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Pregnancy and severe mental illness: Birth choices, best interests and the untapped potential of advance decisions

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Abstract

Choice is a central tenet of maternity care; its importance is emphasised in policy documents, clinical guidelines, and the law. However, the lived experience is often rather different and that is particularly the case in the context of pregnant women with a severe mental illness (SMI). The biomedical discourse is powerful and has successfully constructed pregnancy and birth as risky, as a procedure to be managed by experts using technology to ensure that nothing goes wrong. Within that already risky process, women with SMI are constructed as risky, rather than at risk, posing a risk to themselves and the foetus they carry, as well as to the healthcare professionals who care for them. It is not merely their treatment decisions that are questioned, but their very ability to make those decisions. The consequence of this is reduced choice for women with SMI who are cautioned to act responsibly, but where they fail to acquiesce and comply with medical advice, making the 'wrong' choice, their capacity is called into question and, if found to lack capacity, decisions about mode and place of delivery will be determined by someone else on the basis of that third party's evaluation of her best interests, giving scant regard to her wishes. This article reviews the recent obstetric intervention case law, interrogating the discrepancy between the minimal weight attributed to the birth choices of pregnant women with SMI within the best interests assessment in comparison to the significance accorded to the wishes of non-pregnant individuals in other treatment contexts. It challenges the pregnancy exceptionalism evident in the case law and proposes the use of advance decisions as a tool for women to make birth decisions at a time when their capacity is undiminished, ensuring that their own choices, albeit expressed as refusals of treatment, determine maternity care.

Keywords

Advance decision, best interests, caesarean, severe mental illness, capacity, risk, obstetric intervention

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Introduction: choice as a central tenet of maternity care

Giving birth is an intensely personal experience, an experience shaped by a number of decisions, in terms of how one gives birth (by vaginal delivery or caesarean section), where one gives birth (typically in a hospital either in a midwife-led birthing centre, or an obstetrician-led unit, or at home), what (if any) pain relief one wishes to receive, and with whom one shares the experience. Reflecting the personal nature of those decisions, choice is a central tenet of maternity care; its importance is emphasised in policy documents,[1] clinical guidelines,[2] and the law. As Lady Hale stressed in *Montgomery v Lanarkshire Health Board*[3] in the obstetric context,

> A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the 'natural' and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide. . . Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.[4]

1. See, for example, National Maternity Review, 'Better Births, Improving Outcomes of Maternity Services in England. A Five Year Forward View for Maternity Care', 2016, available at https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf; Department of Health, 'National Service Framework for Children, Young People and Maternity Services: Maternity Services', 2004, available at https://assets.publishing.service.gov.uk/media/5a7b696640f0b6425d592f9d/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Maternity_Services.pdf; NHS England, 'Personalised Care and Support Planning Guidance: Guidance for Local Maternity Systems', 2021, available at https://www.england.nhs.uk/publication/personalised-care-and-support-planning-guidance-guidance-for-local-maternity-systems/.
2. See, for example, NICE Clinical Guideline, 'Intrapartum Care', 2023, available at https://www.nice.org.uk/guidance/ng235/resources/intrapartum-care-pdf-66143897812933; NICE Guideline, 'Intrapartum Care for Women With Existing Medical Conditions or Obstetric Complications and Their Babies', 2019, available at https://www.nice.org.uk/guidance/ng121/resources/intrapartum-care-for-women-with-existing-medical-conditions-or-obstetric-complications-and-their-babies-pdf-66141653845957; NICE Clinical Guideline, 'Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance', 2020, available at https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789; NICE Guideline, 'Cesarean Birth, 2021; NICE Guideline Antenatal Care', 2023, available at https://www.nice.org.uk/guidance/ng192/resources/caesarean-birth-pdf-66142078788805; RCOG, 'Management of Breech Presentation', Green-top Guideline No. 20b, 2017, available at https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/management-of-breech-presentation-green-top-guideline-no-20b/.
3. [2015] UKSC 11.
4. Ibid., 115–116.

Despite this ringing endorsement of pregnant women's[5] autonomy in pregnancy, and the fact that maternity care in the United Kingdom is dominated by the rhetoric of choice, the lived experience is often rather different and that is particularly the case in the context of pregnant women with a severe mental illness (SMI).[6]

No longer characterised as a natural process, birth is framed as a medical procedure, a process to be managed by experts in order to achieve the safe delivery of the foetus. The biomedical discourse is powerful and has successfully constructed pregnancy and birth as risky, as a procedure to be managed by experts using technology to ensure that nothing goes wrong.[7] Within that already risky process, women with SMI are constructed as risky, rather than at risk, posing a risk to themselves and the foetus they carry, as well as to the healthcare professionals who care for them.[8] It is not merely their treatment decisions that are questioned, but their very ability to make those decisions. The consequence of this is reduced choice for women with SMI who are cautioned to act responsibly, but whose capacity is often called into question when they fail to acquiesce and comply with medical advice. If found to lack capacity, decisions about mode and place of delivery will be determined by someone else on the basis of that third party's evaluation of her best interests, giving scant regard to her wishes.

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5. The terms 'woman' and 'women' are used throughout this article while recognising that trans and non-binary people can become pregnant, and so these terms are intended to include all those who may become pregnant and require care during labour and childbirth. The term 'foetus' is used, rather than baby, or unborn child, to reflect the fact that the law draws a crucial distinction between the foetus before birth, and the child after birth, according legal personality only to the latter. However, in its decisions the Court of Protection often blurs the significant status differential, referring to the 'mother' and to the foetus as an 'unborn child', a 'child', or a 'baby'. A particularly egregious example can be seen in *A NHS Foundation Trust v An Expectant Mother* [2021] EWCOP 33 where Holman J deviated from the convention of referring to P by a letter, instead framing her from the outset as 'an expectant mother'. Similarly, he referred to the woman's own mother as the 'grandmother,' the foetus as 'the baby,' but notably her partner, the 'father' of the foetus, was referred to throughout merely as her 'partner'.
6. The majority of the cases have involved women with bipolar disorder or schizophrenia.
7. On medicalisation and risk, see, for example, S. Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (New York: Routledge, 2016); S. Halliday, 'Court-Authorised Obstetric Intervention: Insight and Capacity, A Tale of Loss' in C. Pickles and J. Herring, eds., *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (New York: Routledge, 2019), p. 178; J. McAra-Couper, Marion Jones, and Liz Smythe, 'Caesarean-Section, My Body, My Choice: The Construction of "Informed Choice" in Relation to Intervention in Childbirth', *Feminism & Psychology* 22(1) (2011), p. 81; A. Possamai-Inesedy, 'Confining Risk: Choice and Responsibility in Childbirth in a Risk Society', *Health Sociology Review* 15(4) (2006), p. 406; L. Freeman, 'Confronting Diminished Epistemic Privilege and Epistemic Injustice in Pregnancy by Challenging a "Panoptics of the Womb"', *Journal of Medicine and Philosophy* 40 (2015), p. 44; L. Woliver, *The Political Geographies of Pregnancy* (Champaign, IL: University of Illinois Press, 2002).
8. Halliday, 'Court-Authorised Obstetric Intervention' (see Note 7).

Although few cases are reported, applications for a decision, and/or a declaration,[9] that a caesarean may be performed against the wishes of a pregnant woman have become a regular feature in the Court of Protection.[10] The cases invariably concern an individual with SMI, or a learning difficulty, who is usually refusing clinical advice that her foetus should be delivered by caesarean.[11] As I have suggested elsewhere,[12] the trigger for a capacity assessment is often a refusal to follow medical advice. Capacity operates as a gatekeeper to choice. Laudable though Lady Hale's assertion is (that pregnancy is no longer thought to deprive a woman of her capacity and her right to act as an autonomous individual), it is suggested that once a woman is found to have lost capacity, pregnancy has a transformative effect upon the construction of her best interests. The weight given to her own wishes and feelings is diminished in comparison to non-pregnant subjects and the safe delivery of the foetus is prioritised above all other considerations.

The emphasis placed upon choice within maternity care makes it particularly important that the woman's wishes and feelings,[13] her beliefs and values[14] are taken into account within the best interests assessment. The need to critically engage with the manner in which women's choices in pregnancy can be restricted and undermined is highlighted by a recent, highly significant development in the case law concerning the birth

9. If P lacks capacity, a court can make a decision on her behalf (s. 16 MCA), a s.16 decision can be coupled with a s.15 declaration setting out the lawfulness of an act done, or to be done, in relation to P.
10. A number of the unreported cases feature on the Open Justice Court of Protection Project blog, see, for example, C. Kitzinger (2021) 'C-section and general anaesthesia against her wishes? Capacity and best interests'; C. Kitzinger, 'Refusing Blood Products During Pregnancy and Labour', 2021, available at https://openjusticecourtofprotection.org/2021/09/21/refusing-blood-products-during-pregnancy-and-labour/; S. Halliday, 'Capacity and Elective Caesarean', 2022, available at https://openjusticecourtofprotection.org/2022/01/26/capacity-and-elective-caesarean/; C. Martin and L. Room, 'Court-Authorised Caesarean Section for a Mother With Sickle Cell Disease Who Wants Her Baby to "See Her Face First"', 2022, available at https://openjusticecourtofprotection.org/2022/08/05/court-authorised-caesarean-section-for-a-mother-with-sickle-cell-disease-who-wants-her-baby-to-see-her-face-first/#:~:text=Court%20of%20Protection-,Court%2Dauthorised%20caesarean%20section%20for%20a%20mother%20with%20sickle%20cell,to%20%E2%80%9Csee%20her%20face%20first%E2%80%9D&text=This%20case%20is%20another%20in,Justice%20Court%20of%20Protection%20Project; C. Kitzinger, 'Caesarean: An Emergency Hearing', 2022, available at https://openjusticecourtofprotection.org/2022/03/10/caesarean-an-emergency-hearing/#:~:text=Induction%20of%20labour%20or%20a,have%20not%20been%20well%20controlled.%E2%80%9D.
11. But note *North Middlesex University Hospital NHS Trust v SR* [2021] EWCOP58 where SR wanted to have a caesarean in accordance with clinical advice.
12. Halliday, *Autonomy and Pregnancy* (see Note 7).
13. S. 4(6)(a) MCA 2005.
14. S. 4(6)(b) MCA 2005.

choices of capacitous women with SMI.[15] The earlier quote from Lady Hale's opinion in Montgomery clearly expresses that the right to make one's own decisions is limited by the requirement that one has the capacity to do so. However, recent cases in the Court of Protection evidence a willingness to make anticipatory and contingent orders in relation to a pregnant woman found to have capacity to take decisions concerning the delivery herself, authorising the performance of a caesarean section against her expressed (capacitous) wishes if she were to lose capacity during labour. This new incursion into the right of a capacitous individual to make birth choices for themselves highlights the need to empower women to make decisions that will be given effect even if they no longer have capacity.

As I demonstrate below, the process by which obstetric intervention cases are determined renders the women at the heart of the decision invisible, underplaying her actual wishes and feelings, while promoting 'ideal' values in pursuance of the goal of ensuring the safe delivery of the foetus. One of the key features of the court-authorised obstetric intervention cases is the absence of the woman's unfiltered voice – she is almost never part of the hearing,[16] and she is almost never represented by her own lawyer[17]; instead, her best interests are represented by the Official Solicitor. The woman at the heart of the decision is rendered mute and invisible. Unable to participate in the hearing, she is framed as a passive subject while others decide how the foetus should be delivered. This contrasts starkly with the vision set out in *Better Births*[18] that emphasises the need for personalised care centred upon the woman, baby, and her family.

This article contributes to the existing literature by analysing the discrepancy between the significance attributed within the best interests assessment to the wishes and feelings of pregnant women with SMI regarding pregnancy and birth in comparison to treatment decisions taken by non-pregnant individuals in other contexts. It challenges the pregnancy exceptionalism evident in the case law and proposes the use of advance decisions in order to enable women with SMI to retain the ability to make autonomous decisions about the way in which they give birth. I start by considering the framing of SMI in the pregnancy context, before interrogating the distinctive manner in which the pregnant woman's views are considered and (not) given effect in the evaluation of her

15. *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24, *Guys and St Thomas' NHS Foundation Trust & South London and Maudsley NHS Foundation Trust v R* [2020] EWCOP 4; *North Middlesex University Hospital NHS Trust v SR* (see Note 11). The first two cases form the focus of an interesting case commentary: S. Fovargue, 'Anticipating Issues With Capacitous Pregnant Women: United Lincolnshire NHS Hospitals Trust v CD [2019] EWCOP 24 and Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R [2020] EWCOP 4', *Medical Law Review* 28 (2020), p. 781.
16. For a case where the woman did participate, see *Guys & St Thomas' NHS Foundation Trust v X* [2019] EWCOP 35.
17. An exception is *Re MB (Medical Treatment)* [1997] 2 FLR 426.
18. National Maternity Review, 'Better Births' (see Note 1).

best interests through the lens of three recent cases,[19] suggesting that the approach taken others women with SMI, undermining choice and woman-centred decision-making. The cases exemplify the way in which the decisions of women with SMI can be contested and clearly illustrate the need for advance decisions in this context. Finally, I consider how the use of advance decisions, as distinguished from the more aspirational birth plans, or clinician-determined care plans, can be used to enable the woman's voice to be heard and to determine treatment if she later lacks capacity, empowering the woman to make her own decisions about how to deliver her child, rather than framing her as a passive recipient of care.

