of alternative justice systems such as Lok Adalats might in theory help to reduce the pressure on India's heavily burdened court system whilst at the same time providing parties with the formality of a legally binding result. Despite these advantages, it must also be noted that the presence of alternative justice systems for resolving capacity matters is unlikely to yield any positive results until capacity issues are deemed important enough for cases to be brought before the courts in India. Thus far, capacity cases, particularly involving medical treatment, have not been accorded this importance, and it could therefore also be argued that discussions about Indian alternative justice systems should be deferred in favour of increasing education on capacity law. Hypothetically speaking however, the fact the Lok Adalat system

⁵¹⁷ Ibid s.20 (1)(b).

⁵¹⁸ see <http://pib.myiris.com/pq/article.php3?fl=021219181818> accessed on 22/08/2007. Please note with regards to the quoted figure of 3600 crores; 1 crore is equal to ten million rupees.

emphasises conciliation between parties suggests that the system could be useful in resolving matters of capacity.

CHAPTER 6: COMPARATIVE ANALYSIS AND FINAL CONCLUSIONS

The final chapter in this thesis will provide a summary of the main findings discussed in the previous five chapters. These findings will then be compared and critiqued and final conclusions given. This chapter splits up the comparative analysis up into four sections: ethical underpinnings, capacity assessment, decision-making for the incapable patient and procedural justice.

6.1: ETHICAL UNDERPINNINGS

In terms of the ethical and philosophical concepts which underpin the law on capacity, a clear line can be drawn between the United Kingdom i.e. England and Scotland on one side, and India on the other. Although this thesis is a tripartite comparative study, the comparisons from an ethical perspective are essentially twofold. This is because there is little to distinguish between England and Scotland in terms of the ethical underpinnings of the law in both jurisdictions. The differences lie in the manner in which the relevant ethical concepts manifest themselves in the law.

First, the predominant principle underpinning both the English and Scottish law is the principle of autonomy. The importance of this principle has been emphasised in Article 3(a) of the U.N Convention on the Rights of Persons with Disabilities 2006 and this has been fully endorsed by both English and Scottish capacity law. Both jurisdictions follow an almost identical approach to autonomy, and in the case of England, this applies to both the common law and the Mental Capacity Act 2005. In the case of the common law, England has stated clearly that promoting the autonomy of the incapable individual is of paramount importance. This is perhaps most effectively shown in the judgment of *Re T (Adult: Refusal of Medical Treatment)*⁵¹⁹, through Lord Donaldson's keynote statement that every adult has the right to decide whether or not to accept medical treatment, irrespective of whether the reasons for the decision are rational, irrational or nonexistent⁵²⁰. In a similar vein, the case of *Re C*⁵²¹ stated clearly that even those with a mental disorder must not be precluded from

⁵¹⁹ [1992] 4 All ER 649.

⁵²⁰ Ibid per Lord Donaldson MR at 663.

⁵²¹ [1994] 1 All ER 819.

exercising their autonomy simply by virtue of their condition, again, even if exercising one's autonomy results in death or serious harm.

The prioritisation of the principle of autonomy has subsequently been transposed into the Mental Capacity Act 2005, where the importance of the principle of autonomy can clearly be seen⁵²². Emphasis has been placed upon the need to assume capacity, ergo the ability to act autonomously, as well as the need to help the individual make a decision themselves. Finally, the Act states that an 'unwise' decision should not be deemed as a decision which is not autonomous.

Whilst the English legislation focuses more upon the circumstances in which an individual must be treated as capable of exercising their autonomy, the Scottish Act details what to do once an adult has been deemed incapable. The question then arises as to whether Scotland's approach places less emphasis upon autonomy per se. It is submitted that the answer would be no. Although the 2000 Act may not highlight the ideological similarities with England, documents published prior to the implementation of the Act demonstrates a clear convergence between the two jurisdictions in this regard. In the 1991 discussion paper *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, the Scottish Law Commission clearly stated that the overriding philosophy behind the reform proposals was that of minimum intervention in the lives of those suffering from mental disorder or impairment, coupled with the need to help individuals to maximise their potential⁵²³. This is clear endorsement of the principle of autonomy, and was echoed in the 1995 *Report on Incapable Adults*⁵²⁴.

It was further stated in 1991 by the Scottish Law Commission that the 1971 U.N Declaration on the Rights of Mentally Retarded Persons had been of great influence upon the proposals for reform in Scotland. The 1971 U.N Declaration includes clear endorsements of the principle of autonomy, including the right of the individual to perform productive work to the best of his/her capabilities, and the right of the individual to any education and training which would help maximise his/her potential. The provisions of the 1971 Declaration have since been laid down the U.N Convention on the Rights of Persons with Disabilities 2006, which confirms the

⁵²² Mental Capacity Act 2005, ss. 1(2)-(4).

⁵²³ Scottish Law Commission Discussion Paper No. 94 (1991) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at Para 1.7.

⁵²⁴ Scottish Law Commission (1995) *Report on Incapable Adults* at Para 1.27

importance of the principles of autonomy and non-discrimination for those suffering with disabilities.

It is apparent, therefore, that the principle of autonomy holds great weight in both English and Scottish capacity law. However, both jurisdictions also acknowledge the importance of the principle of paternalism. Indeed, there is a clear acceptance in both England and Scotland that providing for adults with incapacity necessitates at least some application of the principle of paternalism. Again, there are some differences in approach between the two jurisdictions, but the ideological similarities remain.

First, the English common law, whilst clearly favouring a pro-autonomy approach as far as is practicable, also highlights the fact that the presumption of capacity can, and must be rebutted in the event of evidence of incapacity. In the light of this, Lord Donaldson's statement regarding the right of individuals to make whatever decision he/she wishes, irrespective of reason, appears not always to apply in capacity law. The common law has held that factors such as undue influence (*Re T (Adult: Refusal of Medical Treatment)*) and needle-phobia (*Re MB (Medical Treatment)*), will adversely affect one's ability to make a fully autonomous decision, thus requiring the individual's decision to be overridden and a paternalistic approach adopted. The paternalistic approach in English capacity law manifests itself in the form of the best interests test. Cases such as *Re F (Mental Patient: Sterilisation)*, *Re SL (Adult Patient: Medical Treatment)* and *Re A (Medical Treatment: Male Sterilisation)* show application of the best interests test; *Re F* introduced the test into the common law in relation to medical procedures for incapable adults, whilst *Re SL* and *Re A* extended it further to include interests beyond mere medical ones, such as long-term emotional welfare.

The best interests test was subsequently carried through and laid down in the Mental Capacity Act 2005, albeit somewhat differently to the approach adopted in the common law.

The essential purpose of the best interests test remains the same: to provide criteria for making decisions on behalf of those who have been deemed incapable of understanding, retaining, weighing up or communicating a decision on medical

treatment⁵²⁵. In addition, the Act states that proxy decision-makers must not make a decision on best interests based on age or appearance, and must consider whether the individual will regain capacity at some point in the future, an important point considering the ethical implications for making decisions for one who is capable. Instead of adopting a pure best interests model, the Mental Capacity Act 2005 represents an attempt by legislators to bridge the gap between the concepts of best interests and substituted judgment, the latter being considerably more suited to a pro-autonomy approach. In the context of ethics, this represents a shift away from paternalism, although as discussed, it is impossible to disregard it completely. Ultimately, adopting either a pure best interests or a pure substituted judgment test would be unrealistic; the former is too paternalistic, whereas the latter is of little use when the individual in question was never capable of expressing wishes or opinions about a given treatment. Therefore, the 2005 Act adopts a compromise between the two tests, favouring substituted judgment where practicable, but best interests in other circumstances. In ethical terms, paternalism is still an important ethical principle, but it becomes the dominant principle only when the individual displays a complete lack of autonomy.

In Scottish capacity law, the concept of benefit represents a shift away from hard-line paternalism, with the 2000 Scotland Act giving the highest priority to the past and present wishes and feelings of the adult, followed by the views of relatives, carers and so forth⁵²⁶. From an ethical perspective, this confirms that the principle of autonomy takes precedence over the principle of paternalism. If the past wishes and feelings of the individual can be ascertained, these must be the basis of any proxy decision-making, thus in effect allowing the individual to exercise their autonomy by proxy. In the absence of evidence of the individual's past wishes and feelings, it is then ethically acceptable to prioritise the views of those other than the incapable adult. In this way, there is very little, if any difference in approach to the issue of ethics between England and Scotland, notwithstanding the fact that the manner in which these ethical principles are applied do differ significantly between the two jurisdictions.

⁵²⁵ Mental Capacity Act 2005 s. 3(1).

⁵²⁶ Adults with Incapacity (Scotland) Act 2000 s. 1(4).

Having discussed the ethical underpinnings of English and Scottish capacity law, the question remains as to how India compares in this area. The substantive principles of particular relevance to India are the principles of non-discrimination, communitarianism and paternalism.

Literature on India shows that the principle of non-discrimination has not been fully recognised with respect to mental health. Existing literature highlights attitudes towards mental illness in general, with these sources stating that those suffering from mental disorder or impairment are often thought of as having no capacity for understanding⁵²⁷, with the possibility of living life unaided being extremely remote⁵²⁸. Even those involved in the care of mentally impaired individuals have described the condition as the worst handicap imaginable⁵²⁹. This suggests that although there is some recognition that those suffering with mental disorder or impairment are in need of assistance, a status approach is still adopted, so that it is believed that such individuals require help in all areas of life simply by virtue of their condition. Although review of the literature also highlights that fact that work is being done to increase awareness of mental illness in general, particularly by Non-Governmental Organisations⁵³⁰ it remains to be seen when a more functional approach will be taken, which acknowledges that sufferers of mental disorder or impairment may be capable of making autonomous decisions in the same way as others.

