

Autonomy, capacity and vulnerable adults: filling the gaps in the Mental Capacity Act

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This paper explores the distinction between being autonomous and having capacity for the purposes of the Mental Capacity Act. These include where a person misuses affective attitudes in making the decision; where a person's decision is not authentic to their values; and where the Mental Capacity Act prevents use of the context or outcome of the decision in assessing capacity. These gaps mean that a person can be found to have capacity, even though they are not properly autonomous. This, we argue, justifies the courts' use of the inherent jurisdiction to protect vulnerable adults who, while having capacity are not able to act autonomously.

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INTRODUCTION

It is a terrible thing to be assessed as lacking capacity when you do not – to have others make decisions on your behalf and set aside your own wishes based on what they think is in your best interests. You lose control over your life. You are no longer in charge of your destiny.

It is a terrible thing to be said to have capacity when you do not – to be left to cause yourself and those you love great harm on the basis that you know what you are doing and you are making your own choices, when in fact your decisions are not really yours. To have others harm you and to be told no protection is offered because you have chosen this harm, even though it is against your deepest values, is horrific.¹ It also denies the special obligations on the state to protect its most vulnerable members.

The law must try to avoid either of these shocking outcomes. At the heart of the legal response is the Mental Capacity Act 2005 (MCA). This provides a statutory framework to deal with people who lack capacity to make a particular decision. In such a case, substitute decision makers are charged to make decisions on behalf of the person lacking capacity, based on their best interests. However, those who are found to have capacity are free to make decisions for themselves, subject to the constraints of the general law.

1. For a powerful example, see J Benedet and I Grant 'Sexual assault and the meaning of power and authority for women with mental disabilities' (2014) 22 Fem L S 131.

This makes the definition of capacity crucial for the law.² Setting it too high or too low can result in serious wrongs. The importance of the role of the MCA in protecting autonomy is recognised by the courts. Recently, in *PC v York CC*,³ MacFarlane LJ stated:

the structure and provisions of the MCA 2005 are to be applied with clarity and care in order to ensure that the autonomy of the individual is not eroded by the court.⁴

We will argue that there is a gap between capacity as understood by the law and the understanding of capacity that underpins theories of autonomy (for ease of expression, we will use 'capacity' in the legal sense as understood in the MCA, and use the term 'autonomous' to refer to the capacity necessary to be able to exercise autonomy as understood in the philosophical literature).⁵

According to Genevra Richardson:

The law currently employs mental capacity to define the line between legally effective and legally ineffective decisions. It does this because it regards mental capacity as an essential ingredient of individual autonomy, and the law in the UK (and many other comparable jurisdictions) has been designed to respect individual autonomy and self-determination.⁶

This observation raises two points. First, the law uses mental capacity to differentiate between legally effective and legally ineffective decisions. Secondly, that mental capacity is an ingredient of individual autonomy. It follows, therefore, that there are other ingredients of individual autonomy that the law does not use to differentiate between legally effective and legally ineffective decisions. This paper aims to identify these other ingredients and explain how the law ought to account for these other aspects of autonomous decision making.

In Section 1 of this paper, we will outline the task of assessing whether a person has capacity under the MCA and explain how this practical task relates to, and differs from, the philosophical concept of autonomy.

We will then, in Section 2, focus on three related features of autonomy that the current legal approach under the MCA is inattentive towards. In particular, we will argue that:

- (a) an autonomous decision is the result of the combination of a cognitive process (understanding facts) and an affective process (attributing value to an outcome), and that the MCA does not have the apparatus to address circumstances where the interaction between the cognitive process and affective process is impaired;⁷

2. Our primary focus in this paper is on a person's capacity to make decisions. There is always then the question of whether they have exercised their capacity in a particular situation.

3. [2013] EWCA 478 (Civ).

4. *Ibid.*, at [51].