SMI and pregnancy

Louise Howard's research demonstrates that most women with SMI will have children,[20] but the association between SMI and a variety of adverse consequences in pregnancy is well established.[21] There is a significant risk of psychiatric decompensation during pregnancy,[22] a risk heightened by the discontinuation or reduced dosage of psychotropic drugs due to the teratogenic and neurodevelopmental risks they can pose to the foetus. Ideally, reproductive health and preconception discussions should form a routine part of the care of all women of childbearing age with SMI who are considering becoming pregnant. This would ensure that the impact of drugs upon a pregnancy could be taken into account and a detailed treatment plan could be developed prior to conception, to

19. In this article, I focus upon the most recent case law; for an analysis of the previous case law, see Halliday, *Autonomy and Pregnancy* (see Note 7); Halliday, 'Court-Authorised Obstetric Intervention' (see Note 7); S. Fovargue, 'In Whose Best Interests? Childbirth Choices and Other Health Decisions', *LQR* 137 (2021), p. 604.
20. See, for example, L. M. Howard, C. Kumar, and G. Thornicroft, 'The Psychosocial Characteristics of Mothers With Psychotic Disorders', *British Journal of Psychiatry* 178 (2001), p. 427.
21. C. Taylor, Robert Stewart, Jack Ogden, Matthew Broadbent, Dharmintra Pasupathy, and Louise M. Howard, 'The Characteristics and Health Needs of Pregnant Women With Schizophrenia Compared With Bipolar Disorder and Affective Psychoses', *BMC Psychiatry* 15 (2015), p. 88; L. M. Howard and H. Khalifeh, 'Perinatal Mental Health: A Review of Progress and Challenges', *World Psychiatry* 19(3) (2020), p. 313; M. Rusner, Marie Berg, and Cecily Begley, 'Bipolar Disorder in Pregnancy and Childbirth: A Systematic Review of Outcomes', *BMC Pregnancy Childbirth* 16 (2016), p. 331; S. N. Vigod, P. A. Kurdyak, C. L. Dennis, A. Gruneir, A. Newman, M. V. Seeman, P. A. Rochon, G. M. Anderson, S. Grigoriadis, and J. G. Ray, 'Maternal and Newborn Outcomes Among Women With Schizophrenia: A Retrospective Population Based Cohort Study', *BJOG* 121 (2014), p. 566.
22. For example, a relapse rate of 10%–20% for bipolar disorder, Howard, 'The Characteristics and Health Needs of Pregnant Women With Schizophrenia' (see Note 21), citing A. Stevens, Peter J. J. Goossens, Elise A. M. Knoppert-van der Klein, Stasja Draisma, Adriaan Honig, and Ralph W. Kupka, 'Risk of Recurrence of Mood Disorders During Pregnancy and the Impact of Medication: A Systematic Review', *Journal of Affective Disorders* 249 (2019), p. 96 (reporting a 20% risk of relapse) and C. L. Taylor, Matthew Broadbent, Mizanur Khondoker, Robert J. Stewart, and Louise M. Howard, 'Predictors of Severe Relapse in Pregnant Women With Psychotic or Bipolar Disorders', *Journal of Psychiatric Research* 104 (2018), p. 100 (reporting a 10% risk of relapse).

facilitate the optimum management of her mental health during pregnancy.[23] However, while best practice, all too often that is not the case and, in any event, not all pregnancies are planned.

No psychotropic drugs are licenced for use in pregnancy. In the case of sodium valproate (used to treat bipolar disorder and epilepsy), use during pregnancy is known to cause an 11% risk of birth defects and an up to 40% risk of developmental disorders.[24] Due to the well-recognised risks associated with valproate, it should not be used by women of childbearing age unless a pregnancy prevention plan is in place.[25] The case is less clear cut in the case of other medications and the potential harm to the foetus needs to be balanced against the benefit of continuing the medication that allows the woman to maintain her mental health and well-being. For example, one of the most common drugs used to treat bipolar disorder is lithium, but lithium use, particularly during the first trimester, is associated with an increased risk (approximately 2%) of foetal heart defects. However, Anja Stevens' systematic review found that continuation of lithium during pregnancy by women with bipolar disorder led to a 66% reduction in the risk of relapse during pregnancy.[26] Each pregnancy will require a risk-benefit assessment to be undertaken on an individual basis,[27] with clinicians providing information about the relative risks and benefits of pharmacotherapy to enable the woman to make an informed decision about her medication. In view of the potential risk to the foetus, many women choose to discontinue their medication during pregnancy[28]; however, inappropriate discontinuation of medication results in higher relapse rates,[29] increasing the possibility that the affected women will be considered to no longer have the capacity to make decisions for themselves as birth approaches.

23. Halliday, 'Court-Authorised Obstetric Intervention' (see Note 7); R. Catalao, Sue Mann, Claire Wilson, and Louise M. Howard, 'Preconception Care in Mental Health Services: Planning for a Better Future', *British Journal of Psychiatry* 216 (2020), p. 180; NICE, 'Antenatal and Postnatal Mental Health Clinical Management and Service Guidance', 2020, 1.2.1, available at https://www.nice.org.uk/guidance/cg192.
24. Medicines and Healthcare Products Regulatory Agency, 'Guidance Valproate Use by Women and Girls', 2021, available at https://www.gov.uk/guidance/valproate-use-by-women-and-girls; Medicines and Healthcare products Regulatory Agency, 'Valproate: Reminder of Current Pregnancy Prevention Programme Requirements; Information on New Safety Measures to Be Introduced in the Coming Months', 2022, available at https://www.gov.uk/drug-safety-update/valproate-reminder-of-current-pregnancy-prevention-programme-requirements-information-on-new-safety-measures-to-be-introduced-in-the-coming-months.
25. Ibid.
26. Stevens et al., 'Risk of Recurrence of Mood Disorders During Pregnancy and the Impact of Medication' (see Note 22), p. 98.
27. NICE, 'Antenatal and Postnatal Mental Health Clinical Management and Service Guidance'.
28. C. Ross, Tinsley G. Webster, Camille A. Tastenhoye, Alisse K. Hauspurg, Jill E. Foust, Priya R. Gopalan, and Susan Hatters Friedman, 'Reproductive Decision-Making Capacity in Women With Psychiatric Illness: A Systematic Review', *Journal of the Academy of Consultation-Liaison Psychiatry* 63 (2022), p. 61.
29. Howard, 'The Characteristics and Health Needs of Pregnant Women With Schizophrenia' (see Note 21), p. 317.

Capacity

A commitment to person-centred care underpins the Mental Capacity Act 2005; this finds expression in the five principles set out in s.1,[30] the first of which enshrines the presumption of capacity (s.1(2)). The presumption of capacity applies to everyone and the majority of women with SMI will retain capacity throughout their pregnancy, *including* those detained under the Mental Health Act (MHA) 1983.[31] In *GSTT & SLAM v R*, Hayden J recognised the particular challenge posed by obstetric intervention, but emphasised that 'The inviolability of a woman's body is a facet of her fundamental freedom but so too is her right to take decisions relating to her unborn child based on access, at all stages, to the complete range of options available to her'.[32] However, it is important to recognise that the range of options available to a woman with SMI are more restricted than those more generally available. The limited number of mother and baby units and speciality perinatal mental health services reduce choice throughout pregnancy, with access and the type of support available to women highly dependent upon where they live.[33] Delivery options are also constrained – if a woman is detained under the Mental Health Act, the option of a home birth will not be available to her, but even for women who remain well, hospital birth is strongly recommended for all women with SMI.[34]

30. S.1 (2) 'A person must be assumed to have capacity unless it is established that he lacks capacity. (3) 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. (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (5) 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. (6) 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 first three principles are protective of autonomy, the fifth principle requires respect for liberty, while the fourth principle emphasises the best interests/ welfare focus to be adopted in deciding for those who lack capacity. For an excellent analysis of how these principles operate, considering when patients should be protected from their own 'bad' decisions, see E. Cave, 'Protecting Patients From Their Bad Decisions: Rebalancing Rights, Relationships, and Risk', *Medical Law Review* 25 (2017), p. 527.
31. D. Okai, Gareth Owen, Hugh McGuire, Swaran Singh, Rachel Churchill, and Matthew Hotopf, 'Mental Capacity in Psychiatric Patients: Systematic Review', *British Journal of Psychiatry* 191 (2007), pp. 291, 295, reporting that the majority of psychiatric inpatients retain capacity to make their own treatment decisions, with rates of incapacity generally in line with that found in general hospital in-patients.
32. *Guys and St Thomas' NHS Trust v R* (see Note 15), [67].
33. S. Witcombe-Hayes, Ian Jones, Paul Gauci, Jenny Burns, Simon Jones, and Susan O'Leary, 'From Bumps to Babies: Perinatal Mental Health Care in Wales,' 2018, available at https://www.exchangewales.org/wp-content/uploads/sites/14/2020/06/from-bumps-to-babies-perinatal-mental-health-care-in-wales-full-report-english-1.pdf.
34. See, for example, R. H. McAllister-Williams, David S. Baldwin, Roch Cantwell, Abby Easter, Eilish Gilvarry, Vivette Glover, Lucian Green, Alain Gregoire, Louise M. Howard, Ian Jones, Hind Khalifeh, Anne Lingford-Hughes, Elizabeth McDonald, Nadia Micali, Carmine M. Pariante, Lesley Peters, Ann Roberts, Natalie C. Smith, David Taylor, Angelika Wieck, Laura M. Yates, and Allan H. Young, 'British Association for Psychopharmacology Consensus Guidance on the Use of Psychotropic Medication Preconception, in Pregnancy and Postpartum 2017', *Journal of Psychopharmacology* 1 (2017), p. 10.

While the policy literature employs a rhetoric of choice, not all birth choices will be considered valid, or even responsible. This is particularly the case where the woman has SMI, a factor that is seen to augment what is already viewed as a risky endeavour without close management. This is clearly demonstrated in the case of *University Hospitals Dorset NHS Foundation Trust v Miss K*[35] where Lieven J quoted the treating consultant obstetrician, saying, 'the birth process does not simply "happen to" a woman, she has to cooperate in order for it to happen safely'.[36] As Judith McAra-Couper observes, 'the belief that birth is risky – along with a dependence on hospitalization, intervention and technology to ensure safety – actually constrains and regulates choice.'[37] This is particularly evident in the case of *An Expectant Mother*[38] involving a woman with agoraphobia who was determined to lack the capacity to make the decision to give birth at home due to the potential risk that she might refuse transfer to hospital if the need arose. Holman J stressed that this case was 'not about the advantages or disadvantages of hospital birth or home birth'[39]; the focus of the decision was upon the potential for a situation to arise requiring urgent transfer to hospital, a risk reported to be around 10% in cases like P involving young, healthy, primigravida patients electing a home birth, of which around 2% of cases were reported to be 'blue light' situations. P was determined to lack the capacity to determine *where* to give birth, but to have the capacity to make the decision of *how* to give birth. Notably she was not to be permitted a free choice about mode of delivery though, being required to choose between an induction or a caesarean delivery. The option to await the natural onset of delivery was rejected to ensure that the delivery could be managed in a hospital environment, to avoid the potential risk that if an emergency situation arose at home, she might refuse transfer to the hospital.

Given the greater need for monitoring women with SMI in labour (for example, if the woman is taking antipsychotics an electrocardiogram (ECG) will be recommended), it is almost inevitable that she will be allocated to obstetrician-led care, rather than midwife-led care in a birth centre. Obstetrician-led care is associated with cascading interventions following from increased use of technology to monitor the progress of labour.[40] While many women object to the use of technology, there is an expectation that women with SMI will be monitored during labour, to manage risks (and the woman) and she will be expected to comply with medical advice, consenting to such intervention. The case law indicates that where her compliance is in doubt, questions about her capacity to make her own decisions arise.[41]

35. [2021] EWCOP 40.
36. Ibid. [19].
37. McAra-Couper, 'Caesarean-Section, My Body, My Choice' (see Note 7), p. 84.
38. See Note 5.
39. Ibid. [11].
40. P. Lowe, *Reproductive Health and Maternal Sacrifice* (London: Palgrave Macmillan, 2016), p. 147.
41. See, for example, *GSTT v X* [2019] EWCOP 35; *University Hospitals Dorset NHS Foundation Trust v Miss K* (see Note 35); *GSTT & SLAM v R* (see Note 15). This may result in repeated capacity assessments, for example, the woman at the centre of *GSTT & SLAM v R* (discussed in detail below) was subjected to three capacity assessments during the period from 19 June to 22 August, all of which confirmed that she retained capacity to refuse a caesarean, a course of action she described as 'the last thing she would want'. [3] and [56].

A woman's ability to refuse intervention is dependent upon her being found to not lack capacity to do so. In many of the obstetric intervention cases, obstetricians have recommended caesarean delivery, despite the woman's desire for a vaginal delivery and indeed her refusal of a caesarean.[42] In these cases, the clinicians' preference for caesarean birth is based upon a risk management strategy that centres upon the framing of the pregnant woman with SMI as risky, rather than being at risk. She is portrayed as someone who poses a risk to others – the foetus and the healthcare professionals; as someone who may lose control and who will not comply with instructions; as a woman who may become violent towards healthcare professionals in the room, who will not cope with giving birth.[43] All too often the emphasis is upon medical management of the delivery, on the woman needing to remain in control of herself and to allow herself to be controlled by the clinicians, to do as they say and to cooperate throughout the delivery, rather than upon supporting her through the delivery.

As the Court of Appeal stressed in *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S*,[44]

> . . . [An unborn child's] need for medical assistance does not prevail over [a pregnant woman's] rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.[45]

Nevertheless, in Court of Protection hearings women with an SMI are portrayed as other, compared to the idealised mother who would sacrifice even her most deeply held values to ensure the safe delivery of her foetus; thus found wanting, her decision is framed as unreasonable, immoral, and her ability to make decisions as suspect.