Endorsement of the principle of paternalism is also identifiable in certain areas of the Indian approach to capacity, in particular where the death of the individual is at issue. First, consider the incident discussed by Jesani and Pilgaokar regarding the two protesters who went on hunger strike⁵³¹. The incident shows that a paternalistic approach is still prevalent in practice, despite the fact that this has not specifically

⁵²⁷ Varma, L.P; *Mental Disorders: Some Misconceptions*; Souvenir III Conference of Eastern Zone; I.P.S, Gauhati.

⁵²⁸ Tilak, D (1992) *Mentally Handicapped: Care, Financial Security and Guardianship Needs*; Indian Journal of Social Work, Vol. 53(1), 1-15.

⁵²⁹ Ibid at 1.

⁵³⁰ Padmavati, R (2005) *Community Mental Health Care in India*; International Review of Psychiatry; Vol. 17(2); 103-107 at 103.

⁵³¹ Jesani, A and Pilgaokar, A (1993) *Patient's Autonomy: Throwing it to the Winds*; Indian Journal of Medical Ethics; Aug-Oct Vol. 1(1); accessed online on 18/01/2006; available at <http://www.issuesinmedicalethics.org/011mi006.html>.

been endorsed⁵³². There was no evidence to suggest that the two protesters were incapable of making a decision on whether or not to refuse feeding, yet this was not considered as important. This can be compared and contrasted with English cases like *Secretary of State for the Home Department v Robb*⁵³³, in which the Home Office successfully sought a declaration stating that all relevant prison and medical staff should abide by the prisoner's decision to fast, since he was of sound mind and understood that the refusal of nutrition and hydration would result in his death. However, it should also be noted that the court in the English case of *Leigh v Gladstone*⁵³⁴ which was heard almost one hundred years ago, held that the force feeding of an imprisoned suffragette was acceptable to prevent suicide, which was illegal at that time. The cases of the Mumbai protesters and *Leigh v Gladstone* can be compared inasmuch as both cases involved prisoners who were on hunger strike and had their will overborne despite no evidence to suggest a lack of capacity. The fact that these cases took place one hundred years apart would suggest that the differences in approach between England and India are in essence developmental. How then, might cultural factors impact upon issues of capacity?

Chapter 4 of this thesis discussed the Indian approach to end-of-life issues. The literature review revealed that the right of an individual to take control over issues relating to life-sustaining treatment has not been fully recognised to the extent that they have in the U.K. There is no recognition in either common law or statute of any form of advance decision-making in the form of advance statements or welfare powers of attorney, and no protocol in place to govern who may be permitted to make decisions on behalf of an incapable adult. In an ethics context, this means that the individual's right to exercise their autonomy in relation to such matters has yet to be acknowledged in full⁵³⁵. Instead, existing literature comments on how doctors adopt a paternalistic approach and feel obliged to prolong life-sustaining treatment even in this is against the wishes of the patient's family⁵³⁶. Again, as shown with the case of

⁵³² Singh J and Bhushan, V (2004) *Medical Negligence and Compensation*; Bharat Law Publications at 9.

⁵³³ [1995] 2 W.L.R 722.

⁵³⁴ [1909] 25 T.L.R 139.

⁵³⁵ Mani, R K et al (2005) *Limiting Life-Prolonging Interventions and Providing Palliative Care Towards the End-of-life in Indian Intensive Care Units*; Indian Journal of Critical Care Medicine; Vol. 9(2), 96-107 at 97.

⁵³⁶ Rastogi, A K (2005) *End-of-life Issues Neglected in India*; Indian Journal of Medical Ethics; July-Sept 2005(3), accessed on 9/01/2008; available online at <http://www.ijme.in/133di03.html>.

the Mumbai protesters, there is evidence of a paternalistic approach being prevalent when the death of the patient is a central issue. English case law states that life-prolonging treatment on patients in a persistent vegetative state can only be continued if in the best interests of the patient.⁵³⁷ It is submitted that the difference in approach can again be attributed to developmental issues. There is no protocol in place to govern how doctors must act when faced with end-of-life issues, whether the patient is in a persistent vegetative state, or whether the patient, while capable, has expressed a wish to have all life-prolonging treatment terminated⁵³⁸. If guidance was available through either statute or common law, the doctors would have no choice but to comply with this guidance. As things stand, Jindal highlights the fact that without protocol in place, doctors have no choice but to subscribe to cultural practices⁵³⁹. Evidence from English law suggests that there is little difference in attitudes towards death between the U.K and India. This is illustrated in *Re B (Adult: Refusal of Medical Treatment)*⁵⁴⁰, where the healthcare staff in charge of Miss B were extremely reluctant to accede to her wishes to have her artificial ventilation switched off. The reason for this was not because Miss B did not have the requisite capacity to make this decision, but rather, because they felt that she was making the wrong decision in wanting to die. Dame Butler-Sloss's reference to the **“danger of benevolent paternalism”**⁵⁴¹ in her judgment seems particularly apposite in the context of the Indian approach and Rastogi's commentary on the treatment of his comatose mother by healthcare staff in an Indian hospital. Rastogi's statement on how the doctors in charge of his mother felt **“obliged to keep her alive with machines”**⁵⁴² could, it is submitted, equate to the benevolent paternalism that Dame Butler-Sloss spoke of in Miss B's case. Despite the fact that Ms B was competent and Rastogi's mother was in a comatose state, a comparison is warranted because both cases show that a strongly paternalistic approach, however well intentioned, cannot simply be adopted by the decision-maker because they feel that it is ‘the right thing to do’. Both cases ostensibly involve the feelings of the healthcare staff and the apparent obligation felt

⁵³⁷ [1993] 1 A.C 789. .

⁵³⁸ See for example, *Re B (Adult: Refusal of Medical Treatment)* [2002] E.W.H.C 429.

⁵³⁹ Jindal, S K (2005) *Issues in the Care of the Dying*; Indian Journal of Medical Ethics; July-September 2005(3); accessed on 9/01/2008; available online at [http:// www.ijme.in/133di03.html](http://www.ijme.in/133di03.html).

⁵⁴⁰ [2002] E.W.H.C 429.

⁵⁴¹ *Ibid* per Dame Butler-Sloss at Para 100(v).

⁵⁴² Rastogi, A K (2005) *End-of-life Issues Neglected in India*; Indian Journal of Medical Ethics; July-Sept 2005(3); accessed on 9/01/2008; available online at <http://www.ijme.in/133di03.html>.

in both cases to keep the patient alive. Although the capacity levels of both patients were significantly different, it is the approaches and opinions of the healthcare staff in each case which are comparable. Miss B's case illustrated that doctors in the United Kingdom are no less paternalistic on an ideological level than doctors in India; it is simply that the substantive and procedural principles relating to capacity, as laid down first in common law and finally through the English and Scottish legislations, have developed to the extent that doctors are legally forbidden from overriding the wishes of a capable patient. By contrast, the law in India over such issues is not at all established, meaning that there is little to prevent doctors overriding the autonomy of patients and adopting a paternalistic approach even with a patient capable of making treatment decisions.

With regards to the principle of communitarianism, Laungani stated that one's individual role within a family was effectively subordinate to the collective needs of the family⁵⁴³. The problem of one individual is the problem of the whole family, even if that individual is capable of dealing with the problem themselves. One might therefore argue that if the situation is such for a capable person, family involvement will be greater when the individual in question suffers with some form of incapacity. This raises the question as to whether collaborative or deferred decision-making is giving full respect to the principle of autonomy. The English case of *Re T (Adult: Refusal of Medical Treatment)* illustrated how the emotional nature of familial relationships can impact upon valid decision-making; T was not a Jehovah's Witness herself although her mother was, and her vulnerable state meant that her mother was able to unduly influence her to make a treatment decision that reflected T's mother's religious beliefs. Therefore, a communitarian approach to decision-making which involves family members may result in a similar outcome, where the influence of other family members may impact upon the individual to the extent that he/she makes decisions that reflect the wishes of others rather than themselves. However, this must only be considered as a possible outcome of collaborative decision-making, rather than a guaranteed one. Discussion of a communitarian approach to decision-making in India raises the question of whether the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 allow for a collaborative approach to decision-

⁵⁴³ Laungani, P (1997) *Mental Illness in India and Britain: Theory and Practice*; Medicine and Law; Vol. 16(3), 509-540 at 521.

making. This question is of particular relevance to Indians living in the U.K who may be used to making decisions collectively and wish to continue this. Literature on the role of family in India suggests that the concept of a hierarchical system in families, with the elders fulfilling the more important roles, is ideologically ingrained within the lives of many sections of Indian society⁵⁴⁴. Therefore, it could be inferred that for some, deferring decision-making to elders is not an imposition or an erosion of one's autonomy, but rather, is perfectly acceptable and possibly even preferred. In terms of how this relates to individuals of Indian origin living in the U.K, it is submitted that the English and Scottish legislations do allow for communitarian decision-making. The crux of the matter lies in the ability to demonstrate that deferring the decision-making process to family, in particular senior members, is part of a long and deeply held process. In the Mental Capacity Act 2005, the appropriate gateway for deferring decisions to family members would be s.4(6)(b), which states that the person making the determination on the best interests of the individual must consider (so far as is practicable), the beliefs and wishes that would be likely to influence his decision if he had capacity. Provided that deferring to family members on important decisions is a practice which has persisted for a long period of time, and provided that the individual is entirely satisfied with this procedure, it may be entirely possible to argue that deferring decisions to one's parents or grandparents forms as much a part of a belief system as following a religion. Indeed, Article 9 of the European Convention on Human Rights guarantees the right to freedom of thought, conscience and religion alone or in community with others, and the nature of the belief system is not specified in the provision. Therefore, to the Indian family living in the United Kingdom, the right to hold a belief system that defers important decisions to elders in the family is one that is seemingly guaranteed by law.