5. We will not here seek to discuss whether autonomy is desirable or whether standard accounts of autonomy are correct. For current purposes we will assume both of these: but see eg O'Neill 'Autonomy: the emperor's new clothes' (2003) 77 *Proc Aristotelian Soc*'y 1.

6. G Richardson 'Mental disabilities and the law from substitute to supported decision-making' (2012) 65 (1) *Curr Legal Probs* 333 at 334.

7. For the avoidance of doubt, by using the word 'affective' we are not suggesting that all values are emotion based.

- (b) autonomy requires that a person's (first-order) desires are accompanied by the (second-order) appropriation of, or identification with, the desires, and that the MCA is effectively unable to account for circumstances where a person's decision may not be motivated by their authentic own values, wishes or desires; and
- (c) that any particular autonomous decision can only be understood and assessed with reference to substance of the decision and the context in which the decision takes place, and that the 'functional' assessment under the MCA prevents this by bracketing the context and substance of the decision.

This has led to people being classified as having capacity even though they are not able to exercise autonomy. In this paper, we seek to identify and explain that gap.

We will then, in Section 3, outline how the law ought to develop in order to account for the ingredients of autonomy that currently go unaddressed under the application of the MCA. It is our contention that, fortunately, the consequences of the existence of this gap (between those who have capacity and those who have autonomy) are far less concerning than they might be, because the courts have used the inherent jurisdiction to protect vulnerable adults who have legal capacity. This paper, therefore seeks to provide a strong justification for the existence of the inherent jurisdiction, and to support the development of that jurisdiction.

The use of the court's inherent jurisdiction to protect vulnerable adults has been subject to fierce criticism. This paper provides a response to some of those criticisms. First, it is said that there is no adequate definition of a vulnerable adult. This paper can be read as offering a way ahead. The inherent jurisdiction of the court should be available to those who may have capacity under the MCA, but are nevertheless lacking in autonomy. We seek to explain more precisely in what kind of cases that may be true.

Secondly, it is said that the inherent jurisdiction undermines the protection of autonomy. We argue completely the opposite. A proper appreciation of autonomy involves respecting the views of autonomous people, but also being alert to cases where a person is not autonomous and fashioning an appropriate response to those cases. We would also add that in many cases involving the exercise of inherent jurisdiction by the courts, steps are taken to enable the person make an autonomous decision rather than forcing an order on the person.⁸ These might involve, for example, removing the vulnerable adult from an oppressive environment so that they can develop authentic values, and can make their own decisions. The discussion in this paper might help guide the court in determining what needs to be done to enhance autonomy.

1. CAPACITY, AUTONOMY AND THE LAW

The meaning of capacity

In legal terms, 'mental capacity' is what determines whether a person has the ability to make a particular decision. The MCA sets out a definition of capacity.⁹ We will discuss the core provisions.¹⁰ The starting point of the MCA is the presumption of capacity:

8. *Dr A v NHS Trust* [2013] EWHC 2442 (COP).

9. P Bielby 'The conflation of competence and capacity in English medical law: a philosophical critique' (2005) 8 *Med, Health Care & Phil* 357.

10. For a detailed analysis, see eg J Herring *Medical Law and Ethics* (Oxford: Oxford University Press, 4th edn, 2013) ch 4.

A person must be assumed to have capacity unless it is established that he lacks capacity.¹¹

The definition of capacity is found in s 2(1):

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

The notion of being unable to make a decision is explored in s 3(1):

a person is unable to make a decision for himself if he is unable –

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

Hence, under the MCA, a person has capacity to make a particular decision unless two requirements are both satisfied. The first requirement is that they are unable to understand, retain or use the information relevant to the decision (or unable to communicate their decision),¹² and, secondly, their inability to do so is ‘because of’ an impairment of the mind.¹³ The test for incapacity therefore requires a ‘casual nexus’ between the inability and a mental health condition.¹⁴

The legal significance of autonomy and capacity

The issue of capacity arises in three circumstances. The first is when a person is charged with a crime and the question arises of the extent to which they had capacity for their actions and may be held responsible under the criminal law. The second is when a person wishes to exercise a legal power or act as having a particular legal status, such as executing a will or exercising their powers as the director of a company. We are not especially concerned with these issues here. It is, however, the third category that is our primary focus.

