

PROTECTING PATIENTS FROM THEIR BAD DECISIONS: REBALANCING RIGHTS, RELATIONSHIPS AND RISK

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Abstract:

Patients have a right to autonomy that encompasses making medical decisions that others consider 'bad'. The ambits of this right in law and clinical practice are explored in this article, which describes an expansion of welfare protections across different aspects of medical law and explores their justifications and implications. In England and Wales, the Mental Capacity Act 2005 sets out protections for those who fall within its definition of incapacity. Those who retain capacity are ostensibly free to make decisions others consider unwise. But the decisions of those with borderline capacity; those whose decisions conflict with the public interest in protecting the patient from harm; and those considered 'vulnerable' are, in circumstances explored in this article, susceptible to override. The article explores the effects of these developments on the relationship between patients' autonomy rights and clinicians' responsibilities.

Keywords

Autonomy; capacity; consent; necessity; paternalism; vulnerability

I. INTRODUCTION

The question at the heart of this article is: When should patients be protected from their 'bad' medical decisions? It focuses on changing legal conceptions of capacity and their effects in the context of clinical practice. Patients have not always had a meaningful role in the decision-making process. Patient autonomy has replaced the beneficence-model at the heart of ethical medical

practice,¹ but the contested scope of autonomy and paternalism result in a precarious balance.² One of the ways in which the law in England and Wales protects patient autonomy is by requiring informed consent.³ Doctors can be held liable in negligence if they fail to take reasonable steps to ensure that patients are aware of risks that are material to them.⁴ The validity of consent is governed by the law of battery. Consent must be 'real'; that is, the patient must be informed in broad terms, voluntary and competent.⁵ These requirements impose duties on clinicians to protect and respect patient autonomy, but also restrict the powers of patients to consent where they are perceived to lack voluntariness or competence. The latter is governed by the Mental Capacity Act 2005 and accompanying Code of Practice, which set out how to make health, welfare and financial decisions with or on behalf of adults aged 16 and over who are unable to achieve mental capacity. At the core of the Act are five principles, set out in section 1:

(1) A person ['P'] must be assumed to have capacity unless it is established that he lacks capacity.

(2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

¹ See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [68] per Lords Kerr and Reed; [108] per Lady Hale.

² F Freyenhagen, R O'Shea, 'Hidden Substance: Mental Disorder as a Challenge to Normatively Neutral Accounts of Autonomy' (2013) 9(1) IJLC 53.

³ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936, reg 11; *Montgomery* [2015] UKSC 11, [87] per Lords Kerr and Reed.

⁴ *Ibid*, [108] per Lady Hale.

⁵ *Chatterton v Gerson* [1981] QB 432.

(4) 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.

(5) Before the act is done, or the 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.

The principles protect rights to autonomy (Principles 1-3) and liberty (Principle 5). Principle 4 sets out welfare considerations applicable to those who are unable to achieve mental capacity. This occurs when P satisfies the test for incapacity set out in sections 2(1) and 3(1) of the Act; namely that P (i) has an impairment or disturbance in the functioning of the mind or brain; and (ii) is unable to understand the relevant information, retain it, use or weigh it and communicate the decision. Where P lacks capacity, a best interests framework applies. Decisions are made on behalf of P according to a checklist set out in section 4 of the Act.

For those with capacity, freedom to make medical decisions is fettered in a number of ways.⁶ Restrictions in the public interest include possible detention of those with mental disorder under the Mental Health Act 1983 and, in the case of some infectious diseases, limitations on rights to confidentiality and of freedom of movement.⁷ There are also limits on the treatments patients can

⁶ A detailed taxonomy is set out in R Huxtable, 'Autonomy, Best Interests and the Public Interest: Treatment, No-Treatment and the Values of Medical Law' (2014) 22 Med LR 459.

⁷ Public Health (Control of Disease) Act 1984, ss 35-38. More draconian powers may be available in a 'public health emergency of international concern'. The WHO's *International Health Regulations* 2005, Article 18(1) sets out provision for temporary recommendations that 'require vaccination or other prophylaxis'. See also Article 23(4) requiring informed consent and exceptions set out in Article 32(2), 'to the extent necessary to control a risk'. These measures are discussed in E Cave, 'Voluntary vaccination: the pandemic effect' (2016) LS forthcoming.

demand. There is no obligation to offer treatment that serves no therapeutic purpose⁸ and the NHS has limited resources that must be fairly allocated. Subject to these restrictions (which will not be further explored in this article), the law has traditionally upheld the rights of patients with capacity to decide, even when the decision will cause the patient harm⁹ and even when the decision is irrational.¹⁰ The position is neatly articulated by MacDonald J. in *Kings College Hospital NHS Foundation Trust v C and V*:

A capacitous individual is entitled to decide whether or not to accept medical treatment. The right to refuse treatment extends to declining treatment that would, if administered, save the life of the patient. ... Within this context, where a patient refuses life saving medical treatment the court is only entitled to intervene in circumstances where the court is satisfied that the patient does not have the mental capacity to decide whether or not to accept or refuse such treatment.¹¹

As MacDonald J. asserts, the justification is the protection of autonomy rights:

This position reflects the value that society places on personal autonomy in matters of medical treatment and the very long established right of the patient to choose to accept or refuse medical treatment from his or her doctor Over his or her own body and mind, the individual is sovereign (John Stuart Mill, *On Liberty*, 1859).¹²

⁸ See *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [43] per Lady Hale: 'A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability'. And see *R (Burke) v GMC* [2005] EWCA Civ 1003.

⁹ Mental Capacity Act 2005, s 1(4).

¹⁰ *Re MB* [1997] EWCA Civ 3039, [16].

¹¹ *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80, [1]-[3].

¹² *Ibid.*

The next section analyses recent developments that restrict the sovereignty of individuals to make what others perceive to be 'bad' medical decisions. I go on to contend that at the heart of these changes is a commitment in law to a modified form of autonomy rights accommodating both internal and external forces on the mind. Assumptions that the Mental Capacity Act comprised a complete civil law statutory code were flawed.¹³ I argue that law and professional guidance has developed to fill a lacuna that resulted from a predominantly procedural definition of mental capacity which inadequately protected those whose harmful decisions flowed from external forces such as undue influence. However, I warn that the developing legal recognition of autonomy poses dangers of paternalism that are accentuated by new laws on professional accountability for patient neglect. The developments have implications for the relationship between patient rights and professional practice, explored in the latter sections of the article.

II. PROTECTING PATIENTS FROM 'BAD' DECISIONS

This section explores three of the ways in which those who have mental capacity (as defined by the 2005 Act) or are capable of its achievement might nonetheless be subjected to protections from their own decisions when the outcome threatens the individual's life or health. In each case the Mental Capacity Act test for capacity is circumvented by a different mechanism: namely manipulation of the 2005 Act test for capacity; the establishment of an alternative test; and the overriding of a capacitous decision in the public interest. The first concerns borderline mental capacity. The subjective nature of the functional test for incapacity can lead to mislabelling a decision as incapacitated in order to afford the individual welfare protection. The second concerns those whose vulnerability is caused by reason other than mental incapacity. Doubt as to the exhaustive nature of the 2005 Act has recently been resolved, confirming the potential application of the inherent jurisdiction of the High Court as a safety net to protect the vulnerable. Finally, this section considers the ambits of the public interest in protecting patients from serious harm when

¹³ Expressly acknowledged in *XCC v AA* [2012] EWHC 2183 (COP), [52] per Parker J.

they attempt to restrict the disclosure of confidential information to third parties. I shall argue that the public interest defence to breach of confidentiality has expanded in response to the Mental Capacity Act's restrictions of the best interest test to those lacking mental capacity.

A. Allowing the Tail of Welfare to Wag the Dog of Capacity

Where a patient makes a harmful decision about serious medical treatment, the 2005 Act provides that the assumption of capacity can only be rebutted on the basis of evidence of the individual's impairment and understanding of the decision in question. The Act eschews an outcome-based or status-based test in favour of a functional test for incapacity. Nonetheless, there is a possibility that evidence of impairment combined with a harmful decision might in practice lead to a finding that an individual lacks mental capacity.

This has been acknowledged in the Court of Protection. Peter Jackson J. in *Heart of England NHS Foundation Trust v JB* said:

The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular on whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity. Any tendency in this direction risks infringing the rights of that group of persons who, though vulnerable, are capable of making their own decisions.¹⁴

There is scope within the law for discretion in the application of the section 3(1) functional test, which generates considerable debate regarding its correct interpretation (only referred to here in the briefest of terms). Section 3(1) states that a person is unable to make a decision if he cannot (i) comprehend the information, (ii) retain it (iii) use or weigh and (iv) communicate the decision.

¹⁴ [2014] EWCOP 342, [7]. And see *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80.

Martin and Freyenhagen¹⁵ understand this to require a person with mental capacity to have five abilities (understand, retain, use, weigh, communicate) which will lead to more decisions being found incapacitous than would be the case if use and weigh were seen as synonyms or were required in the alternative.