The Mental Capacity Act (MCA) protects the right to make an unwise decision (s.1(4) MCA 2005), but that is only the case if the woman has capacity and as Coggon has argued, 'Patients are ostensibly free to act irrationally, but in reality only in accordance with an unspecified range of "irrationalities."'[46] Conducting post-legislative scrutiny of the MCA in 2014, the House of Lords' Select Committee concluded, 'The concept of unwise decision-making faces institutional obstruction due to prevailing cultures of risk-aversion and paternalism.'[47] This finds particular expression in the obstetric intervention case law – refusals of obstetric intervention are pathologised, framed as being so unwise, so divergent from what might be considered reasonable, as to indicate an inability to

42. See, for example, *GSTT v X* (see Note 41) and *GSTT & SLAM v R* (see Note 15).
43. See, for example, *University Hospitals Dorset NHS Foundation Trust v Miss K* (see Note 35), where K is described as behaving aggressively towards staff; in *GSTT & SLAM v R* (see Note 15), it was suggested that should the need for a caesarean arise, she might resist.
44. [1999] Fam. 26.
45. Ibid., 50, per Judge LJ.
46. J. Coggon, 'Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection', *Medical Law Review* 24 (2016), pp. 396, 401.
47. House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: Post-Legislative Scrutiny* (The Stationery Office, London, 13th March 2014), [104].

decide. The consequence of pathologising non-compliance is to undermine the statutory framework designed to empower and facilitate people making their own decisions.

The MCA's two-stage test for incapacity requires that both the diagnostic criterion (s.2(1)) and the functional threshold (s.3(1)) are satisfied before an individual is found to lack the capacity to make their own treatment decisions.[48] Combined with the principle that a person is not to be treated as unable to make a decision merely because they makes an unwise decision, the functional test should ensure that the focus remains upon the decision-making process, rather than the content of the decision made, but it can be questioned to what extent that principle has translated in practice. The MCA eschews a status-based approach to capacity, making capacity time- and decision-specific; a causal link between the mental impairment and the inability to make a decision is required. However, the obstetric intervention cases illustrate the danger identified by McFarlane LJ in *York City Council v C*,[49] that the ordering of the tests within the statutory framework can lead to the overemphasis of the diagnostic test if transferred to the structuring of the capacity decision.[50] Therefore, as the Supreme Court confirmed in *A Local Authority v JB*,[51] the first question to be determined is whether the woman is unable to make a decision concerning mode of delivery and if so whether that inability is 'because of' an impairment of, or a disturbance in the functioning of, the mind or brain.[52] The sequencing of the test for capacity is particularly important because foregrounding the diagnosis situates the focus of the assessment on the woman's SMI, which may lead to a presumption that she will lack the ability to make a decision.[53]

If the presumption of capacity is not rebutted, the woman's refusal of treatment will be operative; she will remain the sole author of her birth choices and can refuse or consent to intervention as she wishes.[54] If a woman is found to lack capacity and she has no valid and applicable advance decision or Lasting Power of Attorney (LPA) empowered to consent/refuse treatment, a determination of her best interests will have to be made.

48. The diagnostic criterion requires an assessment of whether or not the individual has 'an impairment of, or disturbance in the functioning of the mind or brain'. The functional threshold requires the determination of whether the impairment or disturbance renders the individual incapable of making the decision in question. For a detailed consideration of the assessment of capacity as it operates in obstetric intervention cases, see Halliday, *Autonomy and Pregnancy* and Halliday, 'Court-Authorised Obstetric Intervention' (see Note 7).
49. [2013] EWCA Civ 478.
50. Ibid. at [58].
51. [2021] UKSC 52.
52. Ibid. at [79].
53. Such an assumption was clear in a comment made by Mostyn J in the hearing of the first reported post-MCA obstetric intervention case, where he admitted, 'I am struggling to envisage a circumstance where a patient detained under section 3 as an inpatient with a diagnosed mental illness has got capacity'. *Re AA (Mental Capacity: Enforced Caesarean)* [2012] EWHC 4378 (COP), transcript of proceedings, 4, Mostyn J. The Official Solicitor responded quickly, explaining that it is entirely possible for a detained patient to retain capacity.
54. But note in those cases where her capacity has been found to be intact, the Court of Protection has recently demonstrated a willingness to make anticipatory and contingent orders to take effect should she lose capacity during labour, discussed below.

Somebody else will make her birth choices for her. The question to be addressed in the next section is to what extent her wishes and feelings will be prioritised in the choices made by the Court of Protection.

Patient choice, incapacity, and the assessment of best interests

Where a person lacks capacity s.1(5), MCA requires that any decision made on their behalf must accord with their best interests. There is no single test defining what is in the patient's best interests[55]; rather, it is 'an assessment wide in compass and not confined to an assessment only of the best medical interests of the patient'.[56] A key question is the role and significance to be accorded to P's own wishes and feelings within that assessment.

The MCA made a clear shift towards recognising the importance of P's voice within the assessment of her best interests, emphasising the need for a participatory approach to the best interests assessment.[57] Thus, wherever possible a decision should not be taken about a person without involving that individual (s.4(4)) and the best interests assessment must *consider* their past and present wishes and feelings, beliefs, and values and other factors she would consider if able to do so (s.4(6)), as well as (where practicable) consulting others who care for P, or are interested in her welfare (s.4(7)(b)).[58]

While the common law had not specifically included consideration of the individual's wishes and feelings,[59] they were enumerated as a relevant consideration in s.4(6)(a) MCA 2005, but mere consideration of the individual's wishes and feelings falls far short of the United Nations Convention on the Rights of Persons with Disabilities' (UNCRPD) exhortation in Article 12 that P's will and preferences should be respected. It has long been recognised that the best interests assessment encompasses more that P's best medical interests,[60] but more recently there has been a clear retreat from the Bolamesque construction of best interests with increased focus upon the subjective elements of the test, as Lady Hale emphasised in *Aintree*, 'The purpose of the best interests test is to consider matters from the patient's point of view.'[61] Nevertheless, the Law Commission has recommended that s.4(6) be amended to require *particular weight* to be given to the

55. *R (Burke) v GMC (Official Solicitor intervening)* [2005] EWCA Civ 1003, [63] per Lord Philips.
56. *A Clinical Commissioning Group v P & TD* [2019] EWCOP 18, [45] per Macdonald J.
57. See generally M. Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', *Medical Law Review* 17 (2009), p. 1.
58. Family involvement is often rather limited in the obstetric intervention cases – there was no family involvement in the three cases analysed below.
59. *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 F.C.R. 193, see also *Practice Direction (Declaratory Proceedings: Incapacitated Adults)* [2002] 1 W.L.R. 325.
60. See, for example, Butler-Sloss LJ's comments in the first obstetric intervention case to be considered by the Court of Appeal, *Re MB* (see Note 17), 439. For an excellent analysis of best interests in the context of *Re MB* and an imaginary judgment from Lady Athena, focusing upon substituted judgment and MB, see S. Pattinson, *Revisiting Landmark Cases in Medical Law* (Abingdon: Routledge, 2019), ch.5.
61. *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [39] per Lady Hale.

wishes and feelings of P in the determination of her best interest,[62] having found that 'best interests decisions regularly fail to give essentially any weight to – let alone prioritise – the person's wishes and feelings'.[63]

While the patient's wishes are not determinative of her best interests, a clear shift towards a patient-centred approach to determining best interests is discernible in cases not involving pregnant women refusing obstetric intervention[64]; thus, in *Briggs v Briggs*, Charles J held that 'if the decision that P would have made, and so their wishes . . .can be ascertained with sufficient certainty it should generally prevail'.[65] In *GSTT & SLAM v R*, Hayden J put the position rather more tentatively in recognising the importance of taking account of the pregnant woman's wishes and feelings (refusing a caesarean). Rather than suggesting that her wishes 'should generally prevail', he stated, 'While the identified wishes of P will not in and of themselves be determinative, they will always be given substantial weight and are highly likely to be reflected in the order or declaration the Court makes.'[66] However, recent cases of concerning obstetric intervention, including *GSTT & SLAM v R*, suggest that relatively little weight is given to the woman's wishes and feelings, unless they coincide with clinical advice,[67] and that they are seldom prioritised in the court's determination of her best interests. Instead, the recent case law confirms the criticism made almost a decade ago by the House of Lords Select Committee, stating that the 'the wishes, thoughts and feelings of P are not routinely prioritised. Instead, clinical judgments. . . predominate'.[68]

In the following section, I suggest that the Court of Protection has failed to promote choice and woman-centred decision-making in the obstetric intervention cases involving women with SMI; I interrogate this argument through the lens of three recent cases, considering the way in which their best interests were determined, focussing upon the role accorded to their wishes and feelings within that assessment and the extent to which they participated in the decisions.

62. Law Commission, *Mental Capacity and Deprivation of Liberty* (2017), Law Com. No.372, HC 1079, 161, recommendation 40.
63. Ibid., 158.
64. A similar divergence from the weight accorded to the patient's wishes can also be seen in the anorexia context, see E. Cave and J. Tan, 'Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales', *International Journal of Mental Health and Capacity Law* (2017), p. 4.
65. [2016] EWCOP 53, [62].
66. See Note 15 [33].
67. There have been a few cases recently where women were compliant and had engaged with clinicians in developing a care plan, agreeing to treatment in line with clinical advice. Those care plans have subsequently been confirmed as according with P's best interests, see, for example, *Gloucestershire Hospitals NHS Foundation Trust & Anor v Joanna* [2023] EWCOP 21, *Somerset NHS Foundation Trust v Amira* [2023] EWCOP 25 and *Lancashire Teaching Hospitals NHS Foundation Trust v PM & Ors* [2021] EWCOP 71. PM reportedly told the Official Solicitor's agent 'with force, that she wanted the Caesarean section because Dr C had said it was safest for her baby' [10]. In such cases, where the women have chosen to follow medical advice, their views are emphasised within the best interests assessment.
68. Select Committee (2014) (see Note 47), [104].

X & Y v Ms A[69]. A suffers from paranoid schizophrenia; she was 38 weeks pregnant at the time of the hearing. She already had two children, and prior to becoming pregnant again, she had stopped taking her medication in preparation for the pregnancy; she told her obstetrician that she wanted to have a home birth. Following a relapse, she was detained under the MHA; she declined treatment for her mental health and repeated her desire for a home birth. A scan showed that the foetus was in the breech position, but an attempt to turn the foetus through external cephalic version (ECV) was unsuccessful. A was seen by the Official Solicitor's agent and explained to him that even though she appreciated that it might be safer for the baby, she didn't want to have a caesarean because of the discomfort it would cause her.[70] She emphasised that the single most important thing was 'for me and baby to be healthy, well and safe'.[71] She was, however, adamant that she did not want to have a caesarean.[72]

Both A's consultant obstetrician and psychiatrist formed the view that she lacked capacity to make decisions about mode of delivery. As A was detained, a home birth was out of the question, so it fell to be determined whether she should give birth via a caesarean, or her preferred mode – a vaginal delivery. Cohen J found that she lacked capacity because she could not retain and weigh the information relating to the risk posed by a vaginal delivery to both herself and the foetus, nor could she understand the increased risks associated with an emergency caesarean.[73] Throughout the judgement, Cohen J emphasised the risky choice that A had made by refusing a caesarean despite the breech presentation, stressing that 'the risks in a vaginal delivery were significantly greater and potentially fatal'.[74] Referring to the Royal College of Obstetricians and Gynaecologists (RCOG) guidance, Cohen J noted that there is a 40% risk that a breech birth will require an emergency caesarean. Emergency caesareans are frightening, distressing, and stressful; Cohen J accurately described an emergency caesarean as 'risky to both mother and child'.[75] However, the weighting of risk needs to be considered. A 40% risk is not negligible, but for context that means that there was a much greater chance (60%) that an emergency caesarean would not be necessary. Moreover, the RCOG guidance makes it clear that 'a planned caesarean leads to [only] a small reduction in perinatal mortality compared with planned vaginal breech delivery'. It continues, 'Any decision to perform a caesarean section needs to be balanced against the potential adverse consequences that may result from this.'[76]

Caesarean sections involve greater maternal risks than those associated with vaginal delivery, both in terms of complications that can arise during the caesarean and increased

69. [2021] EWCOP 17.
70. Ibid., [16].
71. Ibid., [18].
72. Ibid., [11].
73. Ibid., [19].
74. Ibid., [9].
75. Ibid., [17].
76. L. W. M. Impey, D. J. Murphy; M. Griffiths, and L. K. Penna, on behalf of the RCOG, 'Management of Breech Presentation: Green-top Guideline No. 20b', *British Journal of Obstetrics and Gynaecology* 124 (2017), pp. 151, 153.

risks of complications for future pregnancies.[77] The consultant obstetrician assessed the risk of foetal mortality as low, but stressed that this was a risky situation, suggesting that if the foetus or A were harmed it would have a significant impact upon A's health. A's obstetrician said that she would ordinarily have supported a vaginal breech delivery for A in view of her obstetric history, but having regard to all the circumstances of the case, her opinion was that a planned caesarean was in A's best interests.[78] The only risks detailed in the judgement relate to the risk that an emergency caesarean might be required; it would appear that what made A's case different was her resistance to a caesarean delivery.

Although A's views were reported in some detail by the Official Solicitor, she was not heard directly and (at least in the judgement handed down[79]) nobody engaged with her concern regarding what Cohen J described as 'discomfort' following a caesarean birth, nor was there any engagement with what the long-term impact would be upon A of overriding her wishes. Ultimately, the clinicians and the Official Solicitor agreed that it would be in A's best interests to have a caesarean, against her clearly expressed wishes; the judge agreed, finding that 'the views expressed by Ms A are not in her best interests',[80] and that notwithstanding her opposition to a caesarean delivery, her overall desire 'would be her wish to have a safe delivery of her child'.[81] A's choice, a choice based upon her previous experience of giving birth, her knowledge of her own body and her desire to ensure the safety of both herself and the foetus, was not given 'substantial weight'. A's concern for her own well-being following a caesarean was minimised, while the potential for harm to the foetus was emphasised. Her own best interests were found to require the safe delivery of the foetus and, therefore, to support an (overly) cautious approach to delivery.