The third set of circumstances is when someone wants to do something that is a *prima facie* wrong (something that is potentially harmful, engages a legally protected interest or otherwise calls for an explanation). That would be anything from touching a person to causing a serious wrong. In these cases of *prima facie* wrong acts, we need the consent of the person to provide a justifying reason for committing that act. In legal terms, that is an effective consent provided by a person with capacity. But why does consent permit someone to do something that that would otherwise be regarded as wrongful? Surprisingly, there is relatively little written on that question in the literature. We adopt here the approach promoted by Michelle Madden Dempsey.¹⁵ Where a person consents to being touched, for example, this gives the other person an option so that if they so choose, they can act in that particular way. The consent allows the person to assume

11. Mental Capacity Act 2005, s 1(2).

12. *Ibid*, s 3(1).

13. *Ibid*, s 2.

14. *PC v York CC* [2013] EWCA Civ 478 at [58].

15. M Madden Dempsey ‘Victimless conduct and the *Volenti maxim*: how consent works’ (2013) 7 *Crim Law & Phil* 11.

that, all things considered, the act is not contrary to the well-being being of the consentor.¹⁶ It allows the actor to rely on P's own assessment that the act is overall in P's interests. In colloquial terms, the actor can say:

This is [P]'s decision. He's an adult and can decide for himself whether he thinks the risk is worth it. In considering what to do, I will assume that his decision is the right one for him. After all, he is in a better position than I to judge his own well-being.¹⁷

This approach is particularly attractive because it is based on an acknowledgement that generally people are not good at assessing what is in someone else's best interests. As Atkins argues:

Respect for autonomy is an acknowledgment of the limitations of our knowledge of other people and a willingness to incorporate that understanding into our world-views. When we respect autonomy we don't simply observe another's freedom from a distance, as it were; we accede to our fundamental fallibility and epistemological humility. It is in recognition of the fact that we cannot experience from another's perspective that we normally refrain from judging what will make another's life good *for them*.¹⁸

Further, it encourages people, in their interactions with others, to seek to engage with them, accepting their values. As Catriona Mackenzie puts it:¹⁹

The principle of respect for autonomy ... gives rise to an obligation to try to empathetically engage with the other's experience, to imagine what the other person's situation is like for her, given her cares, values and concerns. In the context of patient care, it requires carers and medical staff to try to understand, from the patient's perspective, her experience of illness, or of particular treatment options.

For lawyers, the capacity test plays a crucial role in determining whether P is able to provide a justification for an act that would be otherwise be a legal wrong. In medical law, the question of capacity arises when a doctor or healthcare professional wishes to interact with a patient. The consent of the patient is needed to provide the justification (or 'flak jacket', as it was called in one case)²⁰ for the action. So while much of the discussion on autonomy from a philosophical perspective centres on the extent to which an individual is free and able to make a decision for themselves, in the context of the law the focus is slightly different. In law, capacity is only the extent to which another person is entitled to rely on P's decision as a justification for their otherwise wrongful act. Our focus here is therefore on 'passive' notion of consent. This last point reflects the legal position, and not necessarily a point of practise. It is true that a finding of lack of capacity will mean that, in practice, decisions for P about what to eat, where to live, which friends to spend time with and so on will be made on his or her behalf. However, in terms of the legal position, P is still free to make decisions about what to eat and what to wear. It is only if someone wants to dress P or feed P that the corresponding need for consent arises.

16. J Herring 'Rape and the definition of consent' (2014) 26 Nat'l L Sch India Rev 62.

17. Madden Dempsey, above n 15, at 20.

18. K Atkins 'Autonomy and the subjective character of experience' (2000) 17 J Appl Phil 71.

19. C Mackenzie 'Relational autonomy, normative authority and perfectionism' (2008) 39 J Soc Phil 512.

20. *Re W (A Minor)* [1993] Fam 64.