According to the Act, a best interests assessment should be reserved for those situations when the individual is incapable of achieving mental capacity. But it should be noted that section 4(4) of the 2005 Act requires that the incapacitated individual participates in the decision and section 4(6) requires that best interests are determined in light of the individual's past and present wishes and feelings, beliefs and values. In the Court of Protection, the UN Convention on the Rights of Persons with Disabilities 2006 has enhanced protection of the autonomy interests of those lacking mental capacity. Article 12 protects the right to equal protection before the law, and to decision-making that reflects the will and preferences of the individual. Provided the individual is incapable of achieving capacity, this is a positive development. But there is a concern that it further blurs the line between capacity and incapacity. In *Re CD* Mostyn J. warned that: 'it is vital that wishes and feelings are strictly confined to the best interests analysis and do not act subtly to undermine a capacity assessment.'¹⁶

In clinical practice, the propensity for practitioners to decide that P lacks capacity on the basis that the decision is harmful, is well documented.¹⁷ Section 5 protects decision-makers from liability

¹⁵ W Martin, F Freyenhagen, 'Use or Weigh? Or Use and Weigh? A Note on the Logic of the MCA sec 3(1)'

Guest note in A Ruck Keene et al, Mental Capacity Law Newsletter December 2015: Issue 61, Court of Protection: Health, Welfare and Deprivation of Liberty. Online: <http://www.39essex.com/content/wp-content/uploads/2015/12/MC-Newsletter-December-2015-HWDOL.pdf>

¹⁶ [2015] EWCOP 74, [28].

¹⁷ Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-Legislative Scrutiny*, HL Paper 139, (March 2014), paras 56-58.

provided they have taken reasonable steps to establish that P lacks mental capacity. Williams et al refer to the ‘concertina effect’ where best interests and capacity assessments are conflated with the result that best interests determines whether or not an individual has capacity.¹⁸ Banner argues that the procedural legal test for mental capacity fits poorly with clinical reality where substantive elements may legitimately contribute to capacity assessment.¹⁹ In other words, the content of the decision may be relevant to the assessment of understanding. For example, the decision of a patient with anorexia nervosa to refuse food might be seen as evidence of an inability to use or weigh information about related treatment. In cases of borderline capacity there is therefore propensity in both law and practice to allow the outcome of an individual’s decision to affect the assessment of capacity.

B. Vulnerability and the Inherent Jurisdiction

The Mental Capacity Act focuses its protective regime on those incapable of achieving mental capacity, but recently an alternative route to protection for vulnerable individuals has been confirmed. Like the 2005 Act, this measure applies beyond the narrow focus of this article on patients making harmful medical decisions. Though the 2005 Act was designed as a ‘single comprehensive piece of legislation making provisions for people who lack capacity’,²⁰ it did not explicitly deal with those unable to make a valid consent or refusal due to involuntariness. During the passage of the Act, plans for comprehensive legislation that would protect vulnerable people

¹⁸ V Williams, G Boyle, M Jepson, P Swift, T Williamson, P Heslop, *Making Best Interests Decisions: People and Processes* (Mental Health Foundation, 2012), para 3.2.

¹⁹ NF Banner, ‘Can Procedural and Substantive Elements of Decision-Making be Reconciled in Assessments of Mental Capacity?’ (2013) 9(1) *IJLC* 71.

²⁰ Law Commission, *Mental Incapacity*, LawComm (No 231, 1995), para 1.1.

were scaled down in light of the complexity of developing case law on the issues of undue influence and voluntary decision-making.²¹

One of the 'complex cases' was the 1992 case of *Re T (adult: refusal of treatment)*²² in which a 20-year-old woman who was 34 weeks pregnant was admitted to hospital having been injured in a car crash. After a private conversation with her mother, a Jehovah's Witness, she signed a form refusing consent to blood transfusions. Her condition worsened, her child was still-born and T was transferred to the intensive care unit. On the basis of an application from her father and boyfriend, the Court of Appeal held that it would be lawful for the hospital to administer a life-sustaining blood transfusion.²³ A distinction was drawn between incapacity and involuntariness which could, separately or in conjunction,²⁴ justify overriding a patient's decision.²⁵ Incapacity could be the result of learning difficulties or mental illness, or of temporary factors such as pain, drugs or confusion.²⁶ Undue influence, on the other hand, could arise when the views of another acts so as to 'overbear the independence of the patient's decision'.²⁷ In 1886, Sir James Hannen P. in *Wingrove v Wingrove* described undue influence as a form of coercion:

The coercion may of course be of different kinds, it may be in the grossest form, such as actual confinement or violence, or a person in the last days or hours of life may have become so weak and feeble, that a very little pressure will be sufficient to bring about the desired result, and it may even be, that the mere talking to him at that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for

²¹ HM Government, *Making Decisions* (Cm 4465, 1999), para 20.

²² [1992] EWCA Civ 18.

²³ *Ibid*, [22].

²⁴ *Ibid*, [41] per Butler-Sloss L.J..

²⁵ *Ibid*, [22], [33] and [37].

²⁶ *Ibid*, [27] and [37].

²⁷ *Ibid*, per Lord Donaldson M.R., [31]: 'In other words "Is it a decision expressed in form only, not in reality?"'.

quietness' sake, to do anything. This would equally be coercion, though not actual violence.²⁸

The Mental Capacity Act came into force 15 years after *Re T*. The accompanying Code of Practice made clear the need to guard against undue pressure.²⁹ If the Act comprised a complete civil law statutory code, decisions of individuals could not be questioned outside its scope. But recently, the Court of Appeal confirmed in *KC v City of Westminster Social and Community Services & Anor*³⁰ and then *DL v A Local Authority & Others*³¹ that capacity to make decisions *can* be overborne by circumstances other than those covered by the 2005 Act; The inherent jurisdiction of the High Court survives the passage of the 2005 Act.

The facts of *DL v A Local Authority & Others*³² are these: A local authority applied to the court to protect two elderly people from their son, DL, who was exerting duress and undue influence upon them. Mr and Mrs L did not lack capacity under the 2005 Act but there were concerns that they were being pressured to move Mrs L into a care home and transfer ownership of their property to DL.

The Court of Appeal held that Mr and Mrs L lacked the ability to make a decision by virtue of undue influence. McFarlane L.J., who gave the leading judgment, held that the inherent jurisdiction should be applied to enhance the autonomy of the vulnerable, maximising their opportunity to make a voluntary decision.³³ The Court endorsed 'a facilitative, rather than a dictatorial approach ... which enhances, rather than breaches, their European Convention on Human Rights Article 8 rights'.³⁴

²⁸ [1886] 11 PD 81 at page 82, cited in *Re T (adult: refusal of treatment)*, *ibid*, [47].

²⁹ Department for Constitutional Affairs, Mental Capacity Act Code of Practice (TSO, 2007), para 2.8.

³⁰ [2008] EWCA Civ 198, [12]. And see *Local Authority X v MM & KM* [2007] EWHC 2003 (Fam), [87], [111] and [167].

³¹ [2012] EWCA Civ 253.

³² *Ibid*. And see *KC v Westminster* [2008] EWCA Civ 198.

³³ See [2012] EWCA Civ 253, [54] and [66].

³⁴ *Ibid*, [67]. And see *LBL v RYJ and VJ* [2010] EWHC 2665 (COP), [62].

Notwithstanding these safeguards, the decision is ground-breaking. As we have seen, the 2005 Act uses capacity (a fluid state) to determine competence (a legal state) with respect to a particular decision. *DL* affirms that an alternative form of ‘fluid state’ to that set out in the 2005 Act can impact on competence. I would contend therefore, that the inherent jurisdiction serves as an alternative route to incapacity: that ‘mental incapacity’ is governed by the 2005 Act and ‘common law incapacity’ by the inherent jurisdiction.

Jonathan Herring welcomes the development arguing that: ‘The ability to intervene and make decisions will discriminate less on the grounds of whether a person has a mental disorder and enable the law to provide a set of protective mechanisms for those who lack autonomy’.³⁵ There are however potential constitutional issues with this approach. Barbara Hewson argues that it ‘represents an example of impermissible judicial law-making, which undermines the separation of powers’:

In *DL*, we see judges taking protective measures by means of injunctions and ... invoking the inherent jurisdiction as a justification. The problem is ... courts allowing urgent claims for relief by those who are not, strictly, entitled to it. In seeking to protect adults who are not under a disability, the courts have crossed a line, which defines the ambit of their jurisdiction and powers.³⁶

The inherent jurisdiction is no doubt a powerful tool. It will apply to those who lack mental capacity under the 2005 Act so as to make available remedies not available under the Act.³⁷ More pertinently for the purposes of this paper, it will also apply to vulnerable adults who are *not* found to lack mental capacity under the Act. As we shall see in section II.B below, the boundaries of the inherent jurisdiction are far from clear. The powers are not necessarily limited to injunctive relief and, as *Re*

³⁵ J Herring, *Vulnerable Adults and the Law* (OUP, 2016), 96. And see J Herring, K Wall, ‘Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act’ (2015) 25(4) LS 698.

³⁶ B Hewson, ‘Neither Midwives Nor Rainmakers’ — why *DL* is Wrong’ [2013] PL 451.

³⁷ *XCC v AA* [2012] EWHC 2183 (COP).

T³⁸ makes clear, a finding of undue influence in the context of a medical treatment refusal can lead to that refusal being overridden and potentially to treatment without consent.

C. Recognising a Public Interest in Protecting Patients from Harm

This section highlights another example of the susceptibility of the test for capacity to be circumvented, this time where P's decision conflicts with the public interest. Not all serious medical decisions involve treatment. Sometimes patients will be subjected to harm by virtue of their refusal to consent to disclosure of confidential information to a third party. This might occur when the clinician is presented with evidence of abuse or neglect. Where the patient lacks mental capacity, a decision can be made in their best interests in accordance with the 2005 Act. Even if the patient retains mental capacity, disclosure might be justified in the public interest if there is a risk of harm to others; to P's children for example. More controversially, professional guidance recognises that the public interest may extend to protecting the *individual adult* from harm, despite their refusal to consent to disclosure.³⁹

The General Medical Council (GMC) recognises the rights of individuals with capacity to determine their own interests. This extends to decisions about disclosure of confidential information.⁴⁰ But this is a right that is subject to the public interest, a concept broadly defined in law⁴¹ and articulated in more detail in

³⁸ [1992] EWCA Civ 18.