University Hospitals Dorset NHS Foundation Trust v Miss K.[82] The Trust sought a declaration that it would be in K's best interests to have a planned caesarean on the next day. K has a diagnosis of schizophrenia and had been detained under s.2 MHA for around a month by the time of the hearing; she was 37+4 weeks pregnant. Around the time that K was detained, a Child Protection Case Conference was convened and the decision was taken to remove the child at birth, although K was not informed of the decision until 2 days before this hearing. No psychiatric notes were available to the court.

The consultant obstetrician first met K on Monday, 7 June 2021, 3 days before the hearing. Seemingly unaware of K's psychiatric history and that she had been very unwell only the previous week, the obstetrician formed the view that K had capacity to make decisions about her obstetric care. K agreed to the proposed caesarean, without knowing

77. For a detailed analysis of the comparative risks between caesarean and vaginal delivery, see NICE Guideline, *Caesarean Birth*, 2021, Appendix A.
78. See Note 69, [20].
79. As Rosie Harding has noted, 'When only the judgment is available for academic scrutiny, we cannot be clear as to the ways that the various submissions were framed'. R. Harding, 'The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance', *MLR* 78(6) (2015), pp. 945, 962.
80. Ibid., [22].
81. *X & Y v Ms A* (see Note 69), [18].
82. *University Hospitals Dorset NHS Foundation Trust v Miss K* (see Note 35).

that the baby would be removed at birth. In consenting to the planned caesarean, she told the obstetrician that 'she wanted to hold her baby and keep the baby safe and that she was delighted to give birth sooner rather than later (by having a caesarean section) so that she could hold her baby earlier'.[83] However, with the baby to be removed at birth, K would not have the opportunity to hold her baby; once she came round from the anaesthetic, he would have already been taken into care.

The following day K was informed that the baby would be removed and her mental health deteriorated significantly, leading to renewed concerns about her capacity and ability to cooperate with a caesarean. The obstetrician saw K again and concluded that she lacked capacity to make a decision about the planned caesarean, finding that she could not process or understand information, or recall their conversation of 2 days before. The Trust sought a declaration that it would be in K's best interests to perform a caesarean on the next day.

Lieven J was extremely critical of the Trust given that it had been clear for at least a week that there was concern that K might lack capacity to determine her own obstetric care. She found that on the evidence given by K's obstetrician and psychiatrist it was clear that she could not process, or understand the information given to her, retain it, or weigh it up due to her current psychosis and, therefore, lacked capacity to determine the mode of delivery.[84] With no access to medical records and her agent having only had minimal engagement with K while she was extremely agitated and unwell,[85] the Official Solicitor felt unable to take a position on K's best interests. Observing wryly that she did not 'have that luxury',[86] Lieven J began by considering K's wishes and feelings. K was not in a position to make her views known, but Lieven J noted that she had consented to a caesarean earlier in the week and that she had made it clear to the Official Solicitor's agent on the day of the hearing that she was concerned about the baby, leading her to conclude, 'I have no reason to believe her wishes would be anything other than to have the safest birth possible'. However, there are considerable difficulties with placing any reliance on K's consent to the planned caesarean as an authentic expression of her wishes and feelings given that she made it with the express intention of being able to hold her baby sooner, because she did not know that the child would be taken into care before she came around from the general anaesthetic. It may well be true that she would have wanted to have the safest possible birth, but it is not clear that she would have regarded that as being a caesarean.

Moreover, there is nothing in the judgement to suggest that a caesarean was required immediately to safeguard either K or her foetus. At 37+4 weeks, birth was not yet imminently expected, and as Lieven J recognised, there was at least a suggestion that K's capacity was fluctuating; only 3 days before the hearing, the obstetrician had considered her able to give an 'capacitous informed consent'.[87] That being the case, it is difficult to see why it would not have been possible to delay the planned caesarean to see whether K might regain capacity in the intervening period. As a postscript to the judgement, Lieven J does note that prior to the caesarean being performed, a cardiotocography (CTG)

83. Ibid., [17].
84. Ibid., [11].
85. The report from the Official Solicitor's agent was only received after evidence had closed and she had begun giving her closing submission. [4].
86. *University Hospitals Dorset NHS Foundation Trust v Miss K* (see Note 35), [18].
87. Ibid., [17].

showed foetal tachycardia 'which was further supportive of the decision to deliver' that day[88]; however, this information was not available to the court at the time she made her decision and, therefore, formed no part of the best interests assessment.

Lieven J concluded that K's medical best interests required that she have a caesarean. She noted that K was extremely distressed and behaving aggressively, perhaps unsurprisingly given that she had just been informed that her 'baby' would be removed at birth. Lieven J emphasised that the medication K was receiving posed some risks to the 'baby', and 'most importantly' that it was difficult to anticipate how K would react to a vaginal delivery, saying, 'Miss K is unable to physically, or mentally cooperate. Therefore, a vaginal birth would be highly risky to her and her baby'.[89]

Lieven J placed considerable emphasis on K's current situation, noting that she was under considerable levels of restraint, often in seclusion and had been given medication against her will, presenting a risk to her physical and mental health. She also noted the concern that K 'would be unable to reliably alert those caring for her if she experienced reduced foetal movements'.[90] While accepting that a caesarean poses some risks, she minimised those risks, finding that 'there is nothing in her medical history to suggest that she is at any greater risk than any other woman'. She did recognise that there would be considerable difficulties to be addressed after the surgery,[91] but on balance concluded that a planned caesarean was in K's best interests. As a postscript to the judgement, Lieven J noted that K did not resist transfer to the Trust providing obstetric care, engaged fully with the clinicians, and walked into theatre without the need for restraint. The baby boy was reported to be doing well; no mention was made of K, or how she was impacted by the removal of her child.

With no authentic knowledge of what K would want, the best interests assessment is clearly dominated by medical interests, but it is significant that those risks that are highlighted relate primarily to the foetus – that the drugs used to treat K may pose a risk to the foetus and that K may not be able to alert staff if foetal movement reduced. K's treatment in the psychiatric intensive care unit would not be brought to an end by a caesarean, although additional therapeutic measures would be available after delivery. However, in this decision K is framed largely as a conduit to a healthy baby, a baby that (at least in the first instance) she would not parent, or even see because it was delivered under general anaesthetic. K was not present at the hearing; there was no knowledge of her current wishes and no input from her family or partner, and delay in making the application deprived the Official Solicitor of the opportunity to speak to K while she was well. All of these factors combined to render K invisible, to deprive her of the opportunity to participate in the proceedings and to render her mute.

Guys and St Thomas' NHS Foundation Trust & South London and Maudsley NHS Foundation Trust v R.[92] R was 39+6 weeks pregnant, so it could be expected that she would give

88. Ibid., [23].
89. Ibid., [19].
90. Ibid., [20].
91. Ibid., [21].
92. *GSTT & SLAM v R* (see Note 15).

birth imminently. R has bipolar affective disorder and, at the time of the application, was detained under the MHA. She also had polyhydramnios (excess amniotic fluid), the foetus was large and its presentation was uncertain. It was argued that R might lose capacity during labour and that in the event that she might require a caesarean 'for the safe delivery of her baby' there was the potential that she would resist.[93] There was no suggestion that there was a physical risk to R if she were to refuse a caesarean section.

One of the distinguishing facts in this case was that despite multiple capacity assessments, all of the clinicians involved in R's care agreed that she had the capacity to make decisions concerning her obstetric care. That being the case, she had the right to refuse a caesarean. As the Court of Appeal emphasised in *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S*,[94] pregnancy does not obviate the need for consent; it does not diminish a woman's right to refuse treatment.

The MCA Code of Practice emphasises that capacity falls to be assessed at the time when the decision is to be made; it is, therefore, time-specific.[95] For that reason, Hayden J stressed that he was not being asked to overrule a capacitous adult's refusal of treatment, but rather that the question for the court was whether, if P loses capacity, treatment could be authorised that was contrary to her wishes expressed while capacitous.[96] At the time of the hearing, it was agreed that R had capacity; thus, Hayden J held that it was not open to the court to make an order under s. 16 MCA whereby the court makes the decision on P's behalf.[97] However, he distinguished s. 15 MCA, arguing that it is not expressly limited to the situation where P lacks capacity.

S. 15(1)(c) MCA enables the Court to grant a declaration as to 'the lawfulness or otherwise of any act done, or yet to be done, in relation to' P. Emphasising the significance of the words 'yet to be done', Hayden J held that s.15 MCA can apply to foreseeable circumstances, stating,

> In making a declaration that is contingent upon a person losing capacity in the future, the Court is doing no more than emphasising that the anticipated relief will be lawful when and only when P becomes incapacitous. It is at that stage that the full protective regime of the MCA is activated, not before.[98]

93. Ibid. [2].
94. *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* (see Note 44), pp. 42–43.
95. Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, 2007, 4.4, 4.26 and 4.27; *GSTT & SLAM v R* (see Note 15) [28].
96. Ibid., [33].
97. Ibid., [28].
98. Ibid. [36]. Moreover, although he accepted that a declaration granted under s.15(1)(c) MCA cannot authorise the deprivation of liberty that would occur if R were transferred to Guys for obstetric care against her will (deprivation of liberty can only be authorised in accordance with ss. 4A, 4B MCA neither of which apply to an anticipatory and contingent declaration granted under s.15 MCA), he held that the inherent jurisdiction could be used to authorise the deprivation of liberty, describing this as 'a paradigmatic situation for recourse to the inherent jurisdiction. . . It is a classic application of the powers to supplement and give effect to the objectives of the statute' [44, 47].

This represents a very significant development in the law as it recognises that although the woman may currently have capacity, the court may make an anticipatory and contingent declaration that will declare treatment against her wishes lawful if she loses capacity.[99] Although Hayden J noted the invidious position in which the court found itself and the draconian nature of the application,[100] he suggested that the court should be 'involved in a way which anticipates rather than being merely reactive to crisis or emergency'.[101]

Having found that an anticipatory and contingent declaration could be granted to take effect if R were to lose capacity, the question of her best interests fell to be addressed. In doing so, Hayden J stressed the relevance of R's known wishes. Significantly, R was neither present nor represented at the hearing. The Official Solicitor was not appointed to represent her because she had capacity; instead, Mr. Patel QC[102] was appointed to act as an Advocate to the Court, a very different role to that undertaken by the Official Solicitor.[103] Thus, nobody spoke to R's wishes, or her best interests other than the

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99. In *United Lincolnshire Hospitals NHS Trust v CD* (see Note 15), Francis J made a similar order, stating, 'There is a substantial risk that if I fail to address the matter now I could put the welfare, and even the life, of CD at risk and would also put the life of her as yet undelivered baby at risk. . . I am not prepared to take that risk.' Being heard less than 3 months later, *GSTT & SLAM v R* (see Note 15) is significant because Hayden J took the opportunity to fully analyse the basis upon which such an anticipatory and contingent declaration could be granted, directing further written submissions be filed after handing down his extempore judgment, so that he could properly identify more clearly the applicable legal framework [11]. An anticipatory and contingent declaration was also granted in *North Middlesex University Hospital NHS Trust v SR* (see Note 11), although in that case SR wanted to have a caesarean delivery as recommended by her clinicians. In *Shrewsbury and Telford Hospital NHS Trust v T* [2023] EWCOP 20 Lieven J refused to grant an anticipatory declaration in respect of obstetric care on the basis that T had capacity and that there was only a 'small risk' that she might lose capacity. However, like SR, T agreed with the clinical advice. In *Somerset NHS Foundation Trust v Amira* (see Note 67), the Trust had initially sought an anticipatory declaration, but by the time of the hearing Amira was agreed to lack capacity to make her own decisions about obstetric care. Although an anticipatory declaration was no longer relevant, Mostyn J suggested that the Court of Protection cannot make anticipatory orders under s.15 MCA in relation to an individual with capacity, arguing that 'the device of a proleptic declaration under s. 15(1)(c) is in my judgment directly contrary not only to the wording of the Act, but also to its essential scheme' [41]. A declaration (anticipatory, or otherwise) was arguably always unnecessary because Amira agreed with the clinical advice, had engaged in the formulation of the care plan, and she was not refusing treatment. To date, Mostyn J is the only judge to suggest that it would not be possible to grant an anticipatory declaration to come into effect if P were to lose capacity in labour.
100. *GSTT & SLAM v R* (see Note 15) [5].
101. Ibid. [16].
102. Mr. Patel QC acted for the Official Solicitor in *United Lincolnshire Hospitals NHS Trust v CD* (see Note 15), the first reported case of anticipatory and contingent declarations being made in the obstetric context.
103. The Advocate to the Court is not appointed to represent P, or her best interests, but to assist the court 'when there is a danger of an important and difficult point of law being decided without the court hearing relevant argument', Practice Direction 3G – Requests for the appointment of an advocate to the court [3].

clinicians; she did not attend the hearing and there was no direct evidence of her wishes. It was reported that she had always asserted that a caesarean would not be necessary,[104] and that she had told medical staff a caesarean would be 'the last thing she would want'.[105] Hayden J lamented that it had not been possible for the Official Solicitor to speak to R 'to achieve greater clarity as to her wishes and feelings', but it was only the willingness of the court to make an anticipatory and contingent declaration that rendered her best interests relevant. As Butler-Sloss LJ emphasised in *Re MB*, an adult with capacity 'may, for religious reasons, other reasons, or for no reasons at all, chose not to have medical intervention, even though . . . the consequence may be the death or serious handicap of the child she bears or her own death'.[106] R was under no obligation to provide a reason for her refusal; moreover, as a woman who had already given birth five times without the need for a caesarean, her experience, her knowledge of her own body, should have been given considerable weight.