Finding an equivalent gateway under the Adults with Incapacity (Scotland) Act 2000 is not as straightforward, owing to the Act's failure to include reference to matters such as the beliefs and wishes of the individual. The closest approximation to s. 4(6)(b) can be found in s.1(4)(a) of the 2000 Act, which states simply that if an intervention is to be made, account should be taken of the present and past wishes and

⁵⁴⁴ See Rack, P (1982) *Race, Culture and Mental Disorder*, Routledge Press at 73; Juthani, N.V (2001) *Psychiatric Treatment of Hindus*, *International Review of Psychiatry*, Vol. 13(2), 125-130; Venkoba Rao, A (1981) *Mental Health and Ageing in India*, *Indian Journal of Psychiatry*, Vol. 23(1), 11-20.

feelings of the adult so far as they can be ascertained. It could be argued that if an individual is used to deferring treatment decisions to the elders of the family and has always been satisfied with this, then this would form the basis of the individual's past wishes and feelings. However, this argument is not altogether convincing. The Mental Capacity Act 2005 also includes a provision which requires consideration of the individual's past and present wishes and feelings, and this can be found in s.4(6)(a). The fact that past and present wishes and feelings have been interpreted as being independent of one's beliefs and values illustrates that at least according to English capacity law, the two requirements are different. The question which then follows is how they both differ. It is submitted that the past and present wishes and feelings of an individual apply to each particular treatment decision and do not necessarily require the presence of a deeply held-belief system. If for example, an individual makes an advance statement declaring that they do not wish to be resuscitated in the event of a respiratory arrest, this is evidence of an individual's wishes. If, by contrast, an individual makes a statement refusing blood transfusions on the grounds that they have been a practising Jehovah's Witness all their lives, this is in essence a decision based on a belief system; the individual's religion is a constant throughout their lives and is likely to inform many aspects of decision-making, and not simply the treatment decision at hand. As mentioned above, the Adults with Incapacity (Scotland) Act 2000 makes no reference to beliefs and values, nor is there any meaningful reference made to them in neither the discussion and consultation papers nor Adrian Ward's key text on the law, *Adult Incapacity*. One of two things can be inferred from this; first, Scottish law does not consider the need to consider one's beliefs and values to be important to issues relating to interventions to benefit the individual. Alternatively, Scottish law does accept the importance of beliefs and values in the context of interventions, but have failed to reflect this in any useful way within the legislation. Since England and Scotland have approached their respective legislations from similar ideological viewpoints, the latter premise may be the more appropriate.

If misapplied, the principle of communitarianism could potentially conflict with the principle of autonomy and thus invalidate a decision. One has to consider the possibility that the practice of making decisions collaboratively, rather than individually, may ostensibly lead to a scenario whereby the individual's views are in fact deemed unimportant when compared to those of the family. Although there is no

strict rule as to how this may occur, examples of this may be where the views of the elders i.e. parents and grandparents, are given the highest weighting, and the 'children' of the family, despite having attained the age of majority, are expected not just to collaborate, but in fact give up their decision-making rights entirely. Alternatively, the hierarchical structure of the family may be decided on the basis of gender, with the women being expected to defer decisions to the men. Those with partial but not total incapacity e.g. individuals with learning disabilities, may also have their views deferred in favour of others in the family.

Ultimately however, the principle of communitarianism should not be dismissed simply because of its potential for misapplication, as this could ostensibly be the case with any of the key ethical principles. What makes discussion on the principle of communitarianism particularly interesting is that it represents a merging of cultural and developmental issues. The emphasis that the principle places upon family values and living interdependently, has been identified by existing literature as a typically Indian approach⁵⁴⁵, thus highlighting culture as relevant to the principle of communitarianism. At this stage, it is worth considering whether the younger/older family member dynamic would work differently within Indian families resident in the United Kingdom. While young people brought up in India may be brought up to defer to the elders in the family for important decisions, those brought up in the United Kingdom may find themselves exposed to a culture espousing more individualistic, independent behaviour. This is in addition to the individual's family environment, which may still promote a more interdependent, communal way of life. Greater exposure to Western culture may lead the individual to question whether a collaborative approach to decision-making is preferable, and he/she may choose to take decisions on a more individualistic basis. Alternatively, he may be entirely happy with the family's ethos and decide to maintain a communitarian approach. Both are possibilities, and both scenarios are entirely in keeping with the principle of autonomy, provided that the individual has not been coerced or unduly influenced into adopting a particular way of life. In this way, it can be seen how cultural issues can potentially impact upon the decision-making process.

⁵⁴⁵ See Laungani, P (1997) *Mental Illness in India and Britain: Theory and Practice*; Medicine and Law; Vol. 16(3), 509-540; Ahmad, I (2003) *Between the Ideal and the Real: Gender Relations within the Indian Joint Family*; chapter in Pernau, M; Ahmad, I and Reifeld R (2003) *Family and Gender: Changing Values in Germany and India*; Sage Publications New Delhi; Venkoba Rao A (1981) *Mental Health and ageing in India*; Indian Journal of Psychiatry; Vol. 23(1), 11-20; Rack, P (1982) *Race, Culture and Mental Disorder*, Routledge Press London.

Similarly, work published by authors such as Rajan and Menon-Sen and Shiva Kumar suggest that a status approach is still adopted vis a vis women, again highlighting cultural attitudes. However, culture itself evolves and develops over time; even in the United Kingdom for instance, attitudes towards women in the 1950s were markedly different to those of today. It was stated in Chapter 1 of this thesis⁵⁴⁶ that mentally disordered or impaired individuals may also be seen as unable to make important decisions, even if they may retain some capacity to do so. This ties in to attitudes towards the mentally ill and disabled in India, where in some quarters they may still be seen as vulnerable and incapable of conducting any aspect of their lives independently⁵⁴⁷. Therefore, in the context of collaborative decision-making within the family, the wishes of the incapable individual may be considered subordinate to the views of other family members who have ‘full’ capacity, because there is still a lack of awareness of the fact that capacity is not an ‘all or nothing’ concept. Given that this attitude also prevailed in the United Kingdom until *Re C (Adult: Refusal of Medical Treatment)*⁵⁴⁸ highlighted the issue in 1994, this suggests that familial attitudes towards incapacitous family members will change and evolve once education and awareness of issues mental illness issues develop in India in general.

Discussion on the principle of communitarianism and its link to autonomy is inherently complex. This thesis has identified communitarianism as being relevant to Indian families, but of course it is possible for families in other communities to follow such an approach to decision-making. In the same way, Indian families may not follow a communitarian outlook at all, preferring instead to follow a more ‘westernised’ individualistic approach. The intention is not to make generalisations, but rather, to highlight the fact that autonomous communitarianism is one potential avenue to decision-making which the individual should ideally be free to adopt or reject as they wish. Realistically, it is difficult to ascertain with complete certainty whether the line between receiving advice from family members and being coerced or manipulated by them has been crossed, for that can only be done by looking at each

⁵⁴⁶ See page 45 of this thesis.

⁵⁴⁷ Varma, L.P; *Mental Disorders: Some Misconceptions*; Souvenir III Conference of Eastern Zone; I.P.S, Guwahati; Tilak, D (1992) *Mentally Handicapped: Care, Financial Security and Guardianship Needs*; Indian Journal of Social Work; Vol. 53(1), 1-15.

⁵⁴⁸ [1994] 1 All E.R 819.

individual case on its facts. However, it is submitted that ethical principles are essentially idealistic in nature; they provide benchmarks for actions and behaviour, and it may not be possible to achieve them absolutely. With the principle of autonomy, the key factor is whether it has been exercised sufficiently to render a decision valid. If a communitarian approach is utilised in achieving this, then it is itself valid and worth of consideration.

6.2: CAPACITY ASSESSMENT

As highlighted above, there is little to separate the capacity law of England and Scotland in terms of the ethical principles which underpin the law. With respect to the provisions of the law which deal with the issue of capacity assessment, both jurisdictions again approach the issue from similar viewpoints. However, the manner in which the issue is provided for in statute provides significant scope for analysis. With respect to the Indian position, although there is no specific provision for assessment of capacity in relation to medical treatment, analysis of other areas of Indian law help to provide an analogous comparison with the law of England and Scotland.

Both England and Scotland adopt a pro-autonomy, functional approach to capacity assessment. The English Mental Capacity Act 2005 states clearly that capacity must be presumed, meaning that the burden of proof lies on those wishing to prove incapacity. In addition, section 3(2) states that an individual will only be deemed incapable of making a treatment decision if they are unable to understand an explanation which is given in a manner appropriate to his/her circumstances. The Scottish position also emphasises the need for an approach which will override the individual's autonomy only as a last resort. The 1991 Discussion Paper *Mentally Disabled Adults* states that an exhaustive evaluation of the treatment will not be necessary. The individual need only be informed in broad terms about the nature of the proposed treatment⁵⁴⁹.