But let us be clear as to the legal implications of finding that a person lacks capacity. A finding of mental incapacity *per se* does not justify restricting that person's freedom or using force against them. A finding of incapacity removes their ability to authorise others to do otherwise unlawful actions to themselves. In order to use force or detain a person lacking capacity, the Deprivation of Liberty (DoL) safeguards in the MCA must be invoked. These are complex and detailed, but require proof that the force or deprivation is proportionate response to a serious harm. With this in mind, we can appreciate how some comments about the significance of capacity are greatly exaggerated. The claim 'there is no more profound infringement of the rights of citizens than the determination that they are incompetent'²¹ is not really believable. A person found to lack capacity is still entitled to be free to act as they wish. For force or deprivation of liberty to be justified, more than a lack of capacity must be shown. Therefore, when Demain Whitting says that capacity is about, 'what abilities or attributes (or set of abilities or attributes) the presence of which in a person should afford that person (legal) protection from state interference',²² that is not strictly accurate. Incapacity *per se* does not remove a person's protection from state interference. While their interactions with others become somewhat limited (because they cannot provide the consent to be touched or engage in property transactions), it is not until the DoL safeguards are invoked that very serious invasions of their liberty begin.²³ Accordingly, the DoL safeguards require proof that the individual needs protection from serious harm.

Finally, while we contrast autonomy (as a philosophical concept) with capacity (as a legal standard), we ought to appreciate a functional difference between these two notions: while most philosophers who have discussed the issue accept that autonomy is something that is possessed in degrees (someone may be more or less autonomous, in a variety of ways), the legal notion of capacity is typically taken as an all-or-nothing concept – either you have capacity or you do not.²⁴ Legal capacity is therefore typically seeking to determine the minimum necessary for autonomy and treats the person as autonomous once they cross that threshold.²⁵ At the end of this paper, we will challenge this functional difference.

2. CAPACITY WITHOUT AUTONOMY

In this section, we explore the argument that there is a gap between capacity (as understood in the MCA) and autonomy. At the heart of autonomy is the idea that people should be free to live their lives as they wish (and reflect the values that are dear to them). They should be self-governing: 'able to make choices and enact decisions that

21. P Appelbaum 'Ought we to require emotional capacity as part of decisional competence?' (1998) 8 *Kennedy Inst Ethics J* 377.

22. D Whiting 'Evaluating medico-legal decisional competency criteria' (2015) 23(2) *Health Care Analysis* 181.

23. This is not to say that in practice (as opposed to the formal legal position), a finding of lack of capacity will lead to decisions being made on a person's behalf that can impact on their autonomy.

24. Whiting, above n 22; although see eg S Gilmore and J Herring "'No" is the hardest word: consent and children's autonomy' (2013) 23 *Child & Family L Q* 3, for a rejection of this view.

25. In this, and in other ways, legal capacity (the focus of this paper) can be seen as very different from mental capacity.

express, or are consistent with, one's values, beliefs and commitments'.²⁶ As noted above, in the legal context this concept becomes significant when a person is giving consent to an act that is a *prima facie* wrong. The person performing the *prima facie* wrongful act must be able to take the consent as an assessment by the individual that the act is in their best interests. It therefore requires more than just that the person says 'yes', but that they consent with a sufficient understanding of what is involved and having given consideration to their beliefs and values.

We will argue that the MCA's definition of capacity fails to capture this richer notion of autonomy. The gap means that people can be found to have capacity even though they are not acting autonomously. We will explore this gap by looking at three central aspects of autonomy that are not included in the MCA definition of capacity.