Hayden J emphasised that although a weighty consideration, R's known wishes were not synonymous with her best interests.[107] He considered the clinicians' evidence that a caesarean would be 'the last thing she would want', asking whether that should be taken to mean that she would never want to undergo a caesarean, or whether it might mean that she would want a caesarean if all other options failed? However, in a particularly thoughtful passage, he stated that to adopt the latter construction 'would be to distort the essence of the evidence . . . sophistry, designed to enable me to protect the mother and her unborn child without confronting what I consider to be the true evidential picture'.[108] He emphasised that the obstetric context could be distinguished from other treatment contexts by its dynamic nature, noting that many women do change their birth plans in labour, but that were R to lose capacity this option would not be open to her. Therefore, Hayden J stated,

> The strength and consistency of previously expressed views must be considered with intense subtlety and sensitivity in this highly uncertain and emotionally charged obstetric context. . . . I must balance my instinctive inclination to protect the autonomy of a woman's control over the invasion of her own body, with my obligation to try to ensure that her options on losing capacity are not diminished.[109]

He distinguished the case of *St George's* where Judge LJ held that 'If . . . the adult were compelled to agree, or rendered helpless to resist, the principle of autonomy would be extinguished'[110] by emphasising that S, the subject of that obstetric intervention case, had remained capacitous throughout.[111] Of course, at the time Hayden J gave his ex tempore judgement R also retained capacity.

104. *GSTT & SLAM v R* (see Note 15) [12].
105. Ibid., [56].
106. *Re MB* (see Note 17), 436–437.
107. *GSTT & SLAM v R* (see Note 15) [62].
108. Ibid., [56].
109. Ibid., [57].
110. *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* (see Note 44), 47.
111. *GSTT & SLAM v R* (see Note 15), [57].

While we learn in the course of his judgement that R gave birth to a healthy baby, cooperating fully with medical staff throughout the spontaneous vaginal delivery,[112] we are not told whether she did in fact lose capacity. It seems particularly dangerous to view a vulnerable woman's capacitous decision as merely one factor for consideration on the basis that she may not be able to change her mind once in labour, particularly as she had already experienced labour five times, and so had lived experience of the dynamic context within which it takes place. Hayden J rejected the suggestion that R's wishes could be treated as analogous to an advance decision, suggesting that an advance decision was very different, not least because in drafting an advance decision R would have had to specify the circumstances in which her refusal was to apply and because in the case of a valid advance decision, 'the capacitous adult has consciously waived the right to change her mind upon loss of capacity'.[113] Given the paucity of the evidence, it was not possible to determine the circumstances in which R would want her refusal to operate, nor was it possible to be sure that she would want to bind herself to her refusal in all circumstances, but there was also no suggestion that she wanted to keep her options open.

Hayden J was clearly troubled by the fact that he granted a declaration diametrically opposed to the expressed wishes of R, but his reasoning focussed upon the lack of opportunity for R to change her mind if she were to lose capacity during labour. He lamented the fact that the Official Solicitor had not been able to discuss R's views with her, to 'help craft a declaration which kept options open for her and her unborn child'.[114] At the end of the 39th week of pregnancy, birth was undeniably imminent, but R was not in labour. It is not clear from the judgement how long she had been detained. Nevertheless, capacity assessments were conducted at the *South London and Maudsley NHS Foundation Trust* (SLAM) on 19 June 2019, 3 July 2019, and again on 22 August 2019, 8 days before the hearing. The repeated capacity assessments suggest that as early as 19 June (more than 10 weeks before the hearing), doubts had been raised as to R's capacity, making it extremely concerning that no attempt was made to ensure that R was represented at the hearing. Even more troubling, we learn from Hayden J's judgement that R did not give birth until more than a week after the hearing, which should have given ample time to clarify her wishes.

Having noted his concern that R might be unable to change her mind and consent to a caesarean if she were to lose capacity, Hayden J granted the declarations sought. The language of risk runs through the judgement. Hayden J emphasised that there was a substantial risk that R would lose capacity during labour[115]; while no obstetric risks were identified in the judgement relating to R, a number of risks in relation to the foetus were identified,[116] although there was no established need for a caesarean delivery. Instead, there was a 'real risk' that a caesarean would be necessary to affect a safe delivery and that there was a 'manifest risk of non-cooperation or resistance by R if the baby required delivery urgently'.[117] Yet, none of those risks eventuated; the foetus was not in a breech

112. Ibid., [12].
113. Ibid., [65].
114. Ibid., [58].
115. Ibid., [2].
116. Ibid., [4].
117. Ibid.

presentation; R was cooperative throughout the labour and gave birth vaginally as she had wanted. At all times, the risks described were potential risks, yet the emphasis upon those risks and the framing of R's decision as risky sufficed to justify what Hayden J clearly identified as the draconian nature of the declarations granted and their impact upon the woman's autonomy. The increased risks of a caesarean and the impact it would have upon R in the future were not addressed.

Hayden J stressed that while a capacitous woman has the right to refuse treatment, even if that refusal jeopardises the foetus's life and welfare, the court does not have the same latitude[118] and suggested 'it will rarely be the case . . . that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus'.[119] Seen in this light, it seems highly unlikely that a woman's wishes and feelings will ever be respected when they conflict with the clinical assessment of her best interests; instead, her best interests, her values, and perhaps even her own value appear to be reduced to ensuring the safe delivery of the foetus. Moreover, the willingness demonstrated in this case to make an anticipatory and contingent order to take effect if the capacitous women were to lose capacity during labour represents a particularly worrying development. It provides the opportunity to overrule her wishes expressed at a time when she was confirmed to have the capacity to make it. It threatens to subvert the ideology of the Mental Capacity Act to empower and facilitate the taking of decisions by individuals wherever possible.

Reflections on the determination of best interests and the inconsiderable weight given to the woman's wishes. It is well recognised that the patient's wishes are not synonymous with their best interests, as Lady Hale put it, 'We cannot always have what we want',[120] but these cases illustrate the very limited weight attributed to the woman's wishes and feelings in the obstetric intervention context. None of the women took part in the hearing; in each case, their views were presented through the filter of the clinician's evidence, or the representations made by the Official Solicitor. None of the women were independently represented by someone engaged to fight for her choices[121]; in fact, R was not represented at all. In K's case, in the absence of medical records and limited opportunity to engage with K, the Official Solicitor felt unable to make a submission on best interests. It is undoubtedly true that best interests should not be determined solely by the patient's wishes, but as Mary Donnelly has argued where those wishes are clear, there should be particularly 'rigorous scrutiny of the evidence presented in favour of the argument that the decision-maker should act against this preference'.[122]

118. Ibid, [63].
119. Ibid., [63].
120. *Aintree* (see Note 61), [45].
121. The role of the Official Solicitor is to represent the person's best interests, which are not limited to what she wants. It is not unusual for the Official Solicitor to advocate that treatment opposed by P would serve her best interests.
122. Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005' (see Note 57), p. 20.

A significant problem with obstetric intervention cases is the urgency with which they are heard. There will always be a need for emergency applications,[123] but these three cases are typical of the cases considered by the Court of Protection in this context. Framed as urgent applications, none of them involved an emergency situation and, in each case, there were clear indications that capacity to determine obstetric treatment might be in doubt; those indications should have been acted upon at a much earlier stage. Such applications are unpleasant and stressful for all concerned; Trusts are reluctant to bring cases until it is clear there is no alternative, not least due to the cost involved. However, the result is to deny women effective representation, to put the Official Solicitor in the words of Lieven J 'in such an impossible situation where she cannot do the job she is instructed to do, and where her role effectively becomes a tick box exercise'.[124] Where urgent applications are made, there is little scope to call expert evidence, or to test the evidence provided by P's doctors[125] and often limited possibilities to engage with P due to deterioration of her mental health, this directly undermines her ability to participate and make her own decision.

Although judges in the Court of Protection have emphasised the utility of meeting P to gain 'a deeper understanding of [her] personality and view of the world',[126] it appears that none of the judges in these cases had any direct contact with the women concerned. Another notable absence from the cases is family involvement. Nobody gave evidence of what P wanted, or of even what she would have wanted if she had had capacity other than the clinicians involved in her care. In K, her partner was mentioned briefly, as having his own significant mental health issues, but he had taken part in antenatal appointments with her and it is suggested that he may have been able to contribute to the judge's understanding of her as a person.[127] Both the judge meeting the woman concerned and evidence from those close to the woman (even if they do not share the patient's views)[128] can provide an important means of contextualising the woman's reported wishes, of enhancing the judge's understanding of her as an individual. As Paul Skowron has argued, seeing the person as a whole is important because 'Best interests decisions are made for people, not objects, and people have their own perspectives on the world'.[129]

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123. See, for example, *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18.
124. *University Hospitals Dorset NHS Foundation Trust v Miss K* (see Note 35), [4].
125. For an example of a case where expert witnesses were consulted, see *A NHS Foundation Trust v An Expectant Mother* (see Note 5).
126. *Wye Valley NHS Trust v B* [2015] EWCOP 60, [18] per Peter Jackson J.
127. For an excellent analysis of the impact that the judge meeting P can have and the extent to which such meetings take place, see P. Case, 'When the Judge Met P: The Rules of Engagement in the Court of Protection and the Parallel Universe of Children Meeting Judges in the Family Court', *Legal Studies* 39 (2019), p. 302.
128. In relation to the ability of friends of P being able to 'convey [P's] own authentic voice', see *Sheffield Teaching Hospitals NHS Foundation Trust v TH & TR* [2014] EWCOP 4, [39] per Hayden J.
129. P. Skowron, 'The Relationship Between Autonomy and Adult Mental Capacity in the Law of England and Wales', *Medical Law Review* 27 (2018), pp. 32, 48.

In *GSTT v R* Hayden J recognised that

> Loss of capacity in the process of labour may crucially inhibit a woman's entitlement to make choices. At this stage the Court is required to step in to protect her, recognising that this will always require a complex, delicate and sensitive evaluation of a range of her competing rights and interests. The outcome will always depend on the particular circumstances of the individual case.[130]

What follows from an analysis of the cases is that in each case (contrary to the express wishes of R and A), the judge formed the view that the woman would have prioritised the safe delivery of the foetus. Notwithstanding what he described as R's 'strenuous insistence on a natural birth',[131] Hayden J noted, 'there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby. . . . In the circumstances therefore, it seems reasonable to conclude that R would wish for a safe birth and a healthy baby.'[132] John Coggon has distinguished between ideal desire, best desire, and current desire autonomy.[133] The rationale for incorporating the patient's wishes and feelings within the best interests assessment is to allow for some retention of autonomy, even after the onset of incapacity. Clearly, in these cases, the woman's current desire autonomy is not prioritised, but it remains questionable whether that which is promoted is her best desire, or ideal desire autonomy. Best desire autonomy, as conceived by Coggon, 'reflects a person's overall desire given [her] own values, even if this runs contrary to [her] immediate desire'.[134] This would be consistent with Cohen J's suggestion that X's overall desire 'would be her wish to have a safe delivery of her child'.[135] However, Hayden J's conclusion that 'notwithstanding the paucity of information. . . R would wish for a safe birth and a healthy baby'[136] is more consistent with the 'ideal desire' variant identified by Coggon, reflecting 'what a person should want, measured by reference to some purportedly universal or objective standard of values'.[137]

In *Briggs*, Charles J cautioned that 'the decision maker and so a judge must be wary of giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want',[138] yet a review of the obstetric intervention case law demonstrates a commitment to an ideology of 'motherhood' where women are expected to sacrifice their own wishes and interests in order to prioritise the safe delivery of the foetus.[139] As Rebecca Kukla has argued,

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130. *GSTT & SLAM v R* (see Note 15), [67].
131. Ibid., [63].
132. Ibid., [63].
133. J. Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' *Health Care Analysis* 15 (2007), p. 235.
134. Ibid., 240.
135. *X & Y v Ms A* (see Note 69), [18].
136. *GSTT & SLAM v R* (see Note 15), [63].
137. Coggon (see Note 133), 240.
138. *Briggs v Briggs* [2016] EWCOP 53, [62].
139. On the framing of 'good' mothers, see, for example, Halliday, *Autonomy and Pregnancy* (see Note 7); R. Blaylock, Heather Trickey, Julia Sanders, and Clare Murphy, 'WRISK Voices: A Mixed-Methods Study of Women's Experiences of Pregnancy-Related Public Health Advice And Risk Messages in the UK', *Midwifery* 113 (2022), p. 103433 and R. Kukla, 'Measuring Mothering', *International Journal of Feminist Approaches to Bioethics* 1 (2008), p. 67.

> If [the woman] manages her birth 'successfully', making proper, risk-adverse, self-sacrificing choices, and maintaining both proper deference to doctors and control over her own body, then she proves her maternal bona fides and initiates a lifetime of proper mothering. If, on the other hand, she fails at these tasks during labor, she reveals herself as selfish or undisciplined.[140]

This normative construction of what every pregnant woman should want applies even in cases where the child will be removed at birth as in the cases of both K and R.

The ordering of risks within the judgements is significant; on the one hand, potential risks to the foetus are emphasised and often directly attributed to the dangerous maternal environment, for example, through the risk posed to the foetus by K's medication, or A's uninformed and potentially egotistical choice to elect a vaginal breech birth (framed as being to avoid discomfort), rather than consent to a caesarean. The decisions frame the refusals of a caesarean as risky; they characterise the women as risky, emphasising the need for women to comply with directions in order to achieve a safe delivery, to avoid agitation and remain in control. On the other hand, the risks associated with caesarean birth are minimized; major abdominal surgery is normalised. Although the best interests assessments are dominated by best medical interests, the interests primarily protected are those of the foetus and it is suggested that the courts and clinicians have taken an overly cautious approach to ensuring the safe delivery of the foetus while subjecting the woman to increased risk. This is particularly clear in *X & Y v Ms A*.[141] Referring to the RCOG guidance, Cohen J placed considerable emphasis upon the 40% risk that a breech birth will require an emergency caesarean,[142] but significantly less attention was paid to the guidance's recommendation that the small reduction in perinatal mortality affected by planned caesarean delivery should be weighed against the potential adverse consequences of deciding to perform a caesarean,[143] namely, the greater maternal risks associated with caesarean sections.