⁵⁴⁹ Ibid at Para 3.5.

Sections 2 and 3 of the English Mental Capacity Act 2005 address the issue of capacity assessment by providing definitions of a person who lacks capacity and the inability to make decisions respectively. Under s.2(1) of the Act, a person will be deemed to be incapable if they are unable to make a decision for themselves because of an impairment of, or a disturbance in the functioning of the mind or brain, thus forming the diagnostic threshold for accessing the provisions of the Act. The diagnostic threshold is present in the 2000 Scotland Act but in a less concise form. All that the 2000 Act tells the reader is that the criteria of incapacity stated in the Act should be caused by a mental disorder or through an inability to communicate because of a physical disability⁵⁵⁰.

In the light of this, it is submitted that the 2000 Scotland Act suffers from significant weaknesses in the detail and wording, particularly when compared with the 2005 English Act. The diagnostic threshold in the 2000 Act appears to have been included more as an afterthought, rather than the important provision that it is.

The weaknesses in drafting are yet more apparent in section 1(6) of the Adults with Incapacity (Scotland) Act 2000. Section 1(6) reads as follows:

“For the purposes of this Act...

‘adult’ means a person who has attained the age of 16 years;

‘incapable’ means incapable of –

(a) acting; or

(b) making decisions; or

(c) communicating decisions; or

(d) understanding decisions; or

(e) retaining the memory of decisions,”

It is submitted that the criteria of incapacity outlined in subsections (a) to (e) are poorly worded when compared to the equivalent provisions in the English 2005 Act. Particularly unhelpful is the stipulation that the term ‘incapable’ can mean ‘incapable of acting’, which could conceivably encompass almost any aspect of the decision-making process. Making, communicating, understanding and retaining the memory of decisions are ostensibly all examples of acts, yet ‘acting’ has been singled out as being separate from the remainder of the provisions. Readers are given no further

⁵⁵⁰ s. 1(6).

explanation as to what constitutes an act and how it is separate from other considerations, with even the Code of Practice failing to correct this vagary. By comparison, section 3 of the Mental Capacity Act 2005 provides more concise detail on the subject of inability to make decisions. In particular, s.3(1) states that a person will be deemed unable to make a decision if he/she is unable to understand information relevant to the decision; retain the information, use or weigh the information up, or to communicate the decision. It will be noted that these provisions are effectively a restatement of the capacity test laid down in *Re MB (Medical Treatment)*⁵⁵¹. Further qualification of these criteria is provided in the remainder of s.3, with the Act clarifying that any information provided must be conveyed in language appropriate to the individual's circumstances⁵⁵², and also that ability to retain the decision for a short time does not preclude the individual from making a decision⁵⁵³.

It may be seen that the criteria of incapacity laid down in s.1(6) of the Scottish Act are broadly similar to the equivalent criteria in s.3 of the English Act. Both jurisdictions consider the ability to understand, retain and communicate decisions to be of significance in the decision-making process. However the provisions of the 2000 Scottish Act are vaguely worded and ultimately unhelpful. Despite the fact that discussions on the Scottish law continually emphasised a pro-autonomy approach, it is submitted that this has not been adequately reflected in the legislation. At no point in the Scottish Act has it been emphasised that only a broad explanation will be necessary to satisfy the assessment criteria in s.1(6), despite the fact that this had been stated in earlier discussions on the Act. It is submitted that the Scottish Act would have benefited from further criteria highlighting the Act's intention to provide as much scope for the individual's capacity to be upheld as possible. Vague terms such as 'inability to act' only serve to complicate an already difficult area of law. This is not to say however that the provisions of the Mental Capacity Act 2005 should be entirely exempt from criticism. As with Scotland, it could be argued that rather than emphasise the criteria for the inability to make a decision, the Act would have benefited from more positive phrasing, i.e. provisions highlighting when an individual

⁵⁵¹ [1997] 38 B.M.L.R 175.

⁵⁵² Mental Capacity Act 2005 s.3(2).

⁵⁵³ *Ibid* at s.3(3).

will be deemed capable as opposed to incapable. This is ultimately a minor point, but it has been mentioned particularly because of the decision to change the name of the legislation from the Mental Incapacity Act to the Mental Capacity Act, in order to place a more positive spin on the objectives of the Act. By the same token, it is arguable that this reasoning could have been adopted better in the provisions dealing with capacity assessment. This notwithstanding, section 3 of the Mental Capacity Act represents a worthy attempt to promote the principle of autonomy by emphasising that although proxy decision-making may be necessary in many cases, such a mechanism exists mainly as an option of last resort. While it is clear that Scotland endorses the same viewpoint, this does not come across adequately in the assessment criteria contained in the 2000 Act.

With regards to the Indian position on assessment of capacity, the law in India provides no guidance on the issue of capacity assessment in relation to medical treatment. However, analysis of the law relating to capacity to marry provides some guidance by way of analogy. The amended s.5 of the Hindu Marriage Act 1955 states that a marriage may be solemnised between two Hindus, provided that at the time of marriage, neither party is incapable of giving valid consent as a result of suffering from unsoundness of mind. In addition, if an individual is capable of giving consent, but is deemed to be unfit for marriage or procreation as a result of mental disorder, a marriage may not be valid. Clearly capacity is of relevance when making a decision on marriage, as it is when deciding on medical treatment. However, the 1955 Hindu Marriage Act does not provide any criteria to aid decision-making, despite the presence of vague phrases such as ‘unsoundness of mind’. In addition, although the common law on the issue provides some guidance, there appears to be no real system or underlying ethos which is consistent across all decisions. What the common law does tell us is that the threshold for capacity to marry is deliberately low so as to ensure that marriages are not unnecessarily annulled or deemed void⁵⁵⁴, which is comparable to the position in England⁵⁵⁵.

Although a rudimentary functional approach to capacity can be identified through the case of *Usha v Abraham*, this approach is not consistently applied in other Indian cases. It was held for example in *Pravati Mishra v Jagananda Mishra* that a woman

⁵⁵⁴ See *Usha v Abraham* [1988] A.I.R Ker 96.

⁵⁵⁵ *Park v Park* [1953] 3 W.L.R 112; *Durham v Durham* [1885] L.R 10 P.D. 80.

who had a low I.Q could not enter into a marriage because her condition was incurable and she was thus incapable of raising her children and discharging her duties as the member of a middle-class family. In contrast to *Usha v Abraham*, the court in *Pravati Mishra v Jagananda Mishra*⁵⁵⁶ adopted a status approach to capacity, emphasising the nature of the respondent's condition rather than whether it would have an impact upon her capacity to marry. It is submitted that this inconsistency in approach can be attributed to a lack of development in India's law. The decision in *Usha v Abraham* is the more compelling out of the few decisions that exist on capacity to marry, particularly in light of the fact that the English case of *Durham v Durham* was clearly influential. As well as the law relating to capacity to marry, a rudimentary functional approach can be identified through s.12 of the Indian Contract Act 1872, which allows an individual to enter into a contract provided that he/she is capable of doing so. In the case of individuals who may be suffering with some form of incapacity due to mental disorder or impairment, a contract may be entered into if at the time of making the contract, the individual is capable of understanding it and forming a rational judgment as to its effects upon him. This is similar to the approach taken in the Mental Capacity Act 2005, which requires an ability to understand relevant information and the ability to weigh the information as part of the process of making the decision.

The Indian approach to capacity is still very much in a nascent stage and although a functional approach is recognised in a basic form, there is as yet no guidance as to how one's capacity must be assessed. However, it must be noted that the developments in this field in England and Scotland have only taken place comparatively recently. Prior to the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000, neither England nor Scotland had provided guidance on the assessment of capacity and it was only through the development of the common law and cases such as *Re MB* that England and Scotland were in the position to introduce specific capacity legislation. This suggests that the lack of guidance on capacity assessment in India is attributable to developmental issues, which in turn suggests that either through the common law or legislation, the law will eventually recognise the importance of capacity law enough to provide guidance similar to that

⁵⁵⁶ [1995] A.I.H.C 3434.

given in sections 1-3 of the 2005 English Act and s.1 of the 2000 Scottish Act. Prior to the implementation of the English and Scottish Acts, the English common law was able to provide a legal endorsement of the functional approach, even without the recognition of it in statute. This has not yet occurred in India, with the common law having not yet developed to the point where cases relating to capacity and medical treatment have reached the courts. However, this could again be attributed to developmental issues, since the same could be said of the common law in the United Kingdom. It was essentially not until 1994 that the functional approach to capacity was dealt with in common law via the case of *Re C (Adult: Refusal of Medical Treatment)* (although it should be noted that the Law Commission's 1991 report made reference to it). This suggests that at least theoretically, the law in India will eventually recognise the need to explicitly extend the functional approach to capacity by providing for assessment criteria within the law. It would be inaccurate to suggest that Indian law has officially endorsed a status approach to capacity, but in order for a functional approach to be better highlighted, it is necessary for awareness of capacity issues to increase. As with England, development of the common law will help to place the functional approach in context, with legislation then helping to codify this. It does of course remain to be seen when the common law of India will recognise capacity cases and the functional approach therein, although the fact that English law also recognised its importance comparatively recently suggests that the difference is more attributable to developmental issues than to other factors.