(a) Cognitive and affective attitudes

Decisions such as whether to engage in sexual intercourse, to cohabit with another, to procreate, to consent to medical treatment and so on are all practical decisions. They are all practical decisions in so far as each decision requires a person to perform an action, and since the action has practical consequences, the decision to perform the action must be made in light of an assessment and evaluation of the consequences.²⁷

Since practical reasoning involves motivating an action in light of its consequences, it engages a person's evaluative judgement. This is because there needs to be some desire, preference, value, goal or commitment (ie some 'affective attitude') in order for one set of outcomes or consequences to be viewed as better than an alternative set of outcomes and consequences. The comprehension of the relevant information is not, by itself, sufficient for practical reasoning. Our factual understanding of an action and the consequences of the action cannot provide a preference for one option over another, nor the motivation to perform the action. As Louis Charland argues:

without the emotion system to generate values and fix preferences to guide and direct reason, the prefrontal subject remains hopelessly paralysed in the face of innumerable theoretical possible alternatives and hypothetical consequences.²⁸

Our ability to make a decision (to engage in practical reasoning) requires the combination of the cognitive ability to understand the nature and likely consequences of an action, and the evaluative ability to appraise the action and consequences in light of our preferences, desires, goals, values and standards (affective attitudes). So, to make a decision it is not enough to just understand the 'relevant information', be that the mechanics of sexual intercourse, the medical consequences of under-nutrition or the addictive content of narcotics. Making a decision also requires us to attribute value to these facts, such as the relational consequences of sexual intimacy, the desire to gain or lose weight, the goal of longevity of life or a hedonistic lifestyle.

We argue that these affective attitudes are essential to autonomous decision making, as Charland explains:

26. C MacKenzie and W Rogers 'Autonomy, vulnerability and capacity: a philosophical analysis' (2013) 9 *Int'l J L Context* 37 at 42.

27. Practical reasoning can be contrasted with theoretical reasoning: the latter is concerned with asserting matters of fact and asserting explanations of these facts.

28. L Charland 'Is Mr. Spock mentally competent? Competence to consent and emotion' (1998) 5 *Phil, Psychiatry & Psychol* 67 at 72.

Individuals cannot be said to appreciate fully the choices they face unless the choices mean something to them personally ... [They] must have the capacity to attribute personal significance to events and situations.²⁹

Charland's point is that emotions play a crucial role in giving priority to particular values and in fixing preferences. We agree. Indeed, we suggest that it is a universal feature of humanity that emotions fix preferences as well as selecting between them. As Charland puts it:

... the emotionless subject remains paralyzed in the face of innumerable options, with no goals or values to guide and orient decision making. Echoing Kant, we might say that while practical reasoning without cognition is empty, without emotion it is blind. Therefore, insofar as practical reasoning is concerned, Mr. Spock³⁰ is not, and indeed could not possibly be, mentally competent. Indeed, in this case he is a *psychological impossibility* – a fiction of misguided and incorrect intuitions about mental competence and emotion.

Autonomous decision making is therefore built upon the interaction between cognition (giving practical reason content) and emotion (giving practical reason vision). If a person has no desires, goals, values or standards, they have no tools with which to engage the information that is relevant to a particular decision. In order to make a decision that reflects an exercise of autonomy by them, they need to have some understanding of what they want, some conception of what is good.³¹

Capacity, under the MCA, is expressed in terms of rational reasoning. It is about understanding evidence, using it and weighing it.³² Unfortunately, it is not made explicit what using and weighing the information involves. It does not make it clear that emotions, giving practical reasoning vision, are an essential aspect of capacity. As a result, the MCA does not provide the apparatus to address scenarios where the impaired interaction between a person's affective attitudes (their values, preferences, beliefs, goals or commitments) and their cognitive attitudes (knowledge of facts) limits or undermines their capacity for autonomous decision making. We will provide a series of examples of where a person is 'using' the relevant information, and therefore has capacity as defined under the MCA, but the way in which the person uses the relevant information calls their autonomy into question.