³⁹ General Medical Council, *Confidentiality* (2009), para 51, 'It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection and to warn them of the risk of refusing to consent, but you should *usually* abide by a competent adult's refusal to consent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm'. (My italics). The General Medical Council, *Confidentiality: Draft Guidance for Consultation* (2015), paras 29 and 61 maintain this general position. Contrast with Department of Health, *Care and Support Statutory Guidance* (2016) para 14.94 which (citing BMA guidance) does not countenance disclosure to protect the individual with capacity from abuse or neglect, except where a criminal offence has occurred.

⁴⁰ General Medical Council, *Confidentiality* (2009), para 51.

⁴¹ *W v Egdell* [1989] EWCA Civ 13.

professional guidance. Prior to the 2005 Act coming into force, GMC guidance recognised that the best interests test justified disclosure to protect a patient who lacked *either mental capacity or voluntariness*.⁴² As we have seen, the 2005 Act limits best interests assessments to those lacking mental capacity. The GMC responded in 2009 with new Confidentiality guidance outlining a broader public interest defence to capture those cases which previously would have fallen under the best interest framework.⁴³ This blurring of the boundaries between the public interest test and best interest test can be linked to the limited scope of the 2005 Act to recognise that external forces on an individual's will (such as undue influence) can lead to incapacity.⁴⁴ The public interest involves a balancing exercise between the interests in disclosure and the interests in maintaining trust between health professionals and patients; any adverse effects of the disclosure on the autonomy and best interests of the individual are a relevant consideration. The public interest will therefore apply on a case by case basis, *usually* to prevent harm to others, but potentially to prevent harm to a patient with mental capacity.

In other areas too, the public interest in protecting individuals from their harmful decisions is becoming increasingly pervasive. Section 42 of the Care Act 2014 creates a new legal duty incumbent on local authorities to make enquiries where they have reasonable cause to suspect that an adult in their area with care and support needs is at risk of abuse or neglect. Sections 6 requires 'relevant partners' such as NHS bodies to cooperate for a variety of purposes including 'protecting adults with needs for care and support who are experiencing, or are at risk of, abuse or neglect'.⁴⁵ Subject to this, the Care Act stops short of setting out legal powers to protect those with mental capacity against

⁴² GMC, *Confidentiality: Protecting and Providing Information* (2000), paras 38-39.

⁴³ General Medical Council, *Confidentiality* (2009), para 51.

⁴⁴ E Cave, 'Disclosure of Confidential Information to Protect the Patient: The Role of Legal Capacity in the Evolution of Professional Guidance' (2015) 3(1-2) *Journal of Medical Law and Ethics* 7.

⁴⁵ Care Act 2014, s 6(6). Note exceptions in s 7 where cooperation is incompatible with the relevant partner's own duties or would adversely effect the exercise of its functions.

their will.⁴⁶ But guidance recognises that incapacity can flow not only from impairment of the mind or brain as per the 2005 Act, but also from coercion, undue influence or duress and from a psychological process known as ‘Stockholm Syndrome’ where risk of harm can limit an individual’s capacity to safeguard themselves.⁴⁷ The guidance embraces a conception of autonomy that moves beyond the largely procedural test set out in the 2005 Act.

A more paternalistic emphasis permeates recent legal developments that could require professionals to report abuse or neglect, even in light of an individual’s objection. In England, mandated reporting by health professionals against the wishes of the individual concerned has, until recently, been resisted. A new approach emphasises the public interest in securing criminal prosecutions, even when it might conflict with the individual interests of the victim. There is a growing faction in support of broader mandatory reporting laws that aim, in part, to save victims from what might be considered involuntary decisions to reject intervention. The Serious Crime Act 2015 introduced mandatory reporting by regulated professionals (including health professionals) in England and Wales of female genital mutilation (FGM) where there are signs of FGM in children under the age of 18.⁴⁸ A full public consultation on mandatory reporting and a duty to act was launched in July 2016.⁴⁹ If supported, it is

⁴⁶ See Department of Health, *Care and Support Statutory Guidance* (2016), para 14.95.

⁴⁷ Local Government Association and ADASS, *Adult Safeguarding and Domestic Abuse: A Guide to Support Practitioners and Managers* (2nd ed, 2015), 24: ‘When a person who appears to have mental capacity also appears to be choosing to stay in a high-risk abusive relationship then careful consideration must be given to whether they are making that choice free from the undue influence of the person who is causing them harm or others.’

⁴⁸ The Serious Crime Act 2015, s 74 inserts a new section 5B into the Female Genital Mutilation Act 2003. See Home Office, *Mandatory Reporting of Female Genital Mutilation – Procedural Information* (2015).

⁴⁹ HM Government, *Reporting and Acting on Child Abuse and Neglect: Government Consultation* (21 July 2016).

likely to require primary legislation. Scotland and Wales already have laws in place requiring health professionals to pass on information in certain cases of abuse and neglect.⁵⁰

III. AUTONOMY AND THE LIMITS OF ACCEPTABLE PATERNALISM

The previous section has identified ways in which patients might be protected from their ‘bad’ medical decisions whether by imposing protections in the public interest; on the basis of involuntariness; or in cases of borderline mental incapacity. This section analyses the changes through the lens of autonomy. It begins by examining the flaws of a procedural account of autonomy and goes on to recognise the effects of both internal and external forces on an individual’s will. The legal implications are set out and the subsequent section considers the implications in clinical practice.

A. *Procedural and Substantive Autonomy*

What constitutes a ‘bad’ medical treatment decision is a matter of context and perspective. Not only is it difficult in practice to make an objective assessment of what is good or bad for a patient, but the value to the patient of being the author of those decisions is contested.⁵¹ The will (or choice) theory

⁵⁰ Social Services and Well-being (Wales) Act 2014, s 106(1): ‘If a relevant partner of a local authority has reasonable cause to suspect that a person is an adult at risk and appears to be within the authority’s area, it must inform the local authority of that fact.’; Adult Support and Protection (Scotland) Act 2007, s 5(3): ‘Where a public body or office-holder to which this section applies knows or believes— (a) that a person is an adult at risk, and (b) that action needs to be taken (under this Part or otherwise) in order to protect that person from harm, the public body or office-holder must report the facts and circumstances of the case to the council for the area in which it considers the person to be.’ See also extensive mandatory reporting requirements in USA: Department of Health and Human Services, Children’s Bureau, Mandatory Reporters of Child Abuse and Neglect (Washington, DC: U.S., 2016).

⁵¹ See J Coggon and J Miola, ‘Autonomy, Liberty and Medical Decision-Making’ (2011) 70(3) CLJ 523.

emphasises the safeguarding of individual autonomy⁵² and has been influential in the development of informed consent. It holds that the function of a right is to confer power on P to waive other people's duties. A right therefore involves exercising choice in the performance of a duty by another person. The Mental Capacity Act is compatible with this theory insofar as it sets out a test to determine those incapable of 'will' (defined through the proxy of capacity) and the protections that might result. It also predominates in case law. For example, the Supreme Court has held that the right to information on material risks necessary to make an informed consent can be waived.⁵³

According to the interest (or benefit) theory on the other hand, commentators such as Raz and MacCormick argue that the function of a right is to improve P's well-being by imposing duties on others. It is not the benefit that flows from the imposition of duty that makes P a rights-holder, but the fact that P's right flows from the imposition of a duty that exists to serve his interests. Therefore a right can be waived only if it is in the interests of the right-holder to waive it. Acting against P's will might harm P's autonomy interests, but rights go beyond freedom of choice. Regardless of P's legal capacity, rights cannot operate against P's interests unless doing so will protect a more important interest of P's or other persons. Conly argues that individual autonomy is not inviolable.⁵⁴ Our capacity for irrational decision-making renders it important to limit the extent to which our choices are upheld when they do not further compliance with our own goals. 'We should save people from doing things that are gravely bad for them when they do that only as a result of an error in thinking'.⁵⁵ The interest theory of rights emphasises the role played by paternalism in protecting P's interests, including P's future choices.

⁵² See LW Sumner, *The Moral Foundations of Rights* (Oxford: Clarendon, 1987).

⁵³ *Montgomery* [2015] UKSC 11, [85] per Lords Kerr and Reed.

⁵⁴ S Conly, *Against Autonomy: Justifying Coercive Paternalism* (CUP, 2013).

⁵⁵ S Conly, *ibid*, 3.

Whether autonomy is instrumental or has meaning beyond the well-being it brings to P will affect the acceptable limits of paternalism. Paternalism is notoriously difficult to define. Many accept a differentiation between ‘hard’ and ‘soft’ paternalism, but this too is subject to definitional quandaries. Hard paternalism can refer to the removal of choice through compulsion or coercion, whereas soft paternalism nudges or incentivises choice. An alternative sense of paternalism, more relevant to this paper, refers to the *content* of action. Accordingly, soft paternalism brings about action that P would have chosen if autonomous whereas hard paternalism imposes upon P a decision P does not will. Feinberg, in a refinement of Mill’s harm principle, argues that the state should not interfere with voluntary action that does not harm others. Soft paternalism on the other hand, will be justified where it needs to be determined whether the person is acting autonomously and voluntarily, such as treatment of P in a medical emergency, or if P is not acting voluntarily.⁵⁶ From a will theory perspective, hard paternalism is unjustified and whilst it is beyond the scope of this paper to set out a detailed defence of this position, it is clear that in the context of informed consent, it complies with the Mental Capacity Act and the Supreme Court’s assertion in *Montgomery v Lanarkshire Health Board (Montgomery)* that the doctor-patient relationship is no longer governed by a model of medical paternalism.⁵⁷

In 2007, John Coggon outlined three types of autonomy: ideal desire (what a patient *should* want), best desire (reflecting the patient’s values) and current desire (immediate inclinations). To treat P according to P’s ideal desire autonomy when P is capable of a decision reflecting best desire autonomy would reflect hard paternalism: a decision imposed on P against his will, in his best

⁵⁶ J Feinberg, *Harm to Self* (Oxford: OUP, 1986), p 12: ‘Hard paternalism will accept as a reason for criminal legislation that it is necessary to protect competent adults, against their will, from the harmful consequences even of their fully voluntary choices and undertakings. Soft paternalism holds that the state has the right to prevent self-regarding harmful conduct...when but only when that conduct is substantially nonvoluntary, or when temporary intervention is necessary to establish whether it is voluntary or not.’