6.3: DECISION-MAKING FOR THE INCAPABLE PATIENT

The manner in which treatment decisions are made on behalf of incapable adults varies between the three jurisdictions. England utilises the best interests test whereas Scotland makes no reference to best interests, opting instead for a benefit test. India by contrast has no discernible formal system relating to such matters to speak of, although it may possible to discuss the direction that India should take were the country to adopt a system similar to that of England or Scotland. The central premise of both the best interests and the benefit tests are in essence the same; that the decision taken is that which the decision-maker deems is best for the individual. However the tests which both England and Scotland provide for ascertaining this are different in a number of ways.

The best interests test, as preferred in English capacity law, is in keeping with the common law position as laid down in cases such as *Re F (Mental Patient: Sterilisation)*⁵⁵⁷, *Re A (Medical Treatment: Male Sterilisation)*⁵⁵⁸ and *Re SL (Adult Patient: Medical Treatment)*⁵⁵⁹. The best interests test as laid down in the Mental Capacity Act 2005 tells us that age, appearance or behaviour must not inform a determination of what is in the best interests of the individual. The decision not to provide a formal definition of best interests was taken deliberately by the Law Commission on the grounds that the circumstances of the individual should ideally determine the appropriate result⁵⁶⁰. Nevertheless, further guidance on the issue of best interests was provided in s.4(6) and (7) of the 2005 Act, which reads as follows:

“(6) He [the decision-maker] must consider, so far as is reasonably ascertainable-

(a) the person’s past and present wishes and feelings (and in particular any relevant written statement made by him when he had capacity)

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of -

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare,

(c) any donee of a lasting power of attorney granted by the person, and

(d) any deputy appointed for the person by the court,

as to what would be in the person’s best interests and, in particular, as to the matters mentioned in subsection (6).”

The above provisions provide a useful point of comparison with Scotland. The Scottish Law Commission ultimately chose to reject the best interests test on the

⁵⁵⁷ [1990] 2 A.C 1.

⁵⁵⁸ [2000] 53 B.M.L.R 66.

⁵⁵⁹ [2000] 2 F.C.R 452.

⁵⁶⁰ Law Commission Report No. 231 (1995) at Para 3.26.

grounds that it was too vague a term and would require further clarification through other factors. In addition, the Scottish Law Commission stated that the concept of best interests had its roots in childcare law and was therefore inappropriate in the context of incapable adults⁵⁶¹. In the 1995 Report on Incapable Adults, the Scottish Law Commission argued that an incapable adult should not be compared to a child on the grounds that an incapable adult will have gone from a position of full capacity to a position of partial or total incapacity.⁵⁶² By contrast, children have never been able to approach decisions from a position of full capacity, with their incapacity simply diminishing each year as they reach adulthood. This is an unconvincing argument. In rejecting the relevance of best interests to capacity law in Scotland, it is submitted that the Scottish Law Commission has effectively rejected England's common law approach to the issue. That the best interests test is paramount to the issue of decision-making for incapable adults is evidenced by cases such as *Re F (Mental Patient: Sterilisation)*, *Re SL (Adult Patient: Medical Treatment)* and *Re A (Medical Treatment: Male Sterilisation)*.

In addition, The Scottish Law Commission also asserted that incapable adults suffering with mental illness, head injuries or dementia will have had full capacity before their particular condition occurred. However, in making this assertion, the Scottish Law Commission failed to consider the possibility that for some, incapacity will be present since birth, thus falsifying the Commission's assertion that incapable adults will have possessed full mental capacity at some point.⁵⁶³ The Scottish Law Commission only referred to three possible conditions which may lead to incapacity, one of which, mental illness, is extremely general. It could be argued that the Scottish Law Commission in essence felt that the best interests test was too paternalistic, and that paternalism was more appropriate when dealing with children than with incapable adults, who, despite their incapacity, were nonetheless adults. This is perhaps commendable to some extent; since such a view would be in keeping with the pro-autonomy approach espoused on numerous occasions. However, the Commission's view ultimately comes across as unrealistic and naïve. Both children and incapable

⁵⁶¹ Scottish Law Commission Report No. 151 (1995) *Report on Incapable Adults* at Para 2.50.

⁵⁶² *Ibid.*

⁵⁶³ In *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C 1; *Re A (Medical Treatment: Male Sterilisation)* [2000] 53 B.M.L.R 66 and *Re SL (Adult Patient: Medical Treatment)* [2000] 2 F.C.R 452, the condition suffered by all three patients which led to their incapacity had existed since birth.

adults do have one significant commonality, which is that both are likely to require some intervention into at least some aspects of the decision-making process. In this respect, the best interests test is entirely appropriate for dealing with incapable adults as well as children. If the Scottish Law Commission rejected the test on the grounds that it was too paternalistic, this is valid in relation to the test as used in English common law. However, the Mental Capacity Act 2005 has since included a modified version of the best interests test so that it now includes elements of substituted judgment. As the concept of benefit as included in the Scottish Act also includes elements of substituted judgment, it is submitted that the difference between the two concepts is not as significant as it would have been prior to the implementation of the Mental Capacity Act 2005.

As an alternative to the best interests test, the Scottish Law Commission proposed that the appropriate test for proxy decision-making would be the benefit test. The 2000 Act however provides little guidance as to how a proxy decision-maker should determine whether a particular decision will be to the benefit to the individual. All that is really stated about the concept of benefit can be found in s.1(2) of the 2000 Act: **“There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.”**

The above policy statement is essentially no different to the English approach to proxy decision-making. Scottish law states that intervention i.e. adopting a paternalistic approach, is only permissible if attempts to benefit the individual cannot be achieved without making decisions on behalf of the individual. Both England and Scotland have given the highest priority to the same criteria. What does this tell us about the approach to proxy decision-making in England and Scotland? Although the fact that both jurisdictions do not agree upon the appropriate term to describe the test for proxy decision-making, the substantive similarities between the best interests test and the benefit test cannot be ignored; neither term has been given explicit definition, with both England and Scotland preferring to allow individual circumstances to inform the manner of the intervention. However, in both England and Scotland, the past and present wishes and feelings of the individual have been deemed to be of the

highest importance, followed by the wishes of those individuals who are closely connected to the individual, such as family and carers. It must be noted however that with regards to the Scottish position, the 2000 Act does not make it immediately clear as to whether the criteria laid down in s.1(4) is directly applicable to the issue of benefit. What readers are told is that the criteria should to be used when making a decision on the nature of an intervention. 'Benefit' as a concept is not mentioned within s.1(4), but is instead mentioned earlier in s.1(2) independently of the criteria of s.1(4). By contrast, the equivalent criteria in the 2005 English Act is explicitly stated as being connected to the concept of best interests, by virtue of its inclusion within section 4 of the Act, which deals specifically with best interests. However, this could ultimately be argued as being an issue of semantics rather than a discernible difference between the English and Scottish approaches. The s.1(4) criteria of the 2000 Scottish Act is to be relied upon when deciding on whether an intervention is to be made, and how to make it. What the reader has been told is that the intervention must benefit the adult. In essence therefore, the criteria of s.1(4) can ostensibly be directly linked to the issue of benefit. Be this as it may, the fact that this issue has been highlighted in this analysis illustrates that the 2000 Scottish Act suffers from a lack of clarity. Intervention on behalf of an incapable adult is a crucial aspect of capacity law, and this has been accepted in the Scottish discussion and consultation papers. Ultimately, very little of the Act focuses upon the concept of benefit compared to the English Mental Capacity Act. Whilst a determination of what benefits an individual will often depend on individual circumstances, the provisions concerning best interests under the Mental Capacity Act 2005 show that some criteria will be universally applicable in all cases e.g. whether the individual will regain capacity and encouragement of the individual to participate in the decision-making process will be applicable in almost all cases. One might therefore argue that the Adults with Incapacity (Scotland) Act 2000 could conceivably have included greater detail as to what should be taken into account when deciding on whether a particular intervention would benefit the individual, perhaps in a separate section as opposed to three sentences in the 'general principles' section of the Act. It can therefore be seen that the concepts of best interests and benefit are very similar. Both concepts emphasise the need to balance a hard paternalism approach with a more pro-autonomy approach (in essence, both tests contain an element of substituted judgment which has been given priority above the wishes and opinions of others). Both concepts also lack

an explicit definition. However, the best interests test as laid down in section 4 of the Mental Capacity Act 2005 contains significantly more detail than the explanation of the concept of benefit laid down in the 2000 Scottish Act.