Cohen J did not engage with A's concerns relating to the 'discomfort' associated with caesarean delivery. However, the pain and recovery period associated with a caesarean delivery, even if complications[144] do not arise, are significant and impact postnatal recovery and maternal well-being. For example, Annalise Weckesser reports that one woman interviewed reported that '[T]he first three weeks . . . three or four weeks, it was like really painful and sore. I couldn't even bend'.[145] This is not mere discomfort and caesareans can have far-reaching consequences for normal life apart from pain, ranging from not being allowed to drive, to obstacles to breastfeeding due to positioning difficulties. While the decisions frame the refusals as being a result of the woman's SMI, that is not

140. Kukla, 'Measuring Mothering' (see Note 139), p. 74.
141. See Note 69.
142. Ibid. [17].
143. See Note 76, p. 153.
144. Including, for example, sepsis, blood clots, heavy blood lost, and even death; maternal mortality in caesarean delivery is approximately 24 women per 100,000, compared to four women per 100,000 following vaginal delivery, NICE Guideline, *Caesarean Birth*, 2021, Appendix A.
145. Weckesser, Nicola Farmer, Rinita Dam, Amie Wilson, Victoria Hodgetts Morton, and R. Katie Morris, 'Women's Perspectives on Caesarean Section Recovery, Infection and the PREPS Trial: A Qualitative Pilot Study', *BMC Pregnancy Childbirth* 19 (2019), pp. 245, 248.

necessarily the case; many women refuse a caesarean because of concerns about its impact upon them in the postnatal period; indeed, the RCOG guidance recognises that vaginal breech birth is a valid choice that should be left to the woman. None of these considerations that might be considered to rebalance the risk appear to have been considered in the best interests assessment, that is a significant omission.

The focus in the best interests assessments discussed was predominantly directed towards the delivery, but it is suggested that the best interests assessment needs to take greater account of the impact of the decision upon the woman. For the woman, the matter will not end with the birth; if her refusal is overridden, she is likely to be traumatised by the major abdominal surgery (potentially conducted under restraint) performed against her wishes. She will bear the physical scar of that surgery for the rest of her life as a constant reminder that she was forced to have a caesarean. In *Wye Valley NHS Trust v B*, Peter Jackson J spoke of the significance of this factor in relation to a man refusing the amputation of his foot, saying,

> There is in my view a significant chance that Mr B's mental health and well-being will be further compromised following an operation. Even if he does not suffer some of the risks of amputation (phantom pain etc.), the loss of his foot will be a continual reminder that his wishes were not respected.[146]

It would seem likely that the same consideration would apply to a caesarean scar.

Moreover, although A's obstetrician was undoubtedly right that an unsuccessful vaginal delivery that resulted in harm to her, or the foetus, would be very damaging to her health, the fact that her refusal was overridden is also likely to impact her mental health and the therapeutic alliance that is so very important in treating mental illness. The therapeutic alliance relies upon patients feeling involved in decision-making and having a relationship of trust with their clinicians. It is hard to imagine that that trust will not be compromised by the overriding of her refusal. Even in cases where it was suggested that a caesarean delivery would enable the healthcare professionals to prioritise treatment for the woman's SMI, it must be recognised that this is not a neutral choice; it impacts her ability to parent. Moreover, women are less likely to seek help if they relapse if they fear their wishes will be overridden, increasing the risk of harm to both the woman and her foetus. There is also a strong possibility that women will be dissuaded from accessing antenatal care if they are concerned that their wishes will not be respected, again leading to an increased risk of adverse outcomes.

Outside the SMI and pregnancy context, there has been a retreat from the Bolamesque formulation of best interests, with a shift to a much more patient-centred conception of best interests that focuses upon the wishes and feelings of the patient. The patient's views are never determinative of best interests, but they are a significant consideration. However, in the case of a pregnant woman with SMI the paternalistic conception appears to remain – viewed as an obstacle to the safe delivery of the foetus, her wishes and feelings are relativised, their value diminished and displaced by the overriding objective to ensure the safe delivery of the foetus.

146. See Note 126, p. 37.

Advance decisions – the overlooked tool to put women back at the centre of their own birth decisions

As I demonstrated in the previous section, the best interests of a pregnant woman with SMI remain anchored in best *medical* interests and all too often the medical interests protected are not her own, but those of the foetus. Her right to autonomy, both while she lacks capacity, but also in the event that she loses capacity during labour, is displaced by concern for the foetus and the framing of the woman as a vector of harm, posing a hazard not only to the foetus and herself, but also to healthcare professionals caring for her. All too often the woman's voice has been muted, relayed only by the clinicians who are arguing that her best interests require a caesarean section. Often there is little or no opportunity for the Official Solicitor to speak to her to determine what she wants and nobody else (her family and friends) participates in the hearing to speak on her behalf. One way to hear the woman's voice, to put her at the centre of these undeniably difficult decisions, is through greater use of advance decision-making. Advance decision-making is traditionally associated with end of life decision-making, but within the terms of the Mental Capacity Act 2005, an advance decision can take the form of any anticipatory treatment refusal intended to take effect in the event of incapacity. In this section, I argue that its use as a tool to extend autonomy in the context of obstetric care has been overlooked and that the time has come to investigate what would be required to create a valid and applicable advance decision, particularly in the light of the recent development to grant anticipatory and contingent orders in relation to capacitous women. I suggest that the best way to put women at the heart of these decisions is through greater use of advance decisions, maximising the opportunity for the pregnant woman to determine her own treatment while simultaneously encouraging dialogue and collaboration with her clinicians.

Advance care planning is well established in the obstetric setting, but plans usually take the form of care plans, or birth plans, rather than advance decisions. A perinatal mental health care plan will be required for all women with SMI[147]; it is drawn up by healthcare professionals, and ideally agreed with the pregnant woman.[148] Women should be invited to participate in developing the care plan, but that may not always be possible, usually because she is not well enough, or because she does not want to engage in the discussion. Typically, plans will detail antenatal obstetric and psychiatric care; plans for admission to give birth, treatment and care to be provided during labour; care to be provided after birth; and a discharge plan and a plan for postnatal care and support. The care plan is important; it should bring together the pregnant woman (and, where possible, her

147. The NICE Guideline, 'Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance', 2020 states, 'Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. . . The plan should cover pregnancy, childbirth and the postnatal period . . . and should include a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored. . .', 1.6.6.

148. For an excellent view of what should be included in a Perinatal mental health care plan, see Pan-London Perinatal Mental Health Networks, 'Pre-Birth Planning: Best Practice Toolkit for Perinatal Mental Health Services', 2019, available at https://www.healthylondon.org/wp-content/uploads/2019/01/Pre-birth-planning-guidance-for-Perinatal-Mental-Health-Networks.pdf.

partner and family), her obstetrician, psychiatrist, midwifes, and, where relevant, social workers to agree and coordinate care. Care plans are regularly approved by the Court of Protection in determining treatment to be given to a pregnant woman lacking capacity; however, they are clinician-led and do not necessarily reflect the pregnant woman's choices. Therefore, although the woman will ideally have participated in the formulation of the care plan, it is not a tool designed to promote choice-led maternity care for a woman who lacks capacity.

The idea of birth planning was introduced in the United Kingdom during the 1970s by Sheila Kitzinger as a response to what she described as the 'factory farm system of childbearing'.[149] Unlike care plans, birth plans are patient-led and it is now common practice for pregnant women to draft a birth plan setting out her birth choices. Birth plans enjoy significant support at a policy level and form an integral part of delivering personalised maternity care.[150] However, they have been criticised as little more than a tick box exercise, promoting only an illusion of choice by offering a range of (limited) options.[151] For example, the NHS Birth plan[152] lists a number of options relating to place of delivery, birth companions, companions during forceps delivery, companions during caesarean . . . and free text boxes where one can add detail regarding the boxes ticked. Notably, there are no available options to tick for mode of delivery, a startling omission that appears to be based on the assumption that decisions relating to assisted and surgical delivery will be made as necessary, rather than considered as part of contingency planning. Birth plans are regarded as having an educative role and encouraging dialogue between pregnant women and their clinicians; however, the limited time available to healthcare professionals for antenatal appointments (typically 10 minutes per appointment) undermines the potential for discussing, or even negotiating, plans.[153] Nevertheless,

149. S. Kitzinger, 'Birth Plans: How Are They Being Used?' *British Journal of Midwifery* (57) (1999), p. 300. On birth plans as a response to medicalisation of birth, see also J. Lothian, 'Birth Plans: The Good, the Bad and the Future', *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 35 (2006), p. 295.
150. See, for example, *Better Births* (see Note 1), 'Choice is not a tick box exercise and is not just about place of birth, although that is important for many women. Women want to make decisions about a range of aspects of their care, such as how to manage the pain of labour, the role that their birth partner will play, the type of postnatal support, how to feed their baby and many other things'. [4.8]
151. See, for example, C. Bell, Sally Muggleton, and Deborah L. Davis, 'Birth Plans: A Systematic, Integrative Review Into Their Purpose, Process, and Impact', *Midwifery* 111 (2022), p. 103388; Kitzinger, 'Birth Plans' (see Note 149), p. 301; J. Welsh and Andrew G. Symon, 'Unique and Proforma Birth Plans: Aqualitative Exploration of Midwives' Experiences', *Midwifery* 30 (2014), pp. 885, 887; J. Lothian, 'Birth Plans: The Good, the Bad, and the Future', *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 35 (2006), pp. 295–303.
152. Available at https://www.nhs.uk/pregnancy/labour-and-birth/preparing-for-the-birth/how-to-make-a-birth-plan/.
153. See also A. DeBaets, 'From Birth Plan to Birth Partnership: Enhancing Communication in Childbirth', *American Journal of Obstetrics and Gynecology* 31 (2017), p. 31; B. Divall, Helen Spiby, Julie Roberts, and Denis Walsh, 'Birth Plans: A Narrative Review of the Literature', *International Journal of Childbirth* 6(3) (2016), p. 157; Bell et al., 'Birth Plans' (see Note 151), p. 9.

there is a high correlation between birth satisfaction rates and the creation of a birth plan, even where things do not go to plan, satisfaction levels remain high where the woman feels respected and heard.[154]

Birth plans tend to be viewed as aspirational, setting out who the woman would like to be present at the birth, what birthing position she would like to use, and what, if any, pain relief she would like to use . . . Such considerations are entirely valid and extremely important, but inevitably they are broad in scope and subject to change given the dynamic process of birth; indeed, Joanne Welsh reported that healthcare professionals disliked the use of the word 'plan' believing it to lead to unrealistic expectations and a false sense of control.[155] Tellingly, choices set out in a birth plan are often framed as 'suggestions', or 'preferences', rather than decisions; they are not designed to take effect upon incapacity (unlike an advance decision), but to be flexible, to evolve as labour progresses. A birth plan is not intended to bind the woman, or the clinician, for example, should a woman plan a birth without any form of pain relief, but go on to find that she wants pain relief during labour; she is entitled to change her mind.[156] The impact and use of an advance decision are very different.

SS.24–26 MCA provide the statutory basis for advance decisions to *refuse* treatment. An advance decision is a legal instrument that bridges the occurrence of incapacity and provides a mechanism for individuals to make treatment decisions that will take effect if they lose capacity in the future. Drafted at a time when the woman has capacity, an advance decision is intended to take effect only if she becomes unable to make decisions for herself, at that point the advance refusal, provided that it is valid and applicable, has the same effect as a contemporaneous refusal of treatment given by a woman with capacity – it will bind healthcare professionals so that the specified treatment cannot lawfully be given.[157] Thus, while a birth plan will be framed in more tentative terms, outlining treatment preferences that will not bind clinicians, an advance decision provides the means to refuse a specific treatment (for example a caesarean), in specified circumstances that will be operative if the woman lacks capacity to make decisions for herself. If she retains capacity, the advance decision has no legal effect. Advance decisions are widely used in the obstetric context by Jehovah's Witnesses to decline blood products. There are no reported cases in England and Wales of a court authorising a blood transfusion against

154. Bell et al., 'Birth Plans' (see Note 151), p. 9.
155. Welsh and Symon, 'Unique and Proforma Birth Plans' (see Note 149), p. 887. On professionals' concern about the content of birth plans, sometimes reported as hostility, see also DeBaets, 'From Birth Plan to Birth Partnership' (see Note 153), p. 31; H. M. Whitford, Vikki A. Entwistle, Edwin van Teijlingen, Patricia E. Aitchison, Tracey Davidson, Tracy Humphrey, and Janet S. Tucker, 'Use of a Birth Plan within Woman-Held Maternity Records: A Qualitative Study with Women and Staff in Northeast Scotland', *Birth* 41(3) (2014), p. 283; Divall et al., 'Birth Plans' (see Note 153).
156. The National Maternity Survey 2021 reported that 36% of women used different pain relief in labour than originally intended, most commonly because they changed their mind, NHS Patient Survey Programme, 'National Maternity Survey: 2021 Maternity Survey, Statistical RELEASE', 2022, available at https://www.cqc.org.uk/publications/surveys/maternity-survey-2021.
157. S.26 MCA.

the wishes of a pregnant woman.[158] The woman's advance decision will be respected and implemented, even if the consequence is death, or harm, to the woman and/or her foetus.[159] However, outside this very specific context, advance decisions have not been used in relation to obstetric treatment and it is suggested that they provide a significant mechanism to centre obstetric decision-making upon the woman's wishes, rather than allowing others to make decisions prioritising the safe delivery of her foetus.