⁵⁷ [2015] UKSC 11, [81] per Lords Kerr and Reed.

interests. In the context of serious medical decisions, best desire autonomy - incorporating both procedural and substantive elements - is considered more robust, but the law has traditionally adopted a less sophisticated formation, more akin to the current desire autonomy formulation:

On the whole, judges talk of autonomy as being equivalent to self-determination. In English medical law, this allows patients to refuse any medical treatment or intervention, and to choose one of any treatments offered by a medical professional.⁵⁸

There is a potential dichotomy between the Mental Capacity Act definition of incapacity and an expression of P's best desire autonomy. From a will theory perspective this raises the possibility that the law might uphold a harmful decision that is not truly willed and from an interest theory perspective the Act might recognise someone as having capacity even if they do not fulfil what Raz recognises as three essential requirements for autonomy: 'appropriate mental abilities, an adequate range of options, and independence'.⁵⁹ Both would consider that an unwilled harmful decision is capable of infringing P's rights.

As we have seen in section II.A above, the subjective nature of the test for mental incapacity results in cases of borderline capacity. Those who fall within this 'grey area' may be susceptible to a finding of incapacity if their decision would cause them harm. In other words, there is a risk of hard paternalism. The test for incapacity attempts to limit uncertainty by adopting a predominantly procedural conception of autonomy. Whether P makes a decision reflecting current or best desire autonomy is largely an empirical question.⁶⁰ Section 2(1) sets a diagnostic threshold for mental incapacity. Evidence of an inability to make a decision (as set out in section 3) is not on its own enough to establish incapacity. The diagnostic threshold renders the functional approach of the Act

⁵⁸ J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15(3) Health Care Analysis 235, 237.

⁵⁹ J Raz, *The Morality of Freedom* (Oxford: Clarendon Press, 1988), p372.

⁶⁰ J Coggon, J Miola, 'Autonomy, Liberty and Medical Decision-Making' (2011) 70(3) CLJ 523.

more robust and enhances protection of free choice by distancing legal capacity from rational autonomy. The Act requires that those lacking mental capacity must be helped to achieve it⁶¹ and, where this proves impossible, have their views and wishes taken into consideration. Those with mental capacity gain from the Act a zone of freedom to choose. According to section 1(4), 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'. The Act does not require the decision to be rational or even considered.⁶² The test is thus predominantly procedural though there are at least two senses in which substantive elements are present. First, by requiring that capacity is promoted and facilitated, the Act and Code of Practice might be said to subtly endorse a more substantive version of autonomy.⁶³ Second, the section 3(1)(c) requirement that P is able to 'use or weigh' the information requires an assessment of P's ability to balance and consider the information. But these aspects relate largely to the *process* of decision-making rather than the content of the decision. The binary test for mental capacity creates a stark distinction between those who have capacity (and with it a right to make the decision in question) and those who do not. The presumption that those with mental capacity are capable of protecting their own interests is (tacitly, given that the Act focuses on those lacking capacity) at the core of the Mental Capacity Act. This is so even if, in fact, the individual's decision does not reflect best desire autonomy – that is, it is not an authentic decision, consistent with the person's values.

There is evidence that aspects of the law are moving toward an approach that is more reflective of the promotion of best desire autonomy. This might serve both to explain and impose limitations on

⁶¹ Mental Capacity Act 2005, s 1(3).

⁶² The Act adopts the common law position. See *Re T (adult: refusal of treatment)* [1992] EWCA Civ 18, [3], per Lord Donaldson; *Re C (adult: refusal of treatment)* [1994] 1 All ER 819, p 294, per Thorpe J.

⁶³ See C Mackenzie, W Rogers, 'Autonomy, vulnerability and capacity: a philosophical appraisal of the Mental Capacity Act' (2013) 9(1) IJLC 37, who point to the fact that the Code of Practice and the core principles of the Act set out requirements to promote and facilitate capacity. By doing so, they argue, a more substantive version of autonomy is endorsed.

the expansive approach to protecting patients from harmful decisions, described in section II above. In particular, it is contended that commitment to a will theory conception that underlies the 2005 Act - and thus the avoidance of hard paternalism – should guide the development and limitation of attempts to reach a more nuanced and sensitive set of protections for those incapable of a best desire autonomous decision.

Commitment to a more substantive concept of autonomy is evident in the Supreme Court decision of *Montgomery*,⁶⁴ which consigned *Sidaway v Royal Bethlem Hospital*⁶⁵ to the history books and confirmed that patients consenting to treatment must be given information that a reasonable person in the patient's position would want to know. The decision confirms the role of the law of negligence in protecting patients' autonomy,⁶⁶ including 'freedom to decide what shall and shall not be done with their body'.⁶⁷ The doctor must engage in dialogue, tailored to the needs of the individual.⁶⁸ Lady Hale stated:

Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done.⁶⁹

The decision promotes autonomy by requiring health professionals to provide the necessary information to give the patient the opportunity to make a decision reflecting best desire autonomy.

⁶⁴ [2015] UKSC 11.

⁶⁵ [1985] 1 All ER 643.

⁶⁶ Confirming and elaborating on patient autonomy interests expounded by the House of Lords in *Chester v Afshar* [2005] 1 AC 134, [92] per Lord Walker; and the European Court of Human Rights in *Pretty v United Kingdom* (2002) 35 EHRR 1 [61].

⁶⁷ [2015] UKSC 11, [108] per Lady Hale. And see [80] per Lords Kerr and Reed.

⁶⁸ *Ibid*, [90].

⁶⁹ *Ibid*, [109].

In their joint judgment, Lords Kerr and Reed recognise that a patient can decide not to be so informed. This is not incompatible with best desire autonomy, particularly where the information would cause harm. More problematic is recognition of a limited ‘therapeutic exception’ by which health professionals may withhold material information from the patient if disclosure might cause serious harm.⁷⁰ To the extent that it is used to protect patients from specific information that will render them unable to make a decision (for example because of the fear it will induce) it is not necessarily incompatible with best desire autonomy, but there is potential for the exception to be applied more paternalistically, so as to subvert P’s will to avoid P suffering serious harm.⁷¹ Subject to this concern, the decision in *Montgomery* endorses a more substantive version of informed consent. It reduces emphasis on the ‘flak jacket’ approach which views consent as a health professional’s defence to battery and focuses instead on consent as the chief means of safeguarding patient autonomy.⁷² With the opportunity for decision-making reflecting best desires comes responsibility for the choices made:

[S]ocial and legal developments ... point towards ... an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success

⁷⁰ See *ibid*, [85].

⁷¹ I explore these issues in a forthcoming paper entitled ‘The ill-informed: consent to medical treatment and the therapeutic exception’.

⁷² K Keywood, ‘The Death of Sidaway: Values, Judgments and Informed Consent’ BMJ Blogs, (15 March 2015).

Online: <http://blogs.bmj.com/medical-ethics/2015/03/15/the-death-of-sidaway-values-judgments-and-informed-consent/>

and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.⁷³

In establishing enhanced duties of doctors to provide patients with information and the corresponding patient responsibility for their decisions, I would submit that the decision in *Montgomery* represents a shift away from unfettered freedom of choice toward responsible (best desire) decision-making. Patients are seen as rights holders and ‘consumers exercising choices’.⁷⁴ Post-*Montgomery*, we might expect greater rigour in the information routinely provided to patients. There may be a correlating increase in the complexity of the information,⁷⁵ potentially resulting in more individuals falling within section 3 of the Mental Capacity Act 2005 and being found to lack mental capacity. The section 3(2) duty to explain information in a way that is appropriate to the individual will become increasingly important. The focus in *Montgomery* on providing patients with the requisite information to make an autonomous decision and the corresponding responsibility this confers on the patient creates a clearer distinction between those able and unable to take responsibility for their decisions. The Supreme Court in *Montgomery* embraced a substantive version of autonomy in the law of negligence that contrasts with the predominantly procedural approach taken in the 2005 Act. Similarly, the inherent jurisdiction encompasses substantive autonomy in its recognition of both internal and external forces on a person’s will, at least to the extent that the courts attempt to limit the harms that flow to patients whose decisions reflect their current desires but are neither authentic nor consistent with the individual’s overall desire. It is to this matter that we now turn.

⁷³ [2015] UKSC 11, [81].

⁷⁴ *Ibid*, [75].

⁷⁵ Though see *ibid*, [90]: The emphasis is on comprehensibility and patients should not be ‘bombarded’ with ‘technical information’.