To start, consider a decision making process where one factor so dominates their reasoning that there is no evaluation of it. An example may be a person with needle phobia, who although keen to consent to the procedure withdraws consent as soon as the needle is seen. Such a case may be treated as one where the patient has failed to 'use and weigh' the information and so lacks capacity under the MCA. However, it is not clear that all such cases will be covered. In so far as a needle-phobic refusal is simply an instinctive reaction (similar in nature to a blink as an optician approaches to examine an eye), it seems to be neither capacious nor autonomous. On the other hand, a needle-phobic patient may have time to think through the issues, but the fear of the needle so dominates their thinking that no other factor gets a look in. In such a case, they are using the

29. Ibid, at 73.

30. Mr Spock is a character in the television show *Star Trek*. He is portrayed as having considerable knowledge of facts, but lacking any capacity for emotion.

31. A Buchanan and C Brock *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge, UK: Cambridge University Press, 1989) p 24.

32. Mental Capacity Act 2005, s 3(1).

information to reach a decision and so are capacious (as per the MCA). It is, however, clear that they are not being autonomous. Their phobia is preventing them from using their values to assess the facts.

Mental health conditions may also impair a person's capacity to 'balance' competing values or factors as part of the decision making process. For example, in their study of persons with anorexia nervosa, Tony Hope and colleagues found that

People with anorexia nervosa can understand the evidence that they are unhealthily underweight and at physical danger, and they can see the ways in which anorexia nervosa impoverishes their life. At the same time, the profound emotions tell them that eating to put on weight is dangerous and that they will be safer if they lose still more weight.³³

Their suggestion is that, although people with anorexia nervosa have the ability to understand the information relevant to their condition (their weight being significantly low), their belief that they are nonetheless overweight or 'fat' and their fear of weight gain is attributable to a set of affective attitudes that are more powerful in their decision making than their knowledge of objective facts. As they explain:

One way of unpacking this is that the person does perceive herself correctly, and at some level does believe that she is thin, but the affective responses lead her to discount the perception and associated belief, and not give them the appropriate epistemic weight.³⁴

In these instances, a person may be understanding and weighing the relevant information, but their ability to give appropriate epistemic weight to the relevant information is impaired.

More broadly, Freyenhagen and O'Shea suggest that the assessment of whether someone is able to engage in the process of understanding and using information for mental capacity produces 'false positive' accounts of autonomy when the 'mental disorders are more directly entangled with a person's evaluative stances'.³⁵ For example, major depression

... can interfere with decision-making capacity, although not because of any lack of understanding of relevant information, but rather due to stifling negativity or impassive indifference towards future possibilities.³⁶

Conditions such as 'anxiety disorders, schizophrenia, anorexia nervosa, personality disorders, and phobias'³⁷ all impair the capacity for evaluative judgement to the extent that they impair the ability to enact decisions autonomously (despite satisfying the test for capacity).

Hence, there are a number of instances where a person is able to understand the information that is relevant to their decision, but their decision is driven by overriding affective attitudes (fears, anxieties, desires). Despite being able to use and weigh the

33. T Hope et al 'Agency, ambivalence and authenticity: the many ways in which anorexia nervosa can affect autonomy' (2013) 9 Int'l J L Context 20 at 29.

34. Ibid, at 28.

35. F Freyenhagen and T O'Shea 'Hidden substance: mental disorder as a challenge to normatively neutral accounts of autonomy' (2013) 9 Int'l J L Context 53 at 56.

36. Ibid.

37. Ibid.

relevant information, their ability for autonomous decision making is impaired. Such people may well be found to have capacity within the MCA, but would not, we suggest, be autonomous.