There are significant asymmetries between a contemporaneous and anticipatory decision-making, differences that are inextricably linked to the temporal and psychological distance that separates the anticipatory decision from the time at which it should be implemented. The difficulties commonly associated with advance decision-making focus upon the inherent difficult of drafting an advance decision to take effect at a future time when the range of treatment scenarios and treatment available is inherently unpredictable and the argument that when an advance decision comes to be implemented the individual's interests may be radically different to those anticipated.[160] These difficulties are not applicable to the obstetric context. Pregnancy is time limited, the relatively short timeframe between drafting an advance decision relating to labour and delivery and its implementation negates the impact of changing interests. Unlike a patient with dementia who may derive unforeseen enjoyment from their life as a demented patient,[161] a pregnant woman's critical interests are unlikely to change within the space of a few months; she remains the same person, with the same interests applicable to her birth choices. Moreover, the range of treatment scenarios and treatment available are entirely predictable, as Lady Hale recognised in *Montgomery*, 'Once a woman is pregnant, the foetus has somehow to be delivered. Leaving it inside her is not an option'.[162] There are only two potential exit routes from the uterus; thus, a choice must be made between caesarean and vaginal delivery (with, or without instrumental delivery).

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158. There have been a number of such cases in the United States; for a detailed analysis of the US case law, see Halliday, *Autonomy and Pregnancy* (see Note 7), pp. 8–16.
159. RCOG, 'Blood Transfusion in Obstetrics', Greentop Guideline No. 47, 2015, available at https://www.rcog.org.uk/media/sdqcorsf/gtg-47.pdf; A. Berg, Arti Dave, Natalie Fernandez, Brian Brooks, Karen Madgwick, Abha Govind, and Wai Yoong, 'Women Who Decline Blood During Labour: Review of Findings and Lessons Learnt From 52 Years of Confidential Enquiries Into Maternal Mortality in the United Kingdom (1962–2019)', *European Journal of Obstetrics & Gynecology and Reproductive Biology* 271 (2022), p. 20.
160. A. Buchanan and D. Brock, *Deciding for Others: The Ethics of Surrogate Decision-Making* (Cambridge: CUP, 1990), pp. 103–107.
161. The notorious Margo story is often used to discuss the potential for a patient's interests to change. Margo, a patient with dementia, is said to have made an advance refusal of treatment to refuse life-sustaining treatment. However, now demented, she appears to derive pleasure from her life, enjoying music, painting. . . The question raised is when she develops a chest infection should her advance decision be implemented as an expression of her critical interests, or should her current (experiential) interests prevail, so that treatment should be given, see discussion in R. Dworkin, *Life's Dominion* (London: Harper Collins, 1993), p. 224 and analysis thereof in R. Heywood, 'Revisiting Advance Decision Making Under the Mental Capacity Act 2005: A Tale of Mixed Messages', *Medical Law Review* 23 (2015), pp. 81, 83–85. Such a scenario is dementia-specific and will not apply in the obstetric context.
162. *Montgomery v Lanarkshire Health Board* (see Note 3), [110].

Due to the differences between anticipatory and contemporaneous decisions, additional safeguards are built into the statutory framework governing advance decisions, intended to ensure careful decision-making and protect the individual's autonomy.[163] In order to draft an advance decision capable of taking effect the pregnant woman will need to comply with these safeguards. The ability to make an advance decision is restricted to adults[164] with capacity. In order for the advance decision to be valid the author must have capacity at the time of drafting. However, there is some concern that the presumption of capacity[165] may not apply to advance refusals as when the time comes to implement an advance decision, the attending clinician must satisfy themself of its validity,[166] an assessment that will encompass a retrospective consideration of P's capacity to make the decision at the time of drafting. This raises a clear practical problem as any doubts as to the patient's previous capacity arise at a time where she is no longer able to demonstrate that the requisite capacity existed. In *Re E (Medical treatment: Anorexia)*[167] Peter Jackson J emphasised that

> For an advance decision relating to life-sustaining treatment to be valid and applicable, there should be clear evidence establishing on the balance of probability that the maker had capacity at the relevant time. Where the evidence of capacity is doubtful or equivocal it is not appropriate to uphold the decision.[168]

Although advance refusals of obstetric intervention will rarely refuse treatment that would be life-sustaining for the woman, it is suggested that when drafting an advance decision the woman should at least discuss it with her clinicians and request that they certify her capacity to make the decision at the time of drafting. However, out of an abundance of caution it would be preferable for her to undergo a formal capacity assessment in order to

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163. NHS Cumbria CCG v Rushton [2018] EWCOP 41, Hayden J [25]. For a detailed analysis of the safeguards imposed upon advance decision-making, see S. Michalowski, 'Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of an Absolute Right', *MLR* 68(6) (2005), p. 958 (focussing upon the regulation of advance decisions in England and Wales) and S. Halliday, 'Legislating to Give Effect to Precedent Autonomy: Comparative Reflections on Legislative Incompetence', *Medical Law International* 11 (2011), p. 127 (providing a detailed comparative analysis of the regulation of advance decisions in England, Germany, and Austria).
164. Generally, the MCA applies to those aged 16 and over (s.2(5) MCA), but the ability to make an advance decision is limited to those aged 18 and over (s.24(1) MCA). As the ambit of advance decisions is restricted to refusals of treatment, this is consistent with the courts' approach to minors refusing treatment considered to accord with her best interests, that the refusal is subject to recidivism by a parental responsibility holder, or the court, See, for example, *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627; *South Glamorgan County Council v W and B* [1993] 1 FLR 574; *Re E (a minor)(wardship: medical treatment)* [1993] 1 FLR 386; *Re M (a child) (refusal of medical treatment)* [1999] 2 FLR 1097.
165. S.1(2) MCA 2005.
166. S.26(2) MCA 2005.
167. [2012] EWCOP 1639
168. Ibid., [55].

avoid retrospective consideration of her capacity to make the decision.[169] This would seem particularly important given the stance taken by Peter Jackson J in *Re E*[170] where he suggested that ‘a full, reasoned and contemporaneous assessment evidencing mental capacity to make such a momentous decision’[171] would be required to demonstrate that E had the requisite capacity to draft an advance decision. Such a requirement is not set out in the MCA, E had received advice from a solicitor, from an independent Mental Health advocate and the judge recognised that the general medical view at the time was that E had capacity.[172] Nevertheless, in view of the fact that E was detained under the Mental Health Act shortly after writing the advance decision and that her capacity had fluctuated over a period of time, absent a formal assessment Peter Jackson J was not satisfied that she had the requisite capacity at the time of drafting and, therefore, her advance refusal of treatment was not valid.[173]

As discussed above, there is a danger that a focus upon the woman’s SMI might overshadow the question of whether she is able to make the relevant decision. *A NHS Trust v An Expectant Mother*[174] provides a good example of the danger of foregrounding the woman’s diagnosis of SMI in the context of a contemporaneous decision – the woman’s diagnosis of agoraphobia was found to satisfy s.2(1) MCA, before any consideration was given to her ability to make a decision about where to give birth.[175] It is suggested that this is equally problematic in relation to retrospective consideration of whether the woman had capacity at the time of drafting her advance decision. Therefore, despite the presumption of capacity that runs through the MCA[176] it is suggested that without a formal capacity assessment an advance decision will remain vulnerable to a finding of initial invalidity on the basis that it cannot be established on the balance of probabilities that the woman had capacity at the time of drafting.

While a contemporaneous decision may consent to or refuse treatment, advance decisions are restricted to refusals of specific treatment.[177] Moreover, the ambit of a valid advance decision is defined by reference to clinically indicated treatment; thus, just as in the case of contemporaneous treatment decisions, precedent autonomy is conceived as a right to defend one’s bodily integrity, rather than a right to mandate non-indicated treatment.[178] While most of the case law has concerned women seeking to refuse obstetric intervention, some women may wish to elect a caesarean, rather than vaginal delivery.

169. A requirement to certify the patient’s capacity is imposed on all advance decisions intended to be binding by the Austrian *Patientenverfügungs-Gesetz* 2006, Austria, BGBl I 2006/55, §5 PatVG. See Note 163, p. 145. For an excellent account of the problems that have arisen in relation to capacity in the context of advance decisions, see Note 161.
170. See Note 167.
171. Ibid. [65].
172. Ibid. [64].
173. Ibid. [64–65].
174. See Note 5.
175. Ibid., [7].
176. S.1(2) MCA.
177. Just as in the case of contemporaneous refusals, an advance decision cannot refuse medical treatment for the mental disorder from which she is suffering provided under s.63 MHA.
178. *R (Burke) v General Medical Council* (see Note 55), [55].

The National Institute for Health and Care Excellence (NICE) Guideline *Caesarean Birth* stresses that where women without clinical indications request a caesarean, her reasons should be discussed and support should be offered, but ultimately, if vaginal delivery is not acceptable to her, a planned caesarean should be offered.[179] In such a case, a woman may set out a preference for caesarean delivery in an advance statement[180]; while not binding, the preference should be given significant weight if a best interests assessment becomes necessary, particularly as s.4(6)(a) stresses the importance of written statements made by P when she had capacity for the purposes of the best interests assessment. In *RGB v CWM Taf Health Board*, Moor J considered the weight to be given to an advance statement as evidence of P's wishes and feelings, concluding that 'her wishes and feelings as clearly articulated in her Advance Statement are absolutely central to the matter. There would have to be some extremely compelling reason to go against such clearly expressed wishes'.[181]

In *Shrewsbury and Telford Hospital NHS Trust v T*,[182] Lieven J underlined the importance of advance care planning, suggesting that inviting the woman to draft an advance statement setting out her wishes and feelings about obstetric care in birth might be a viable alternative to seeking an anticipatory declaration.[183] In this case, Lieven J refused to grant an anticipatory declaration in respect of obstetric care on the basis that T had capacity and that there only a 'small risk' that she might lose capacity. Unlike the cases discussed above, T agreed with the clinical advice and had engaged in the drafting of the care plan. She had not completed an advance decision, because she was not refusing treatment; instead, she had prepared an advance statement setting out her wishes and feelings. Lieven J described this advance declaration as 'a far more appropriate way to deal with a potential loss of capacity, rather than engaging the Court in making an invasive and draconian [anticipatory] order. Such an approach protects the woman's autonomy, in a way that an anticipatory declaration does not do'.[184] However, it is notable that unlike R, K and A, T was compliant; she agreed with the clinical advice and had agreed

179. NICE Guideline *Caesarean Birth*, 2021 [12.25–12.31]. For an interesting discussion of maternal requests for caesareans, see E. C. Romanis, 'Appropriately Framing Maternal Request Caesarean Section', *JME* 48 (2022), p. 554, responding to K. T. Eide and K. Bærøe, 'How to Reach Trustworthy Decisions for Caesarean Sections on Maternal Request: A Call for Beneficial Power', *JME* 47 (2021), p. e45.
180. For an excellent analysis of the benefits of combining an advance decision with an advance statement, see J. Samanta, 'Advance Decisions, Welfare Attorneys and Statements of Wishes: The Belt, Braces and Corset Approach to Advance Care Planning', (2023) 23 *Medical Law International 325*. While a woman could appoint an LPA to make a decision on her behalf, LPAs are required to make decisions on the basis of P's best interests, rather than prioritising their wishes.
181. [2013] EWCOP B23, [39]. Were the decision-maker to 'go against' the wishes expressed in an advance statement, she must record the reasons why, MCA 2005 COP (see Note 95), [5.43].
182. [2023] EWCOP 20. Although the case was decided on 1 August 2022, the judgment was not handed down until 23 May 2023.
183. Ibid. [25].
184. Ibid. [23].

to be induced. Lieven J suggested that if a true emergency arose, clinicians could rely upon the doctrine of necessity to protect the 'mother'.[185] However, while clinicians could rely upon the general authority (ss.5 and 6 MCA) to treat T in an emergency, they could not, it is suggested, rely on the defence of necessity in a case such as *GSTT & SLAM v R*[186] where R had specifically refused a caesarean while she had capacity. As Sir Andrew Macfarlane P stressed in *E & F (Minors: Blood Transfusion)*,

> Doctors undoubtedly have a power, and may have a duty, to act in an emergency to save life or prevent serious harm where a patient lacks capacity or cannot express a view, for example because of unconsciousness. However, we very much doubt that such a power exists in respect of treatment that has been foreseen and refused by a capacitous patient. It is doubtful whether such circumstances can properly be described as an emergency.[187]

At common law, a dual specificity requirement was imposed upon advance decisions, requiring that they specify the particular treatment to be refused and the circumstances in which that refusal is to operate.[188] However, S.24(1) MCA 2005 refers merely to 'such circumstances as [she] *may* specify', suggesting that although there is an expectation that the scope of the refusal should be specified, that may not be a requirement for validity.[189] Nevertheless, in *GSTT & SLAM v R* Hayden J held that 'In preparing and drafting a carefully worded Advanced Decision, which is compliant with the statutory safeguards, P will, *of necessity*, have been required to identify the clear circumstances in which the refusal to comply is made'.[190] Therefore, it seems clear that pregnant women drafting an advance decision will be required to meet the higher dual specificity requirement and that if the scope of the refusal is not defined, the advance decision will be vulnerable to a finding that the woman did not intend it to apply in the situation that arises.

In the obstetric setting, the range of treatments and treatment scenarios is more limited than in the case envisaged by a more general advance decision and, therefore, the specificity problem that besets anticipatory decision-making should largely be addressed by the collaboration between the woman and her doctor. The dialogue involved in such advance planning should enhance the potential for cooperation between the healthcare professional and the woman, providing the obstetrician with an opportunity not only to gain a clear understanding of what the woman wants, but also providing the possibility to discuss alternatives and even to persuade her to accept treatment indicated for foetal well-being. Crucially, this dialogue can take place in what should be a calm and constructive atmosphere far removed from the emergency settings described in the case law above.