B. Internal and External Forces

Recognition of both procedural and substantive aspects of capacity is enhanced by the recent confirmation of the ‘safety net’ provided by the inherent jurisdiction of the High Court. By focusing on internal forces that affect capacity, the Mental Capacity Act failed to adequately protect those unable to make a decision by virtue of external forces that might flow, for example, from abuse, undue influence or neglect – at least in those cases where the inability to make a decision does not satisfy section 2(1). To establish mental incapacity, the inability to decide must be ‘because of’ an impairment of the mind or brain.⁷⁶ Whilst it may be possible to establish mental incapacity where undue influence is a factor but impairment is the operative cause of the inability to decide,⁷⁷ this will not be possible where undue influence is the sole cause. And yet, the protection of those who cannot be empowered to make autonomous treatment decisions is at the core of the mischief the Act intended to address.⁷⁸

Aristotle distinguished involuntariness from non-voluntariness. The latter may be brought about by internal forces. The emphasis in the Mental Capacity Act definition of incapacity on a therapeutic threshold and the effect of this internal force on the individual accords with this conception. But Aristotle⁷⁹ also recognised that voluntariness can be affected by *external* forces which can be used to

⁷⁶ Mental Capacity Act 2005, s 2(1). See *PC & NC v City of York Council* [2013] EWCA Civ 478 and commentary in P Skowron, ‘Evidence and causation in mental capacity assessments’ (2014) 22(4) Med L Rev 631.

⁷⁷ See *Norfolk County Council v PB* [2014] EWHC 14 (COP), [86]. In *Re A (Capacity: refusal of contraception)* [2011] Fam 61, [73] Bodey J. held that a woman whose ‘decision not to continue taking contraception is not the product of her own free will’ lacked mental capacity; And see *London Borough of Redbridge v G and Ors* [2014] EWHC 485 (COP) where it was decided that, on the balance of probabilities G, who was subject to undue influence, lacked mental capacity. For comparative perspective see Singapore Court of Appeal case *Re BKR* [2015] SGCA 26.

⁷⁸ Law Commission, *Mental Incapacity* (Law Com No 231: 1995), Para 1.2.

⁷⁹ L Brown (ed) D Ross (translator), *Aristotle, The Nicomachean Ethics Book III* (Oxford World Classics, 2009).

compel a person and deny them control. In an Aristotelian sense, a voluntary act is one which we bring about ourselves. An act is not voluntary if it is brought about by physical or psychological external forces or is caused by (as opposed to done in) ignorance. Policy considerations dictate the extent to which different areas of law hold or depart from this conceptualisation. The law of negligence, for example, focuses on *conduct* not state of mind. The standard of care will not take into account subjective personal characteristics (except in the case of children) even if they point to the defendant's incapacity.⁸⁰ By way of contrast, in the Chancery Division, evidence of benefit to a stronger party in a transaction will raise a presumption of involuntariness. Consider *Hart v Burbidge*,⁸¹ where a lifetime gift from a mother to her daughter and son-in-law raised a presumption of undue influence when other relatives would have inherited the property under the terms of her will.

What of medical treatment? The central role of voluntariness in the law of consent is undisputed. Consent is only valid if it is voluntary.⁸² But the law on consent can only go so far in its protection of those incapable of making a voluntary decision. A patient who is treated without a valid consent can bring a claim in battery against the doctor. But the law on consent alone cannot protect those whose *refusals* of treatment are involuntary.

C. A Facilitative Approach?

Recognition that the inherent jurisdiction survives the passage of the Mental Capacity Act makes clear the relevance of external as well as internal forces on a person's will and might enhance protection of best desire autonomy over free choice. In so doing, the decision in *DL* represents a measured approach protective of welfare rights, but facilitative of autonomy rights. A facilitative role implies that any restrictions must be placed on third parties so as to enable P's unencumbered

⁸⁰ *Dunnage v Randall* [2015] EWCA Civ 673.

⁸¹ [2014] EWCA Civ 992.

⁸² *Chatterton v Gerson* [1981] QB 432.

decision-making. Indeed McFarlane L.J. endorsed the approach taken in *LBL v RYJ and VJ*⁸³ where Macur J. said:

I reject what appears to have been the initial contention of this local authority that the inherent jurisdiction of the court may be used in the case of a capacitous adult to impose a decision upon him/her whether as to welfare or finance. ... [T]he relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions.

In the context of medical treatment decisions, however, reliance in *DL* on *Re T*⁸⁴ and dicta supporting the availability of the inherent jurisdiction beyond cases of ‘borderline [mental] incapacity’,⁸⁵ suggest that evidence of undue influence might justify treatment against the expressed wishes of an individual, particularly in the case of an acute illness requiring one-off treatment, such as occurred in *Re T*.⁸⁶ Imagine, for example a patient whose refusal of treatment for a broken jaw is found to be involuntary due to abuse of a relative. The patient has mental capacity but is vulnerable and has welfare needs that could be protected through a best interest decision requiring medical treatment. A facilitative approach would take time to implement at considerable detriment to the health of the patient. Would a welfare-based approach requiring treatment be justified as necessary and proportionate? Such a decision might be justifiable on the basis that the patient’s harmful decision was not autonomous.⁸⁷ This sub-section explores the potential for the law to impose treatment decisions on P under the inherent jurisdiction and considers the risks this poses of hard paternalism.

⁸³ [2010] EWHC 2665 (COP), [62].

⁸⁴ [2012] EWCA Civ 253, [21], per McFarlane L.J.

⁸⁵ *Ibid*, [31-33], per McFarlane L.J.

⁸⁶ [1992] EWCA Civ 18.

⁸⁷ As in *A NHS Trust v Dr A* [2013] EWHC 2442, discussed below.

The aim is to emphasise the importance of clarifying the extent of the court's powers. As we shall see in the next section, a failure to do so could lead to defensive practices flowing from enhanced professional accountability.

The significance of the decision in *DL*⁸⁸ goes beyond the narrow confines of its facts. First, the potential for the inherent jurisdiction to be used to bring about decisions that conform to the judge's idea of a 'good' decision, is surely great. Nothing will demonstrate that voluntariness has been facilitated more than a decision that accords with the health interests of the individual. Second, the inherent jurisdiction is not limited to cases of involuntariness. Post-*Re T* the ambits of the inherent jurisdiction were expanded in *Re G (An Adult)*, *Re SA (Vulnerable Adult with Capacity: Marriage)* and *Re SK*.⁸⁹ In *DL*, McFarlane L.J. stated that:

The jurisdiction is ... aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are (to adopt the list in paragraph 77 of *Re SA*): a) Under constraint; or b) Subject to coercion or undue influence; or c) For some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.⁹⁰

The autonomy-enhancing inherent jurisdiction effectively asserts a common law route to incapacity that might flow from: 'deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others.'⁹¹

⁸⁸ [2012] EWCA Civ 253.

⁸⁹ [2004] EWHC 2222 (Fam); [2005] EWHC 2942 (Fam); [2004] EWHC 3202 (Fam).

⁹⁰ [2012] EWCA Civ 253, [54].

⁹¹ *Re SA (vulnerable adult with capacity: marriage)* [2005] EWHC 2942 (Fam), [78] per Munby J, as cited by McFarlane L.J. in *DL* [2012] EWCA Civ 253 [22].

Third, there are questions as to the extent of the powers of the ‘great safety net’⁹² which forms the inherent jurisdiction. A number of developments indicate that they are broad. For example, the inherent jurisdiction has transcended jurisdictional boundaries, applying in the case of a vulnerable British citizen habitually resident in Saudi Arabia;⁹³ and to recognise orders made by the Irish High Court allowing emergency treatment for eating disorder.⁹⁴ Additionally, in *XCC v AA* it was established that the court can make orders of its own initiative (even if they have not been raised by the parties to the case).⁹⁵ In the same case, the High Court made clear that it is not restricted by the terms of the Mental Capacity Act: Parker J. held that in place of the principle of least restriction in section 1(6) of the 2005 Act, orders of the court under the inherent jurisdiction must simply be ‘necessary and proportionate’.⁹⁶

Munby J. in *Re SA* refers to the ‘largely unfettered jurisdiction to grant appropriate injunctive relief’⁹⁷ stating:

More generally, ... the court has the power to make whatever orders and to give whatever directions are needed to ascertain the true wishes of a vulnerable adult or to ascertain whether a vulnerable adult is able to exercise her free will or is confined, controlled, coerced or under restraint.⁹⁸

⁹² So-called by Lord Donaldson MR in *Re F (mental patient: sterilisation)* [1992] AC 1, p 30(e).

⁹³ *Al-Jeffery v Al-Jeffery (vulnerable adult: British citizen)* [2016] EWHC 2151 (Fam).

⁹⁴ *Re Z (recognition of foreign order)* [2016] EWHC 784 (Fam).

⁹⁵ [2012] EWHC 2183 (COP), [85].

⁹⁶ *Ibid*, [77]. And see *A NHS Trust v Dr A* [2013] EWHC 2442, [93] per Baker J. where deprivation of liberty which would not have been permissible under the Mental Capacity Act 2005 was permissible under the inherent jurisdiction.

⁹⁷ [2005] EWHC 2942 (Fam), [86].

⁹⁸ *Ibid*, [94].