As with much of its capacity law, the position in India with regards to proxy decision making and best interests has not been formally developed. The 1994 Pune hysterectomies scandal highlights similar issues to those raised in English sterilisation cases. The operations were proposed in order to help the women manage their menstrual hygiene and also to safeguard against unwanted pregnancy⁵⁶⁴. However, the proposed operations were denounced by women's rights groups who stated that hysterectomy operations were not justifiable for the purposes of eliminating menstrual periods, as the primary motivation was for the convenience of the carers rather than the welfare of the individual⁵⁶⁵. This in essence mirrors the approach taken by English cases such as *Re F (Mental Patient: Sterilisation)*, *Re A (Medical Treatment: Male Sterilisation)* and *Re SL (Adult Patient: Medical Treatment)* which confirm that any proposed operation can only be justifiable if in the best interests of the individual. In addition, the guidelines published by the Forum for Medical Ethics confirm that performing a hysterectomy operation for the purposes of eliminating menstrual hygiene is justifiable subject to evidence that any breach of hygiene is hazardous to the patient's well-being, again illustrating a rudimentary best interests approach. In addition, reference is made to the principle of least restrictive alternative by virtue of the fact that a hysterectomy is not permitted solely to prevent pregnancy when there are less invasive procedures which would accomplish this objective⁵⁶⁶. It can therefore be seen that both the U.K and Indian approach to best interests have similar starting points. The main difference lies in the extent to which India's system has developed. Literature on India shows recognition of the need to safeguard the welfare of incapable adults, but this has not yet developed to the extent that it has been brought before the courts or enshrined in legislation. In addition, the literature

⁵⁶⁴ Author unspecified (1994) *Removing the Uterus from Mentally Handicapped Women: Some Ethical Considerations*; Indian Journal of Medical Ethics; Vol. 1(3); accessed on 18/01/2006; available online at <http://www.issuesinmedicalethics.org/013mi010.html>.

⁵⁶⁵ PARYAY (1994) *Hysterectomy in the Mentally Handicapped*; Indian Journal of Medical Ethics; Vol. 2(1); accessed on 18/01/2006; available online at <http://www.issuesinmedicalethics.org/021mi006.html>.

⁵⁶⁶ Author unspecified (1994) *Suggested Guidelines for Hysterectomy in Mentally Handicapped Women*; Indian Journal of Medical Ethics; Vol. 1(4). Accessed online on 18/01/2006; available at <http://www.issuesinmedicalethics.org/014mi002.html>.

highlights that there is a greater emphasis placed upon the status approach in India in comparison to the United Kingdom. This notwithstanding, the fact the discussion on the relevant issues has begun means that there is scope for development in the future.

As stated earlier in this chapter, the literature review pertaining to India has shown that communitarian and familial values carry as much importance as values which emphasise the needs of the individual. This must not be taken as meaning that the needs, wishes and feelings of the individual are disregarded altogether; it is simply that the emphasis on the individual appears not to be as pronounced as it is in England and Scotland. How then might a communitarian approach apply to decision-making on behalf of an incapable adult? In his twelve point checklist⁵⁶⁷ which is discussed in Chapter 4.3 of this thesis⁵⁶⁸ Ward gives primary importance to the competent decisions of the individual, past and present. He subsequently states that the choices, wishes and feelings of the individual should be considered if a competent decision is not ascertainable. The crux of the issue is that any ascertainable decisions and wishes of the individual must be given paramount importance in keeping with the empowerment ethos of the law of capacity. Ward also highlights any information from those closest to the individual as being a potentially useful factor in proxy decision-making. It is submitted that of particular relevance to an Indian approach to decision-making is the ninth factor on Ward's list; the shared views and ethos of the adult's family. This criterion suggests a communitarian approach to decision-making, where the family get together and collectively decide on the best approach. Ward does not give particular importance to this approach, only prioritising it above the shared views and ethos of others associated with the individual, such as religious or ethnic groups, and the norms of society. Given the apparent importance placed upon collaborative decision-making, one could argue that were Ward's list to be constructed in an Indian context, the shared views and ethos of the family would occupy a higher position in the list alongside the views and decisions of the individual themselves. It is difficult to be definitive on this of course, but existing literature suggests that decision-making within Indian families can be a collaborative

⁵⁶⁷ Ward, A.D (2003) *Adult Incapacity*; W. Green/Sweet and Maxwell Edinburgh at Para 15.9.

⁵⁶⁸ See Chapter 4.3 of this thesis at 146.

process⁵⁶⁹. Such an approach would necessitate greater priority being given to the views and ethos of family members as well as the individual themselves.

Given that the English and Scottish approach to decision-making on behalf of the incapable adult prioritises the decisions, wishes and feelings of the individual as far as these are ascertainable, this raises the question of whether the English and Scottish legislations allow for best interests or benefit determinations to be made in the context of a collaborative i.e. communitarian approach. Such an approach will be possible, particularly under the Mental Capacity Act 2005. Section 4(6)(b) of the Mental Capacity Act 2005 allows for the decision-maker to consider the beliefs and values that would be likely to influence the incapable adult's decision if capacity was present. The Act does not permit the family members to actually make a final treatment decision on behalf of an incapable family member, but it may be possible to ascertain evidence showing that collaborative or deferred decision-making was part of the individual's value system, i.e. that the individual often or always made the autonomous decision to make treatment decisions with family members or defer decisions to them entirely. This is no less of an autonomous process than if the individual had come to a decision entirely by themselves. Therefore, the decision maker must consider whether the adult, before the onset of incapacity, chose to collaborate with or defer decisions to family members and whether this process was part of the individual's belief or value system as specified under s.4(6)(b) of the Mental Capacity Act 2005. Although the family would not retain the right to make any final decisions, their consistent involvement in the decision-making of the incapable adult could be used by the healthcare professional when deciding whether a particular course of action is in the individual's best interests.

Whether the Adults with Incapacity (Scotland) Act 2000 equally takes account of communitarian decision-making as part of a belief or value system is more difficult to ascertain. Although s.1(4) of the Act does make reference to the present and past wishes of the adult as well as the views of the nearest relative and primary carer of the

⁵⁶⁹ Laungani, P (1997) *Mental Illness in India and Britain: Theory and Practice*; Medicine and Law; Vol. 16(3), 509-540; Rack, P (1982) *Race, Culture and Mental Disorder*, Routledge Press at 73; Juthani, N.V (2001) *Psychiatric Treatment of Hindus*, International Review of Psychiatry, Vol. 13(2), 125-130; Venkoba Rao, A (1981) *Mental Health and Ageing in India*, Indian Journal of Psychiatry, Vol. 23(1), 11-20.

adult, there is no reference made to the beliefs and values of the adult. Therefore, the only possible way for a family to establish that a collaborative or deferred system of decision-making was part of the incapable adult's belief or value system is to establish that this approach was an important aspect of the individual's past wishes or feelings. However the fact that the Mental Capacity Act 2005 refers to the past and present wishes and feelings of the individual separately from any reference to the beliefs and values of the individual⁵⁷⁰ shows that there is a difference between the two criteria. The past and present wishes and feelings of the individual are applicable to each particular treatment decision, as opposed to beliefs and values, which will inform many aspects of an individual's life. In the light of this, the Adults with Incapacity (Scotland) Act 2000 arguably fails to sufficiently consider the impact of beliefs and values when deciding whether a particular intervention will benefit the individual. This is not to say that beliefs and values are specifically excluded from the legislation, but their potential impact upon families of Indian origin residing in Scotland appears not to have been fully appreciated.

6.4: PROCEDURAL JUSTICE

There is little doubt that both England and Scotland had virtually identical objectives when their respective governments drafted both pieces of legislation. Both jurisdictions have placed maximum emphasis upon the welfare and best interests of the individual throughout both statutes, and this stance has been maintained in relation to the procedural aspects of incapacity law for both England and Scotland. Although England and Scotland are both ostensibly similar in terms of what they are trying to achieve, closer examination of the procedural aspects reveals some differences in approach.

With regards to the English position, analysis of the procedural mechanisms provided by the Mental Capacity Act 2005 show that the incapable adult has been provided with ways in which they can take control of medical treatment decisions even after the onset incapacity. The option to specify an advance refusal of treatment is provided for under sections 24 to 26 of the Mental Capacity Act 2005 which will allow the

⁵⁷⁰ Mental Capacity Act 2005, s.4(6).

incapable adult to make a treatment decision which is as valid as a decision made when capable. This is in keeping with the empowerment theme of the Act, and also satisfies the procedural principle of participation, which stipulates that the individual be provided with the opportunity to participate as fully as is practicable in any proceedings relating to themselves. This principle is also satisfied through the option of creating a Lasting Power of Attorney document under s.9(1) of the Mental Capacity Act 2005. As with advance refusals of treatment, Lasting Powers of Attorney enable the incapable adult to specify what should be done in relation to welfare matters upon the onset of incapacity. The attorney appointed must carry out his/her duties in keeping with the general principles of the Act and the scope of the attorney's powers are at the discretion of the donor i.e. the individual who created the L.P.A document. The fact that the donor can specify precisely when the attorney can and cannot act again satisfies the procedural principle of participation. In addition, the principle of accuracy is satisfied because the detail required by both advance refusals of treatment and L.P.A documents means that there is less chance of the individual's wishes being incorrectly carried out or ignored.

As an additional safeguard, Part 2 of the Mental Capacity Act 2005 establishes a Court of Protection. Under s.47(1), the Court of Protection has the same rights, privileges and authority as the High Court, which retains its inherent jurisdiction and power to issue declarations wherever there is a serious justiciable issue concerning the best interests of an incapable adult⁵⁷¹. Section 15 of the Act confirms the power of the Court of Protection to make declarations on specific issues relating to the capacity of an individual and the lawfulness of any act done in furtherance of the individual's best interests. This power would also ensure compliance with Article 6 of the European Convention on Human Rights, which provides the right to a fair and impartial trial within a reasonable amount of time. In the context of capacity, this must include the right to challenge any finding of incapacity particularly since, as Ward states, **“The right to act for oneself and make one's own decisions in matters of one's own personal welfare, or about one's own property and financial affairs, is a fundamental civil right.”**⁵⁷² In addition under s.50 of the Mental Capacity Act 2005, the incapable adult does not require permission to apply to

⁵⁷¹ *Re F (Adult Court's Jurisdiction)* [2001] Fam 38.