In *GSTT & SLAM v R*, Hayden J considered R's statement that a caesarean was 'the last thing I would want' and found that it would not comply with the MCA requirements for a valid advance decision, not because it was expressed in lay terms, but because 'it is

185. Ibid.
186. See Note 15.
187. [2021] EWCA Civ 1888, [24].
188. *In re T (Adult: Refusal of Treatment)* [1993] Fam 95, 103, per Lord Donaldson.
189. Halliday, 'Legislating to Give Effect to Precedent Autonomy' (see Note 163), p. 133.
190. *GSTT & SLAM v R* (see Note 15), [65], my emphasis.

not sufficiently choate. A woman might choose, for example, not to have a caesarean even though her own life is at risk but elect to do so if the life or health of her baby is compromised'.[191] This suggests that a high degree of specificity will be required, both in terms of treatment refused and the circumstances in which those refusals operate. Therefore, it is suggested that women drafting an advance decision should specifically address whether her refusal of specified interventions should apply even if her own life or health, or that of the foetus were compromised and outline what, if any, circumstances would not be covered by her refusal. For example, in the case of *Ms A*,[192] A consistently refused to consent to a caesarean, but Cohen J emphasised that she had said that the most important thing was 'for me and baby to be healthy, well and safe'.[193] A could have drafted an advance decision at a time when her capacity was undiminished stating that she refuses a caesarean in all circumstances, including if a caesarean is necessary to avert the risk of harm or death to herself or the foetus. Alternatively, she could have stated that she refused a caesarean unless necessary to avert the risk of significant harm or death to herself, or the foetus, requiring her clinicians to facilitate a vaginal breech delivery until such a time as a caesarean became necessary to avert the risk of significant harm, or death. In such circumstances, a 40% risk that an emergency caesarean would become necessary would not, it is suggested, suffice to deviate from her advance refusal, the risk being a general risk calculation for all women in the context of vaginal breech presentation delivery. This is particularly the case because the RCOG guideline recommends that the women should be informed of the risks and benefits associated with caesarean delivery in this context, so that she can make her own decision about mode of delivery.[194] However, such a caveat would permit the performance of a caesarean were it to become *necessary* to avoid significant harm/death to either the woman or her foetus.

The MCA only imposes a form requirement on advance decisions to refuse life-sustaining treatment, requiring such decisions to be written, signed, and witnessed, and to include a specific statement that the refusal is intended to operate even if life is at risk.[195] Life-sustaining treatment is defined as 'treatment which in the view of a person providing health care for the person concerned is necessary to sustain life'.[196] Refusals of non-life-sustaining treatment are not subject to the enhanced form requirements and may be communicated by any means, including an oral statement and do not need to be signed or witnessed. Nevertheless, in considering whether R's oral refusal of a caesarean could be treated as analogous to an advance decision, Hayden J stated that 'the requirement for a signature in the presence of a witness [is not] to be regarded as a mere legal formality. It is part of a process in which a competent and capacitous adult can safely be regarded

191. Ibid. [65].
192. *X & Y v Ms A* (see Note 69).
193. Ibid., [18].
194. RCOG Green-top Guideline No. 20b: Impey et al. on behalf of the RCOG, 'Management of Breech Presentation' (see Note 76).
195. S.25(6) MCA. Failure to comply with the form requirements will invalidate an advance refusal of life-sustaining treatment, *Barnsley Hospital NHS Foundation Trust v MSP* [2020] EWCOP 26, although it will provide evidence of P's wishes and feelings.
196. S.4(10) MCA.

as having made prospective instructions on issues of the utmost gravity'.[197] This is somewhat surprising – no risk to R's life was set out in the judgement; rather, the risk enumerated was that she might refuse to cooperate if a caesarean became necessary 'for the safe delivery of her baby'.[198] This may suggest that although the foetus does not have a right to life under English law,[199] the additional requirements relating to anticipatory refusals of life-sustaining treatment are to be applied to safeguard the life of the foetus. That would be a very significant development and should give considerable pause for thought given the impact this could have upon every woman's right to refuse treatment that might result in harm to, or even the death of the foetus. Such a construction, based upon protecting the life of the foetus, would also be inconsistent with the Court of Appeal decisions in *Re MB* and *St George's*, emphasising the right of a woman with capacity to refuse treatment whether her own life or that of her unborn child depends upon it.[200] As Butler-Sloss LJ stated,

> The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a Caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.[201]

Notwithstanding these objections, from a pragmatic point of view, it is suggested that a pregnant woman's advance decision should comply with the enhanced form requirements in view of the beneficial effect this would have of providing clear evidence of the woman's wishes and in demonstrating that the advance decision represents her considered decision. Moreover, by including a specific statement specifying the circumstances in which her refusal is to apply, it should be possible to exclude the potential for a clinician to form a reasonable belief that the advance decision is inapplicable (and therefore not binding) due to the existence of circumstances that the woman had not anticipated, but which would have affected her decision.[202]

If the woman's advance decision is valid and applicable to the treatment in question, her decision will have 'effect as if [she] had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued'.[203] However, the continued validity and applicability of the advance refusal must be considered. In *GSTT & SLAM v R* Hayden J stressed that by constructing a valid and applicable advance decision the individual 'consciously [waives] the right to change her mind upon loss of capacity'. Throughout his judgement, he expressed concern that R

197. *GSTT & SLAM v R* (see Note 15), [65].
198. Ibid. [2].
199. *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276, 279, per Sir George Baker P.
200. *Re MB* (see Note 17), 436–437 per Butler-Sloss LJ; *St George's* (see Note 44), 50, per Judge LJ.
201. *Re MB* (see Note 17), 561.
202. S.25(4)(c) MCA 2005.
203. S.26 MCA.

should not be bound by her refusal, that the option to change her mind should remain open to her.[204] The fact that the consequences of a woman's decision may be serious, that they may be regarded as unreasonable, or 'morally repugnant',[205] does not mean that her decisions should be considered transitory, merely because the hope persists that she may change her mind. A woman can revoke her advance decision at any time while she has the capacity to do so,[206] but it should be remembered that capacity is decision-specific and it is likely that a much lower level of capacity will suffice to revoke an advance refusal of treatment required to ensure the safe delivery of the foetus.

An advance decision will be invalid if P 'has done anything else clearly inconsistent with the advance decision remaining [her] fixed decision'.[207] In a case that pre-dates the MCA, *HE v A Hospital NHS Trust, AE*,[208] Munby J stressed that 'The continuing validity and applicability of the advance directive must be clearly established by convincing and inherently reliable evidence'.[209] AE had drafted an advance decision refusing blood and blood products in all circumstances, including where doctors believed there to be a threat to her life. At the time of drafting, she was a Jehovah's Witness. Munby J accepted that her refusal was faith-based and, therefore, that her subsequent conversion to Islam called into question the continuing validity and applicability of her advance refusal. He held that 'if there is doubt the advance directive cannot be relied on and the doctor must treat the patient in such way as his best interests require'. Nevertheless, a real reason for doubting that the advance decision remains her fixed decision would be required in order to render a woman's advance refusal of obstetric intervention invalid. It would not be sufficient, for example, to point to fleeting suggestions that she would be prepared to have a caesarean.[210] As Charles J noted in *Briggs v Briggs*, s.25(2)(c) operates as a safety net, but an interpretation 'that sets a low threshold to rendering an advance decision invalid or inapplicable would run counter to the enabling intention of ss. 24 to 26 of the MCA'.[211]

In *GSTT v SLAM* Hayden J concluded that 'an Advance Decision, properly constructed, with the appropriate safeguards in place would . . . be binding',[212] confirming that advance decisions are capable of being used in the obstetric context to create a binding refusal of treatment intended to take effect if the woman lacks the requisite capacity to make a contemporaneous decision. In cases of doubt, the Court of Protection may make a declaration concerning the existence, validity, and applicability of an advance decision,[213] but cannot overturn a valid and applicable advance decision, no matter what the consequence of that decision is for the foetus, or the woman's health and life.

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204. Ibid. [37, 67].
205. *GSTT & SLAM v R* (see Note 15) [63], quoting Judge LJ in *St George*'s (see Note 44), 50.
206. S.25(1) MCA.
207. S.25(2)(c) MCA.
208. [2003] EWHC 1017 (Fam).
209. Ibid., [24–25]. Note the Supreme Court confirmed in *Re B (Children)* [2008] UKHL 35 that the standard of proof in civil proceedings remains the balance of probabilities, per Baroness Hale [70].
210. See, for example, the (obiter) comments made by Keehan J in *Re QQ* [2016] EWCOP 22.
211. See Note 65, [22].
212. *GSTT & SLAM v R* (see Note 15), [65].
213. S.26(4) MCA.

The benefits associated with advance decision-making are significant – first, they provide a mechanism for an individual to exercise her autonomy past the onset of incapacity, ensuring that control remains with the individual, rather than being devolved to a third party. Second, the process of drafting an advance decision should encourage dialogue and collaboration between the woman and her healthcare professionals, providing both parties with a better understanding of the other's point of view. This should ensure that clinicians understand why women are refusing treatment, but also provide an opportunity to engage with the woman and potentially to persuade her to reconsider her opposition to specific treatments. An advance decision does not render clinicians mere 'body mechanics'[214]; they have an important role to play in facilitating the drafting and use of advance decisions, in enabling women to make their own decisions. The woman needs to be given the appropriate information to make her own decision; the information needs to be accurate and reliable; thus, dialogue with her clinicians will be essential. Moreover, that dialogue needs to take place at an early stage of pregnancy, ideally by the end of the first trimester, to allow time for full discussion to take place before the risk of relapse and incapacity increases. As the Supreme Court's decision in *Montgomery v Lanarkshire Health Board* demonstrates, the courts expect doctors to collaborate with patients, to facilitate informed decision-making and to respect the patient's right to make her own choice. So far that message seems to have been lost in relation to women with an SMI, but it is suggested that advance decisions have the potential to redress the balance.

Conclusion

In this article, I have focused upon the caveat expressed by Lady Hale in *Montgomery*, that 'The medical profession must respect [a pregnant woman's] choice, *unless* she lacks the legal capacity to decide',[215] reflecting upon the limited weight accorded to the choices of women who lack capacity as part of the best interests assessment and proposing the use of advance decisions as a means for women to make binding decisions prior to the onset of incapacity, ensuring that her own choices, albeit expressed as refusals of treatment, determine maternity care.

Alex Ruck Keene has described the impact of a finding of incapacity as a 'cliff edge off which one falls into the clinging embrace of paternalism'.[216] However, as the cases demonstrate, in the context of treatment refusals by pregnant women with SMI, this is no protective embrace; rather, it is a choke-hold, designed to protect others from the risk that the woman represents. A diagnosis of SMI amplifies the risk both that the woman will be found to lack capacity (her decision being framed as an inability to weigh the information due to the SMI) and thereafter that her wishes will be disregarded as part of the best interests assessment. Compared to 'good' mothers who are motivated to make choices

214. M. Bayles, 'Physicians as Body Mechanics', in J. W. Davis, B. Hoffmaster, S. Shorten et al., eds., *Contemporary Issues in Biomedical Ethics* (Humana Press, 1978), p. 167.

215. *Montgomery v Lanarkshire Health Board* (see Note 3), p. 116.

216. A. Ruck Keene, 'Capacity Is Not an Off Switch – Case Commentary', *Mental Capacity Law and Policy Newsletter*, 1 October 2015, available at http://www.mentalcapacitylawand-policy.org.uk/capacity-is-not-an-off-switch/.

promoting foetal welfare at all times, women with SMI are stigmatised, framed as an obstacle to the safe delivery of the baby; their wishes are portrayed as deviant. The SMI, rather than the woman, becomes the focus of the assessment and thus objectified she becomes an object for clinical intervention. Particularly where the woman is detained under the Mental Health Act, she is situated at the margins of the decision-making process, often unable to take part in the proceedings and even to meet with the Official Solicitor, her allocated legal representative appointed to represent her best interests, rather than what she wants. Ultimately, she is the subject, rather than the addressee of the court order determining how her foetus will be delivered.

The consequence of a finding of incapacity is coercion, subjecting women who lack capacity to treatment that others can refuse and managing the women as a risk, rather than respecting them as individuals. While judges in the Court of Protection now regularly assert the great weight to be accorded to the individual's wishes and feelings within the best interest assessment, the cases demonstrate that in the context of a pregnant woman with SMI her wishes and feelings appear to be but a minor element of the best interests assessment, easily dismissed as a reflection of the impairment of her mind. Almost entirely reduced to best medical interests, the best interests assessment invariably focuses upon prioritising the safe delivery of the foetus, minimising increased risks imposed upon the woman and failing to take account of the broader impact the decision will have, the trauma she will experience at the hands of the state and the lasting impact the overriding of her wishes may have upon both her physical and mental health. This stands in stark contrast to the rhetoric of choice set out in *Better Births* that concludes that 'women should be informed of risks and be supported to make decisions which would keep them as safe as possible. . . . Once a woman has made her decisions, she should be respected and the services should wrap around her'.[217]

The Ockendon Review emphasised that 'Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care'.[218] Advance decisions address the need to anticipate and try to avoid conflict about the management of pregnancy and labour, they provide a mechanism to enable women at risk of losing capacity with an effective tool to enable them to participate equally in decision-making processes and to make informed choices about their care at a time when their capacity is undiminished. A valid and applicable advance decision will enable a woman to remain in control of her own birth choices, even after the onset of incapacity; safe in the knowledge that her refusal will be implemented, rather than merely forming an element to be considered as part of a heteronomous third-party decision about her best interests. Therefore, it is suggested that the time has come to move on from preferences expressed in birth and care plans, to embrace advance decisions in the obstetric context in order to ensure that the care a pregnant woman with SMI receives is patient-centred, centred upon her own choices and moreover that she is the patient upon whom care is centred.

217. *Better Births* (see Note 1), 4.18.

218. *Ockenden Review of Maternity Services at Shrewsbury and Telford NHS Trust* 2020, HC 1081 2020-21, 196, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064303/Final-Ockenden-Report-print-ready.pdf

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