Might the powers extend beyond injunctive relief?⁹⁹ In *DL*, McFarlane L.J. recognised that the exercise of the inherent jurisdiction is not limited to interim relief (for example to give P space to exercise free will).¹⁰⁰ Furthermore, Parker J. in *Norfolk County Council v PB*¹⁰¹ (*obiter*) saw ‘no indication that the inherent jurisdiction is limited to injunctive relief’.¹⁰² Though PB had mental capacity under the 2005 Act to decide where to live, a ‘residence requirement’ could be imposed on her under the inherent jurisdiction, provided the aim was to ‘protect, liberate and enhance personal autonomy’¹⁰³ and the order was necessary and proportionate. As Ruck Keene has argued:

[W]hilst Parker J. was at pains to identify the approach that she was suggesting as being supportive of PB’s autonomy, it is perhaps not impertinent to suggest that it is very unlikely ... that PB would regard this as being the case. There is a distinct flavour here of forcing an individual to be free.¹⁰⁴

In *Nottinghamshire Healthcare NHS Trust v RC*, Mostyn J. set out the wide powers of the court:

There are three circumstances where adult citizens may have treatment or other measures imposed on them without their consent. i) Adults lacking capacity ... may have treatment forced upon them in their best interests pursuant to the terms of the MCA. ii) Similarly, adults who have capacity but who can be categorised as ‘vulnerable’ and who as a consequence of their vulnerability have been robbed of the ability to give a true consent to a

⁹⁹ Notwithstanding Macur J.’s dicta in *LBL v RYJ and VJ* [2010] EWHC 2665 (COP), [62] (quoted above).

¹⁰⁰ See [2012] EWCA Civ 253, [68].

¹⁰¹ [2014] EWHC 14 (COP).

¹⁰² [2014] EWHC 14 (COP), [114]. And see J Herring, *Vulnerable Adults and the Law* (OUP, 2016), 90-91.

¹⁰³ [2014] EWHC 14 (COP), [113].

¹⁰⁴ A Ruck Keene ‘A true tangle – capacity, influence and the inherent jurisdiction’ (2014) online at <http://www.mentalcapacitylawandpolicy.org.uk/a-true-tangle-capacity-influence-and-the-inherent-jurisdiction/>.

certain course of action, may also have treatment or other measures imposed on them in their best interests pursuant to the inherent jurisdiction of the High Court ... iii) Under the Mental Health Act 1983 a detained patient may have treatment imposed on him or her pursuant to section 63 ...¹⁰⁵

This not only conflates the consequences of involuntariness and mental incapacity but Mostyn J. also refers expressly to the power to impose treatment on P. Nonetheless, the approach of the courts is likely to be cautious. Emphasis on facilitation in *DL* suggests, as Parker J. recognised in *XCC v AA*, that ‘in contrast to incapacitated adults, the decisions of adults with capacity cannot be overridden on the best interests test or welfare grounds’.¹⁰⁶ A cautious approach is also evident in the case of *Re FD (inherent jurisdiction: power of arrest)*¹⁰⁷ where Judge Bellamy made a distinction between the power to make orders and the power to enforce them,¹⁰⁸ acknowledging that the powers of the inherent jurisdiction do not extend to attaching powers of arrest to an injunction.¹⁰⁹

Furthermore, Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014¹¹⁰ requires that ‘care and treatment of service users must only be provided with the consent of the relevant person’. Regulation 11(3) sets out the exceptions to this rule including situations where ‘the service user is 16 or over and is unable to give such consent because they lack capacity to do so’, in which case the registered person must act in accordance with the Mental Capacity Act 2005. Reference to the 2005 Act might seem to preclude extension of the inherent jurisdiction beyond a facilitative role. One might conclude that welfare-based decisions requiring treatment are prohibited

¹⁰⁵ [2014] EWHC 1317 (COP), [13].

¹⁰⁶ [2012] EWHC 2183 (COP), [57].

¹⁰⁷ [2016] EWHC 2358 (Fam).

¹⁰⁸ *Ibid*, [43].

¹⁰⁹ Applying *Re G (wardship) (jurisdiction: power of arrest)* [1983] 4 FLR 538.

¹¹⁰ SI 2014/2936.

on the basis that Regulation 11(3) refers to those lacking capacity (and not those who are vulnerable) and to the Mental Capacity Act (and not the common law).

On the other hand, I have argued that P can be said to ‘lack capacity’ to consent if their decision is found at common law to be involuntary. Provided the inherent jurisdiction is styled as an alternative route to incapacity, it could be argued that treatment decisions fall within the 11(3) exception. Nor is the reference to the 2005 Act in Regulation 11(3) necessarily problematic. McFarlane L.J. has made clear that the inherent jurisdiction of the High Court is compatible with the Mental Capacity Act.¹¹¹ Decision-makers can act in accordance with the Act even though their decisions are not expressly contemplated in the legislation. The common law protects those with capacity from treatment without consent,¹¹² but this protection is susceptible to changes in the definitions of capacity, through statutory interpretation of the 2005 Act test or development of the inherent jurisdiction. Acceptance of the argument that the inherent jurisdiction can incorporate best interest decision-making is not necessarily incompatible with Regulation 11(3).

Consider *A NHS Trust v Dr A*.¹¹³ Dr A was a patient with psychosis on hunger strike in protest at a decision made by the UK Border Agency. Dr A could not be treated (force-fed) under the Mental Health Act because it was for a physical rather than mental disorder;¹¹⁴ and though he lacked capacity, he could not be deprived of his liberty under the 2005 Act because he was detained under the Mental Health Act.¹¹⁵ Baker J. confirmed that the inherent jurisdiction is not limited to those who

¹¹¹ See [2012] EWCA Civ 253, [62] per McFarlane L.J.

¹¹² See for example *Re T (adult: refusal of treatment)* [1992] EWCA Civ 18, [5]: ‘The law requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment of him is to be lawful’.

¹¹³ [2013] EWHC 2442.

¹¹⁴ *Ibid*, [79]-[80].

¹¹⁵ *Ibid*, [66].

are vulnerable for reasons other than mental incapacity.¹¹⁶ He made an order authorising treatment and deprivation of liberty which, he held, is within the powers of the inherent jurisdiction providing it complies with Article 5 of the European Convention on Human Rights.¹¹⁷ In conclusion, where there are questions about the voluntary nature of a refusal of treatment there is a blurred line between a facilitative approach and one which focuses on broader welfare considerations. By limiting the force of the patient's (involuntary) decision, the court might facilitate a future autonomous decision, but in the interim any medical treatment imposed in the individual's best interests would be, in a very real sense, dictatorial. Furthermore, the extent of the powers of the inherent jurisdiction is still unclear. Graeme Laurie and Ken Mason have eloquently argued for greater articulation of the Court's powers and this is particularly necessary insofar as they may be used not merely to facilitate choice but to make decisions on P's behalf.¹¹⁸

This section has described legal developments around the principle of autonomy that move away from a simplistic articulation of capacity as freedom of choice on the basis that it fails to adequately protect vulnerable patients. In its place is an increasingly sophisticated concept of autonomy which promotes best desire autonomy and protects those who are vulnerable by virtue of their inability to take responsibility for their decisions. I have set out justifications for this approach but also sounded notes of caution. The dearth of case law outlining the powers of the court; its extension to measures imposing treatment on P; and the lack of cases specifically on the application of the jurisdiction in

¹¹⁶ *Ibid*, [91] per Baker J.; *Westminster City Council v C* [2008] EWCA Civ 198, [54] per in Wall L.J.; *Re F (Adult: Court's Jurisdiction)* [2001] Fam 38.

¹¹⁷ *Ibid*, [96]-[97]. And see [89]: '[T]he High Court retains jurisdiction in respect of incapacitated adults and in particular to give or withhold consent for medical treatment on the grounds that it is in the best interests of the patient.' See also *An NHS Trust v HN* [2016] EWHC 43 (COP).

¹¹⁸ GT Laurie, KJ Mason, 'Trust or Contract: How Far Does the Contemporary Doctor/Patient Relationship Protect and Promote Autonomy?' in PR Ferguson, GT Laurie (ed), *Inspiring a Medico-Legal Revolution: Essays in Honour of Sheila McLean* (London: Routledge, 2015), chapter 5.

relation to serious medical decisions creates potential for hard paternalism. This has important implications for practice which I explore in the next section.

IV PATIENT RIGHTS AND PROFESSIONAL ACCOUNTABILITY

A. Professional Accountability

Doctors must now have in mind the potential not only for mental incapacity under the 2005 Act, but also for common law incapacity borne of involuntariness. Developments regarding professional accountability amplify the effects of these changes. Where traditionally the scope and extent of health professionals' duties depended on the group status of the individual, the emphasis is increasingly on P's characteristics and vulnerabilities. Mental incapacity – and now also common law incapacity resulting from involuntariness - have crucial roles to play in defining the ambits of doctors' and providers' responsibilities.

Enhanced professional accountability flows in part from high profile scandals demonstrating all too clearly that poor standards of care render *all* patients vulnerable, regardless of their capacity for decision-making.¹¹⁹ The Francis Inquiry Report in 2013 responded to serious failures in care at Mid Staffordshire NHS Foundation Trust between 2005 to 2008.¹²⁰ The 290 recommendations addressing systemic deficiencies and a lack of effective governance were largely accepted by Government.¹²¹ As we shall see, the report prefaced an era of enhanced accountability and transparency¹²² that

¹¹⁹ HM Government, *Hard Truths, the Journey to Putting Patients First* (November 2013), p 6.

¹²⁰ Robert Francis QC (Chair), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, (HC 947, February 2013).

¹²¹ HM Government, *Hard Truths: The Journey to Putting Patients First* (November 2013).

¹²² Department of Health, *Culture Change in the NHS: Applying the Lessons of the Francis Inquiries*, (CM 9009, 2015).

enhances the duty of health professionals and providers to act, potentially in a manner that is contrary to the current desires of the patient.