⁵⁷² Ward, A D (2003) *Adult Incapacity*; W Green/Sweet and Maxwell Edinburgh at Para 1.47.

the Court of Protection, which will help to uphold the procedural principle of participation.

It can be seen that the principles of accuracy and participation are appropriately represented within the procedural mechanisms of the Mental Capacity Act 2005. In addition, a number of safeguards are in place to ensure that the Court of Protection discharges its duties towards the individual appropriately. The Act makes provision for the court to appoint deputies should there be a need for an ongoing process of decision-making powers and if a Lasting Power of Attorney has not been set up⁵⁷³. Deputies are in turn supervised by the Public Guardian to ensure that they are suitable to carry out their duties. In order to provide further support to the incapable adult who has nobody else is available for consultation, s.35 of the Act establishes a system of Independent Mental Capacity Advocates to further enable the individual to participate in any proceedings relating to them thus further upholding the principle of participation.

The procedural mechanisms laid down in the Mental Capacity Act 2005 appropriately consider the need to empower the individual to take control of decisions relating to themselves through the creation of documents such as advance refusals of treatment or Lasting Powers of Attorney, whilst also giving importance to the need to adequately safeguard the welfare and best interests of the individual, particularly when an application needs to be made to the Court of Protection. However, one important procedural principle, the principle of conciliation, has not been represented as effectively as it could have been.

The Court of Protection is intended to be accessed as an option of last resort, with the ideal scenario being that an individual will have successfully utilised other options to have their welfare needs met, such as advance refusals of treatment or Lasting Powers of Attorney. The Draft Court of Protection Rules 2006 made extensive reference to pre-action protocols, which it was envisaged would encourage dispute resolution between parties in a more conciliatory manner which would not require an application to the Court of Protection⁵⁷⁴. However, any reference to pre-action protocols has since been removed and the final Court of Protection Rules 2007 make no reference to

⁵⁷³ Mental Capacity Act 2005, s.16.

⁵⁷⁴ Draft Court of Protection Rules 2006, Draft Rule 12.

them. Further research in to why this is the case has provided no answer as to why this has happened, and it is submitted that the removal of pre-action protocols from the Court of Protection Rules 2007 was a mistake in the context of upholding the principle of conciliation.

How then, does the provision of procedural justice under the Mental Capacity Act 2005 compare with procedural justice as provided by the Adults with Incapacity (Scotland) Act 2000? As with the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 promotes the autonomy of the incapable adult wherever practicable, coupled with appropriate measures to safeguard the individual's welfare. However, it is submitted that the procedural mechanisms that are in place prioritise safeguarding the individual ahead of empowering them to take control over treatment decisions in the event of incapacity.

Section 16 of the 2000 Act allows the creation of a Welfare Power of Attorney which, as with the Lasting Power of Attorney in English law, allows the individual to appoint an attorney to act on their behalf once incapacity has manifested. The attorney must apply the general principles of the Act at all times and must encourage the individual to exercise any skills that might be present despite the onset of incapacity. In this way, the substantive principle of autonomy and the procedural principle of participation will ideally be upheld. This can be compared to the position regarding Lasting Powers of Attorney under the Mental Capacity Act 2005. However, a major failing of the Adults with Incapacity (Scotland) Act is the exclusion of the option to create advance statements on medical treatment.

As evidenced by the Mental Capacity Act 2005, advance statements are arguably the most effective way that an individual can take control of treatment decisions even after capacity no longer exists. This is central to the pro-autonomy ethos of capacity law and also upholds the procedural principles of accuracy and participation. The principle of accuracy will be upheld because advance statements provide a clear statement of the individual's wishes, thus minimising the chances of misinterpretation of these wishes. Furthermore, the principle of participation will be satisfied through the execution of the individual's wishes even after the onset of incapacity. It is therefore surprising that advance statements are not provided for within the legislation, particularly given that they would subsequently be included in legislation

via the Mental Health (Care and Treatment) Scotland Act 2003. Therefore, an opportunity to further promote the principles of autonomy, whilst also promoting important procedural principles has been missed.

As with the Court of Protection in English capacity law, Scottish capacity law allows for court applications to be made, this being the Sheriff Court.

As things stand, applying to the Sheriff Court is a complicated process. To illustrate this point, consider the fact that there are effectively three ways in which an individual may make an application to the Sheriff court; these are under s.14 (Appeal against decision as to incapacity), s.50 (Medical treatment where guardian etc. has been appointed) and s.52 (Appeal against decision as to medical treatment) of the 2000 Act. In addition to this, s.50 appeals are again split into sub-categories; under s.50(3) and s.50(6), and can only be utilised when a decision has been made by a medical practitioner. By contrast, s.52 is more general in scope. Whilst it cannot be doubted that the purpose of this overabundance of formal procedure is to safeguard the interests of the individual, it could equally be argued that the opposite effect will be achieved.

It is submitted that in order to achieve procedural justice for the individual, it is not only necessary to provide adequate safeguards, but also necessary to do so without unnecessarily stigmatising the individual in the process. The English case of *R v Bournewood Community and Mental Health N.H.S Trust, ex parte L*⁵⁷⁵ highlights the potential incompatibility of these two factors:

Bournewood concerned L, a 48 year old autistic and mentally retarded gentleman who had a history of self-injurious behaviour. Although L had been resident in a hospital for over thirty years, he had eventually been released to live with paid carers whilst still under the care of the hospital. In 1997 L became agitated a day care centre, and since his carers could not be contacted, he was taken to the behavioural unit of the hospital. L's consultant decided that it would be in his best interests to be readmitted so that his condition might stabilise. Since L was compliant, it was not considered necessary to detain him compulsorily under s.3 of the Mental Health Act 1983. L was therefore detained informally in an unlocked ward under s.131(1) of the 1983 Act. L's

⁵⁷⁵ [1999] 1 A.C 458; hereafter referred to as *Bournewood*.

carers did not believe that L was lawfully detained and sought judicial review on his behalf. The court held that since L had been informally admitted and that the doctrine of necessity had been complied with, his detention was lawful and the application for habeas corpus was subsequently refused. On appeal, the Court of Appeal held that s.131 was designed for patients who actively complied with informal admission. Since L had not actually consented, but rather, simply not objected, his detention could not be justified. Bournemouth subsequently appealed the decision and won. In his decision, Lord Woolf outlined the possible justification for L's detention, and in doing so, outlined the potential dichotomy between safeguarding the individual and stigmatising him:

“The starting point of the common law is that when a person lacks capacity, for whatever reason, to take decisions about medical treatment, it is necessary for other persons, with appropriate qualifications, to take such decisions for him... against this common law background the Percy Report recommended a shift from the ‘legalism’ whereby hospital patients were ‘certified’ by special procedures, to a situation in which most patients would be ‘informally received’ in hospital, the term ‘informally’ signifying ‘without legal formality’... the desired objective was to avoid stigmatising patients and to avoid where possible the adverse effects of ‘sectioning’ patients. Where admission to hospital was required compulsion was to be regarded as a measure of last resort.”⁵⁷⁶

In essence, the conflict in *Bournemouth* was as follows: In detaining L informally, the process was considerably less stigmatising for him; he was not locked in his room nor forced to remain against his will. However, in being detained informally, L was effectively denied the legal safeguards that a patient formally detained under s.3 of the Mental Health Act 1983 would be privy to.

Ultimately, it is a question of which of the two aspects of patient care deserves priority. One could argue that Scotland's decision to put large amounts of formal procedure in place clearly indicates that the need to adequately safeguard the incapable adult has been prioritised, albeit at the expense of stigmatising the individual. Proponents of this approach could argue that an exhaustive set of

⁵⁷⁶ Per Lord Woolf at 496.

safeguards is essential when dealing with incapable adults; unfortunate though it may be, incapable adults are in a more vulnerable position, and the very fact that specific legislation has been deemed necessary in both England and Scotland confirms further that this is the case. The concept of 'benefit' plays an important part in the 2000 Act, and ensuring that individuals are protected at all times against ill-treatment and unnecessary interventions could be argued to be of the most benefit. Furthermore, such benefit might arguably be worth drawing attention to an individual's condition. Conversely however, opponents of Scotland's approach to procedural justice could argue that the 2000 Act has failed to adhere to another important principle of capacity law, namely the principle of non-discrimination. The need to promote an individual's autonomy and to keep them involved in their own lives as much practicable is one of the fundamental principles of the law of capacity in both England and Scotland. It could therefore be argued that the level of emphasis placed upon formal procedural justice in Scotland potentially draws too much attention to an individual's incapacity. Indeed, an individual's incapacity has been 'formalised' to a great extent in Scotland as shown by the requirement that a certificate of incapacity must be filled out once a medical practitioner has confirmed an individual's incapacity. In addition to this, it could be argued that the methods of lodging an appeal are so convoluted that individuals may be put off from seeking justice in this manner. Also, there is little emphasis placed on the fact that some disputes could potentially be resolved without recourse to the courts, thereby effectively leading individuals to believe that going through the lengthy process of applying to the court is the only option available. Therefore, an individual's condition is brought to the forefront of proceedings further, thus potentially stigmatising the individual further. In turn, it could be argued that Scottish capacity law, by over-emphasising the need for formal procedure are doing the same to the individual's incapacity, and thus failing to satisfy the principle of non-discrimination. Scottish capacity law, as with England, stresses the importance of promoting the autonomy of the individual, and along with this, the premise that the presence of incapacity should not always be a barrier to being able to make decisions as a person with full capacity would. However well intentioned Scotland's penchant for formal procedure may be, a potential consequence of this is that the individual would be required to formally and publicly state that he/she is suffering with some particular form of incapacity, which in turn increases the chances of the individual being labelled with the status of an incapable adult whose decision-making abilities