In particular, three recent legislative changes emphasise improving patient safety and delivering safeguarding according to need.¹²³ First, the Health and Social Care (Safety and Quality) Act 2015¹²⁴ imposes an obligation on the Secretary of State (and the powers to make relevant regulations) to ensure that no avoidable harm is caused to service users. The Act sets out fundamental standards to be met by health professionals. Second, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the requirements that all providers must meet in order to be registered with the Care Quality Commission. Regulation 13 requires that service users are safeguarded from abuse and improper treatment. They must be protected by adequate systems and processes¹²⁵ and care must not be provided in a way that discriminates against individuals 'on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010)'.¹²⁶ Service users must be protected from 'abuse', which incorporates sexual offences, physical and psychological ill-treatment and neglect.¹²⁷ According to Regulation 22, an offence is committed¹²⁸ where breach leads to physical or psychological avoidable harm to a service user or exposure to the service user of a significant risk of such harm occurring. Finally, sections 20-25 of the Criminal Justice and Courts Act 2015 create an offence of ill treatment or wilful neglect that applies to health professionals. The offence covers conduct by all paid care workers in a healthcare setting. The outcome of the conduct is irrelevant – no harm need be proved. What matters is the culpability of the care worker. The

¹²³ And note Law Commission consultation ongoing at time of writing: *Reforming Misconduct in Public Office: A Consultation Paper* (Law Com Consultation Paper No 229, 5 September 2016).

¹²⁴ Amending the Health and Social Care Act 2008, ss 20(1) and 2(2).

¹²⁵ Reg 13(2).

¹²⁶ Reg 13(4)(a).

¹²⁷ Reg 13(6).

¹²⁸ Punishable by fine: reg 23.

legislation is expected to yield up to 240 prosecutions per annum.¹²⁹ These legislative changes represent significantly enhanced accountability of professionals and an expanding duty to act.

Prior to the 2015 Act, statutory duties to avoid wilful neglect focused on patients who were deemed vulnerable by virtue of their status. Protections extended to children, those with mental disorder and those with mental incapacity.¹³⁰ In the context of the Mental Capacity Act, ill treatment or wilful neglect of a person lacking or reasonably believed to lack mental capacity is an offence under section 44 of the 2005 Act. As Mandelstram points out, prosecutions under section 44 are rare, though neglect – and persistent recklessness – is not.¹³¹ Since 2015 statutory protections extend to all patients, whether or not they have capacity. This is not to say that incapacity is irrelevant. A finding of incapacity (whether mental incapacity *or common law incapacity*) could in certain circumstances be indicative of a duty to act to prevent potential harm to the patient.

Could a health professional who failed to act in contravention of an individual's harmful refusal of treatment be found guilty of neglect if there was clear evidence of mental incapacity or involuntariness? There is no case in point, but the 2015 Act is designed to enhance accountability. Pre-2015 case law does not preclude such a finding. In the context of child cruelty, 'wilful' neglect has incorporated recklessness. In *R v Sheppard*¹³² the House of Lords held that a failure to provide medical attention for a child was 'wilful' if the defendant knew there was a risk that the child's health would suffer without medical attention or did not care whether or not the child was in need of medical attention. A broad view of the definition of 'wilful neglect' was also taken by the Court of Appeal in the context of section 44 of the Mental Capacity Act in the 2013 case of *R v Parulben*

¹²⁹ N Grant, J Dirmikis, 'The Impact of New Care Quality Commission Powers on Providers' Health Service Journal (9 April 2014).

¹³⁰ Mental Health Act 1983, s 127; Mental Capacity Act 2005, s 44; Children and Young Person Act 1933, s 1.

¹³¹ M Mandelstam, 'Wilful Neglect and Health Care' (2014) 16(6) The Journal of Adult Protection 342, 350.

¹³² [1981] AC 394.

Patel.¹³³ The defendant was convicted even though her omissions (the failure to administer CPR) were the result of panic and stress.

It is possible that a doctor who accepted a refusal of treatment from a patient who lacked capacity at common law due to involuntariness might be found guilty of wilful neglect if it could be shown that the doctor acted recklessly. Let us imagine that a patient refuses a recommended round of chemotherapy under pressure from a relative; or refuses treatment for fractured ribs by command of an abusive partner. Provided the abuse does not operate as an 'impairment of the mind or brain' sufficient to satisfy the diagnostic threshold in section 2(1) of the 2005 Act, an argument might be made that conforming with the expressed will of these patients constitutes neglect if the doctor ought reasonably to have approached the High Court to exercise its inherent jurisdiction in order to facilitate a voluntary decision. As has been argued above, it is conceivable that the High Court would make a best interest decision if treatment were necessary and proportionate and removal of the coercive force would not bring about a voluntary decision in time to prevent significant harm.

The Criminal Justice and Courts 2015 Act is unlikely to lead to a rash of prosecutions against doctors who comply with harmful patient treatment refusals despite their lack of mental capacity or voluntariness. It might, however, lead to greater caution and defensiveness and thus to a greater willingness to apply a best interests framework if the patient might reasonably be said to lack mental capacity (in other words, in cases of borderline mental capacity); or to applications to the High Court where there are questions as to the voluntariness of the decision or the vulnerability of the patient.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 exacerbates this prospect. It sets out penalties against providers for neglect that falls short of 'wilful'. In light of the 2014 Regulations, providers are likely to encourage health professionals to more readily view P as statutorily incapacitated where P's decision would otherwise cause P harm, in

¹³³ [2013] EWCA Crim 965.

order to avoid potential liability. After all, Section 5 of the 2005 Act provides that where a proper assessment of mental capacity and best interests is made, the health professional will not incur liability for acting without the consent of a patient reasonably thought to lack capacity. If the 2014 Regulations result in a risk-averse approach to mental capacity assessments, there is potential to undermine efforts to counteract the poor implementation of the presumption of mental capacity outlined by the Select Committee and referred to below.¹³⁴

In conclusion, health professionals and providers who fail to approach the court to exercise its inherent jurisdiction when faced with patients making involuntary decisions to refuse treatment, might fear liability for neglect under the 2014 Regulations or even wilful neglect under the 2015 Act. In time this may lead to an increase in cases to the High Court or exacerbate recourse to findings of incapacity under the 2005 Act in cases of doubt.

B. Necessity

The safety net operated by the High Court through its inherent jurisdiction poses a number of legal and practical problems. At a judicial level, there is pressure on the courts to ensure that protections are equal whether the source of incapacity is external or internal.¹³⁵ For patients, reliance on the High Court to exercise its inherent jurisdiction is problematic for a number of reasons including the associated costs, timeliness and bureaucracy; and the risk that only the most extreme cases will reach the courts. For clinicians, enhanced professional accountability may necessitate change. The inherent jurisdiction presents to clinicians a means to protect vulnerable patients that was not thought previously to exist. Clinicians must be aware of its existence and consider bringing relevant cases before the High Court, even if this means questioning a patient's decision to refuse treatment.

¹³⁴ Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-Legislative Scrutiny*, HL Paper 139, (March 2014).

¹³⁵ See *XCC v AA* [2012] EWHC 2183 (COP), [54], per Parker J.

Must the clinician bring each case before the court? Prior to the Mental Capacity Act coming into force doctors relied on the common law doctrine of necessity.¹³⁶ In *Re F (mental patient: sterilisation)*¹³⁷ the House of Lords invoked the defence of necessity to what would otherwise have constituted a battery in the case of sterilisation in the best interests of a person unable to provide consent. Lord Donaldson warned:

The ability of the ordinary adult patient to exercise a free choice in deciding whether to accept or to refuse medical treatment and to choose between treatments is not to be dismissed as desirable but inessential. It is a crucial factor in relation to all medical treatment.¹³⁸

The defence as set out in *Re F* is broad, encompassing actions to save life and improve or prevent deterioration in health.¹³⁹ Section 5 of the Mental Capacity Act created a narrower, general defence to those acting in P's best interests on the basis of a reasonable belief that P lacks mental capacity. It seems that the common law defence of necessity has no application where the Mental Capacity Act applies,¹⁴⁰ and nor would section 5 apply if the patient retained mental capacity but lacked voluntariness. There is no general defence of necessity.¹⁴¹ Is *Re F* good law post-Mental Capacity Act? The defence of necessity has been ruled inapplicable as a defence to assisted suicide under

¹³⁶ Notably by Brooks L.J. in *Re A (Children) (Conjoined Twins: Medical Treatment)* [2001] Fam 147; and *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112 in relation to the provision of contraceptive advice which might cause or encourage unlawful sexual activity contrary to the Sexual Offences Act 1956, s 6.

¹³⁷ [1990] 2 AC 1.

¹³⁸ *Ibid*, p 19.

¹³⁹ *Ibid*, per Lord Brandon p 55; and per Lord Goff, p 76.

¹⁴⁰ *ZH v Commissioner of Police for the Metropolis* [2012] EWHC 604 (Admin) (*obiter*) upheld on appeal [2013] EWCA Civ 69.

¹⁴¹ *R v Dudley and Stephens* (1884) 14 QBD 273.

section 2 of the Suicide Act 1961¹⁴² and to the criminal use of cannabis to alleviate suffering,¹⁴³ but recognition that the inherent jurisdiction survives the 2005 Act supports the argument that the doctrine of necessity also maintains relevance. As such, this reopens a dilemma described by Straughton L.J. in *Re T*:

The notion that consent or refusal of consent may not be a true consent or refusal presents a serious problem for doctors [particularly where] ... the choice is, as in this case, between [(a) no decision and (b) refusal of consent]. The surgeon will be liable in damages if he operates when there is a valid refusal of consent, and liable in damages if he fails to operate in accordance with the principle of necessity when there was no valid decision by the patient. ... Some will say that, when there is doubt whether an apparent refusal of consent is valid in circumstances of urgent necessity, the decision of a doctor acting in good faith ought to be conclusive. ... However, I cannot find authority that the decision of a doctor as to the existence or refusal of consent is sufficient protection, if the law subsequently decides otherwise. So the medical profession, in the future as in the past, must bear the responsibility unless it is possible to obtain a decision from the courts.¹⁴⁴

Until further guidance is handed down from the courts, the responsibility is onerous. Given academic concerns over judicial law-making in *DL*,¹⁴⁵ the extent of the powers of the inherent jurisdiction and the dangers posed to patient autonomy rights and interests, the courts would rightly be reluctant to delegate broad powers to doctors to make best interests decisions on behalf of patients who make involuntary decisions. Nor is it likely that doctors would seek such onerous responsibility. To date a restrictive view of any duty to act on the basis of necessity has been taken, at least with respect to

¹⁴² *R (on the application of Nicklinson) v Ministry of Justice* [2014] UKSC 38, [130].