are lacking across all aspects of life. This status approach has been rejected in Scottish law by virtue of the emphasis that has been placed upon the autonomy of the individual⁵⁷⁷, yet placing an individual in a position whereby their disorder or impairment is made the focus of proceedings, as opposed to simply using proceedings to allow the individual to express wishes and opinions, may actually do more to promote the status approach than to reject it. In comparison, England's proposals for the new Court of Protection appear at least in principle to have struck the correct balance between safeguarding the individual and not stigmatising them unnecessarily. When it is decided that an application to the court is necessary, the process is simpler when compared to Scotland's. However, by proposing a simpler approach, it does not mean that England has disregarded safeguards entirely. Instead, a pragmatic approach has been proposed, where the Court of Protection is available should a case warrant its involvement, but with emphasis placed upon the individual taking control over decisions so that applications to the Court will not be necessary. By contrast, Scotland's approach, though undeniably well intentioned, is arguably too complicated for many to comprehend, and the convoluted approach risks alienating those who are in genuine need of procedural justice. Furthermore, the lack of emphasis upon resolving cases without court intervention also increases the possibility of courts being overburdened with cases, thus increasing the possibility of non-compliance with Article 6 of the E.C.H.R on the grounds that access to the courts may not be possible within a reasonable amount of time. It should be noted that Scottish capacity law has not yet been challenged under Article 6 of the E.C.H.R, but it is submitted that a greater emphasis upon alternatives to Sheriff Court applications would further reduce the chances of such a challenge being made.

The importance of the procedural principles as laid down in the Council of Europe's Recommendation (99)4 was discussed in Chapter 2.2 of this thesis. To what extent do the procedural mechanisms of both the English and Scottish legislations take note of the guidance given in Recommendation (99)4?

With regards to the Mental Capacity Act 2005, some of the points raised in the procedural guidelines are dealt with in the general principles of the 2005 Act.

⁵⁷⁷See Scottish Law Commission Discussion Paper No. 94 (1991) *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at Para 3.5.

Principle 11, in stating that an individual must be informed of proceedings in a manner and language which they will understand, is in essence a re-iteration of s.3(2) of the Act, which states that an individual should not be deemed incapable of understanding information if he/she is able to understand an explanation given in a manner appropriate to their circumstances. The rule which allows informing the individual of proceedings to be bypassed on the grounds of health could be argued to be covered by the Act via the inclusion of the best interests standard in s.4. As this states that any intervention on behalf of an individual must be in their best interests, it could be argued that this includes omissions as well as acts i.e. not disclosing information to protect the health of the individual. Indeed, the best interests standard is unsurprisingly a common thread throughout the procedural guidelines of Recommendation (99)4. This can be seen in particular in principles 12-14, which deal with investigation and assessment, the right to be heard in person and duration, review and appeal respectively. Emphasis has been placed upon the incompatibility with European guidance of actions which unnecessarily restrict the legal capacity of the individual, commit the individual to proceedings which are unnecessarily long in duration, and which provide no adequate rights of appeal. All these rules could be identified as clear indicators that the interests of the individual take priority.

With regards to Scotland, the fact that the legislation has been in operation for the last five years suggests that the 2000 Act has adequately taken into consideration the guidelines of the Council of Europe. However, it could be argued that greater priority has been given to the procedural guidelines given in Recommendation (99)4 than the general principles that the document provided. As stated earlier, Scotland's procedural mechanisms are considerably more formal and complex than those proposed by England in the 2005 Mental Capacity Act. The advantage of this could be argued as being that the individual would be privy to a significant amount of legal safeguards. Furthermore, certain aspects of the procedural guidelines proposed by the Council of Europe appear to have been followed by Scotland to the letter. An example of this can be found s.11 of the 2000 Act, which deals with the intimation of proceedings to the individual. This is essentially a reiteration of Principle 11 of Recommendation (99)4, which deals with the institution of proceedings, and more specifically, the requirement that the individual must be informed of the institution of any proceedings made concerning them. In addition, both Recommendation (99)4 and s.11 of the 2000

Act state that this requirement may be waived if the health of the individual would be affected by being notified of the institution of proceedings. As per Principle 12 of (99)4, the individual's capacity must be investigated and assessed. A section 47 certificate could be construed as satisfying the requirement that an up-to-date report must be published in writing. The individual also has the right to be present at the proceedings as dictated by Principle 13 of Recommendation (99)4⁵⁷⁸ Rights of appeal are also present⁵⁷⁹ as per Principle 14 of (99)4.

It is clear that Scottish capacity law under the 2000 Act has placed procedural protection at a high priority. This is to be commended, particularly in the light of the apparent influence of the Council of Europe. However, the great emphasis placed upon procedural justice could be argued to have led to a neglect of the potential discomfort of the individual during proceedings. Although intimation of proceedings can be waived on the grounds of health, the complexity of the procedural aspects of the 2000 Act means that individuals wishing to utilise the courts may be daunted by the process involved. Whilst it is undoubtedly crucial to adhere to the procedural guidelines laid down in Recommendation (99)4, it is equally important to adhere to the general principles which concern the welfare of the individual. Whilst well intentioned, it is arguable that Scottish capacity law has prioritised procedure over other considerations.

Given that the capacity law of India has not yet developed in any significant way, it is unsurprising that procedural justice for incapable adults is equally undeveloped. Indian law does however make provisions for declaratory relief to be sought. This means that the system could theoretically be used in a capacity context similar to the English approach. Prior to the implementation of the Mental Capacity Act 2005, declarations could be granted by the High Court if there was a serious justiciable issue brought before it, which, as was confirmed in *Re S (Hospital Patient: Court's Jurisdiction)*⁵⁸⁰ and *Re F (Adult: Court's Jurisdiction)*⁵⁸¹ could be any issues relating to the best interests of the individual. The common law jurisdiction still prevails in India, and given the availability of declaratory relief, this jurisdiction could be invoked to resolve capacity matters. However, as stated in Chapter 5 of this thesis, it

⁵⁷⁸ Scottish Law Commission Discussion Paper No. 94 (1991) at Para 6.7

⁵⁷⁹ Adults with Incapacity (Scotland) Act 2000 s. 53.

⁵⁸⁰ [1996] Fam 1.

⁵⁸¹ [2001] Fam 38.

is first necessary for somebody to want to avail themselves of this, and it currently remains to be seen when the law of capacity will develop to the extent that declaratory relief will be sought in its context. However, the system of declaratory relief did not develop in the context of capacity until *Re F (Mental Patient: Sterilisation)*⁵⁸² in 1990. In the same way, the possibility of a similar development in Indian law cannot be discounted entirely.

Indian law also recognises the importance of alternative methods of dispute resolution. This is highlighted by the system of Lok Adalats which are used to resolve financial disputes before in a conciliatory compromising manner as an alternative to seeking redress in the courts. This shows that the importance of the principle of conciliation is recognised to some extent in India, and it is therefore submitted that a similarly modelled system may be useful in resolving disputes relating to capacity before an application to the courts are made. Again, it will first be necessary for capacity issues to be deemed legally significant, but the system of Lok Adalats are worth highlighting as potentially useful were this to happen.

6.5: SUMMARY OF FINAL CONCLUSIONS

The research that has been undertaken for this thesis has revealed that the differences between the capacity law of England, Scotland and India are affected by both developmental and cultural issues. India's system is particularly underdeveloped when compared to that of the United Kingdom's, although analysis of existing literature has revealed that this development has begun, with journal articles in particular highlighting the Western approach to capacity and the potential impact of this upon Indian law. The crux of the matter is that this development is taking place more through academic commentary via journal and newspaper articles and books; the point has not yet been reached where these issues are being brought before the courts, much less being enshrined in legislation. The fact that some of the existing Indian literature makes direct reference to U.K and American capacity law suggests that the approach of these jurisdictions is becoming more influential. Subsequently, this influence could ostensibly translate to changes and development of the law.

⁵⁸² [1990] 2 A.C 1.

In addition, the research also confirmed the relevance of culture upon aspects of capacity law, as shown in particular by the principle of communitarianism and its potential impact upon the decision-making process. Research has shown that developmental and cultural factors may not always be mutually exclusive; shifts in ideology and culture may be significant enough so as to influence development of legal precedent. As attitudes towards women in the United Kingdom changed, so the law changed to reflect this in areas such as marital rape and the voting rights. Similarly, as U.K attitudes towards the incapable adults changed, development in the law continued to the point where there is now specific legislation governing capacity issues. Of course it is perhaps too simplistic to say that culture and legal developments will always have a symbiotic relationship; Indian law for example does not allow for discrimination against women, yet discriminatory practices and attitudes still continue. In England and Scotland, the existence of mental health and capacity legislations will not necessarily equate to a complete recognition of the relevant principles which underpin them. The purpose of this thesis is not to provide definitive answers to these questions, but rather, to raise and highlight them in greater detail than has already been done in existing literature. Speculatively, it is submitted that for Indians resident in both India and the United Kingdom, a communitarian approach to decision-making is likely to prevail and thus remain an important cultural aspect of decision-making within families.

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