¹⁴³ *R v Quayle* [2005] EWCA Crim 1415.

¹⁴⁴ *Re T* [1992] EWCA Civ 18, [60-61].

¹⁴⁵ B Hewson, "Neither Midwives Nor Rainmakers' — why DL is Wrong' [2013] PL 451.

local authorities.¹⁴⁶ However, in the event of a significant increase in applications to court, articulation of clinicians' powers under the doctrine of necessity might be considered prudent. One possibility would be to restrict the defence of necessity to those situations where there is a duty to act to prevent neglect of the patient.¹⁴⁷ The new laws on wilful neglect by doctors and neglect by providers could be utilised to carve out a limited sphere in which doctors might be expected to intervene to prevent potential harm to a patient making an involuntary treatment refusal. Only in these rare cases would a doctor be justified in acting without the consent of the patient or the court. The cases could be restricted to emergency situations and to cases where the doctor is unable to facilitate an unencumbered decision in time to avoid risk of serious harm. Carefully framed, such a development would generally take the decision away from the courts and extend to doctors the power and responsibilities they currently exercise in relation to patients with mental incapacity. There would be greater equity between decisions that are not autonomous because the decision-maker lacks mental capacity or voluntariness. If the combined effects of enhanced professional accountability and the potentially broad ambit of the inherent jurisdiction lead to an increase of cases to the High Court, this option presents a possible mechanism to enhance access to justice whilst limiting the potential scope of medical paternalism.

V. CONCLUSION

This article has charted legal developments that enhance protection of individuals from their 'bad' medical decision-making and considered the implications for healthcare practitioners. What constitutes a challengeable 'bad' decision was ostensibly controlled by the Mental Capacity Act 2005, which applies a functional test to determine incapacity. Where the test for incapacity is not

¹⁴⁶ *Re A and Re C* [2010] EWHC 978 (Fam) 64; *Re Z (Local Authority: Duty)* [2004] EWHC 2817 (Fam), [19]; *Staffordshire County Council v SRK and Ors* [2016] EWCOP 27, [38].

¹⁴⁷ See related argument of P Gooding, E Flynn, 'Querying the Call to Introduce Mental Capacity Testing to Mental Health Law: Does the Doctrine of Necessity Provide an Alternative?' (2015) 4 *Laws* 245.

satisfied then the decision is, subject to a number of exceptions, left to the individual, no matter how bizarre or irrational others may find it.¹⁴⁸ The emphasis is on free choice rather than autonomous choice. In 2011 Coggon and Miola criticised legal developments perpetuating this approach in the context of information disclosure on the ground that it misrepresented what constitutes patient 'choice'.¹⁴⁹ Since then, legal developments analysed in this article have tackled the potential for the bright line approach that dominates the 2005 Act to harm the interests of vulnerable people. The scope of a 'bad' and challengeable decision is now subject to a range of different approaches, which I have assessed through a consideration of the principle of autonomy. The 2005 Act incorporates health, financial and welfare decisions but this article has focused on medical treatment decisions which raise special issues not least because of their potentially serious nature but also because of their intersection with the wider body of jurisprudence on informed consent and potentially wide-ranging impacts on clinical practice which flow from recent expansions of professional accountability.

The focus has been on three developments in particular. First, paternalistic protections have in practice been extended to those with borderline mental capacity, thus allowing 'the tail of welfare to wag the dog of capacity' (to use the Peter Jackson J.'s phrase). In 2014, the Select Committee pointed to poor implementation of the 2005 Act.¹⁵⁰ Since then, emphasis has been on improving awareness of its core principles. Second, the High Court has developed the inherent jurisdiction to protect those making involuntary decisions. I have explored the likely ambits of these powers in relation to medical treatment decisions, including the potential to move beyond injunctive relief to

¹⁴⁸ Mental Capacity Act 2005, s 1(4).

¹⁴⁹ J Coggon and J Miola, 'Autonomy, Liberty and Medical Decision-Making' (2011) 70(3) CLJ 523.

¹⁵⁰ Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-Legislative Scrutiny*, (HL Paper 139, March 2014), paras 56-58. And see E Cave, 'Determining capacity to make medical treatment decisions: Problems implementing the Mental Capacity Act 2005' 36(1) (2015) Statute Law Review 86.

make dictatorial decisions and to incorporate deprivations of liberty.¹⁵¹ Third, the article has documented an expansion of the public interest in protecting individuals from harm in law and professional guidance on confidentiality.

When these developments are analysed through the lens of autonomy, they can be understood as attempts to add substance to the predominantly procedural account of autonomy inherent in the 2005 Act. The 2015 Supreme Court decision of *Montgomery v Lanarkshire Health Board*¹⁵² emphasises responsibility as a component of autonomy. But there are cases when an individual with mental capacity cannot take responsibility for their decision, for example, when their decision is a result of undue influence. Both external and internal forces can affect an individual's will. Failure to recognise this in law would be to uphold certain involuntary decisions. Such cases will be few: Many involuntary decisions will satisfy the statutory test for mental incapacity. Even capacitous decisions to consent are protected where they are involuntary because the law of consent would render them invalid.¹⁵³ Patients would not, however, be adequately protected from the harmful effects of their involuntary treatment *refusals*. The developing inherent jurisdiction potentially operates as an important safety net in this regard.¹⁵⁴

¹⁵¹ See A Ruck Keene, *The Inherent Jurisdiction: Where are We Now?* (2013), paras 15 and 18 online at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2016/02/Inherent-Jurisdiction-Note.pdf> notes the existence of powers in the Scottish Adult Support and Protection Act 2007 which might influence development in this direction.

¹⁵² [2015] UKSC 11.

¹⁵³ *Chatterton v Gerson* [1981] QB 432.

¹⁵⁴ Note that Ashton sets out an alternative means of addressing the lacuna by separating the terms 'mind' and 'brain' in the s 2(1) part of the test for incapacity so as to move away from a medical approach to incapacity and incorporate external forces that affect the 'mind'. See GR Ashton OBE (ed), *Court of Protection Practice 2014* (Jordan Publishing, 2014), Introduction and see reproduction in A Ruck Keene, 'Reflections on the COP

This approach is not without risk. Insofar as the 2005 Act respects current desire decisions of those who are not found to lack capacity, the Act upholds free choice. The challenge for the increasingly nuanced legal approach to decision-making capacity outlined in this article is to resist the pull from a model focussed on 'best desire' autonomy to one which reflects 'ideal desires'. The 2005 Act provides guiding principles and McFarlane L.J. warned in *DL* that care must be taken to ensure that in exercising the inherent jurisdiction the court does not subvert the will of Parliament.¹⁵⁵ As we have seen, Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 also imposes limitations on the situations in which treatment without P's consent is legally permissible. But ultimately, commitment to human rights - and Articles 5 and 8 of the European Convention on Human Rights in particular - is needed to mitigate the risks of a gradual slide toward hard paternalism. In *X v Finland*¹⁵⁶ it was made clear that compulsory medical treatment must be subject to procedural and substantive safeguards in order to be Article 8 compliant.

What is required of domestic law is a symbiotic development of law and practice to fill the lacuna in the 2005 Act's protection of vulnerable people whilst upholding the principle that anyone capable of making an autonomous decision is able (and, if necessary, facilitated) to do so. Commitment to this aim requires that cases of borderline mental capacity are resolved in strict accordance with the Act; that development of common law capacity develops in line with the 2005 Act; and that further expansion of the 'public interest' defence to confidentiality in order to protect individuals from harm is constrained lest it restrict those capable of making a decision from doing so.

I have suggested that the risks of hard paternalism are particularly strong in clinical practice where the assessment of (in)capacity is increasingly complex and the extension of liability for neglect has

and MCA by Gordon Ashton' *Mental Capacity Law and Policy Blog* (14 March 2014). Online:

<http://www.mentalcapacitylawandpolicy.org.uk/reflections-on-the-cop-and-mca-by-gordon-ashton/>.

¹⁵⁵ [2012] EWCA Civ 253, [62], per McFarlane L.J..

¹⁵⁶ *X v Finland* (Application no. 34806/04; judgment of 3 July 2012)

potential to lead to defensive practices whereby patients may be said to lack capacity on the basis of their vulnerability. There is a risk that in preference to approaching the High Court to exercise its inherent jurisdiction, some practitioners will make assessments of mental incapacity that are not truly justified. This in turn risks exacerbating the well-documented problems associated with implementing the 2005 Act. If, on the other hand, the number of applications to the High Court rises, I have suggested that the judiciary might look to the doctrine of necessity to justify medical treatment that preserves life or prevents significant harm where there is doubt that a treatment refusal is voluntary, and suggested novel ways in which it might be controlled. Given the complex intersection of the various legal developments at the point of clinical practice, much emphasis will be placed on professional guidance and the court's articulation of the powers and application of the inherent jurisdiction as the new common law route to incapacity develops.