Linked here is a specific problem with the wording of the MCA. Earlier, we quoted ss 2 and 3 MCA, which rely on what *A Local Authority v TZ*³⁸ explains involves a ‘diagnostic test’ and a ‘functional test’. Under the diagnostic test, it must be found that a person has impairment or a disturbance in the functioning of the brain. Under the functional test, it must be determined whether as a result of the disturbance a person must be unable to make the decision. Importantly, it must be shown that the inability to make the decision results from the impairment. So, a person who has a mental disorder, but is unable to make a decision because, say, they are drunk, will not lack capacity, because their inability to make the decision does not result from the mental impairment. Similarly, patients with no mental impairment who refuse all treatment because of their religious belief that God will cure them will not lack capacity, even if the doctors try to argue that the patients do not properly understand the reality of their situation. They do not have a mental impairment and so cannot, under the MCA, be found to lack capacity to make a decision. Here, we have another category of cases where a person has capacity under the MCA, but lacks autonomy; that is, a person who does not understand a key piece of evidence or is unable to use the evidence to make a decision as a result of something that is not a mental impairment.

Peter Bartlett has made a powerful case that this breaches the United Nations Convention on the Rights of Persons with Disabilities.³⁹ Article 12(2) provides that people with disabilities may enjoy legal capacity ‘on an equal basis with others in all aspects of life’. Yet, under the Mental Capacity Act, if we have two people with delusions – in one case as a result of a mental disorder and the other not – the two cases are treated differently.⁴⁰ There is no reason from an autonomy perspective to differentiate the cases, yet only one is treated as lacking legal capacity. We now move on to consider a second situation where a person has capacity, but is not autonomous.

(b) First-order desires and second-order appropriation

Autonomous decisions are decisions that align with our own affective attitudes. To understand the ‘authenticity’ of the values, preferences and commitments that autonomous decisions require, it is helpful to view personal autonomy as having two levels: personal autonomy requires that our first-order desires (our values, preferences, commitments) are accompanied by a second-order appropriation of, or identification with, the first-order desires. Catriona Mackenzie and Wendy Rogers explain that to have autonomy, one must be ‘able to determine one’s own beliefs, values, goals and wants, and to make choices regarding matters of practical import to one’s life free from undue interference. The obverse of self-determination is determination by other persons, or by external forces or constraints.’⁴¹ Not only that, but a person must have authenticity:

38. [2013] EWHC 2322 (COP).

39. P Bartlett ‘The United Nations Convention on the Rights of Persons with Disabilities and mental health law’ (2012) 75 Mod L Rev 752.

40. Although it is arguable that the person with the disability is treated more favourably in that they can be protected by the Mental Capacity Act 2005.

41. MacKenzie and Rogers, above n 26, at 43.

a person's decisions, values, beliefs and commitments must be her 'own' in some relevant sense; that is, she must identify herself with them and they must cohere with her 'practical identity', her sense of who she is and what matters to her. Actions or decisions that a person feels were foisted on her, which do not cohere with her sense of herself, or from which she feels alienated, are not autonomous.⁴²

To give an extreme example, a person who has been 'brainwashed' into adopting a belief may be acting on a value, but it will not be their value. We need to identify with our values, preferences and commitments. In short, we have to want the things we want.

The problem is that the MCA has no way of assessing whether the set of values, preferences or commitments that are motivating a decision are authentic. It is enough that a person has the ability to understand and use the information relevant to the particular decision; there is no examination of whether the values, desires or preferences that are motivating the decision those of the decision maker. Here, we will consider a series of examples where a person may be acting on inauthentic values, desires or preferences, yet is deemed to have capacity, without being able to act autonomously.

We might imagine a case where P has values and has reached a decision that is consistent with some of their values and not others. This is, of course, common. The best-known scenario is where a person satisfies their short-term desire over a longer-term goal. Dieters or those trying to quit smoking, for example, will inevitably experience a clash between a carefully thought out decision, to diet or quit smoking, and an immediate desire, to eat or smoke. Common experience teaches that immediate gratification often trumps a more settled thought. Many will feel some connection with the reported comment of St Paul: 'I do not understand my own actions. For I do not do what I want, but I do the very thing I hate.'⁴³ Further, we might question a friend who allowed us to follow our short-term desires, knowing we would deeply regret it the next day. We might feel that a friend who replied that she was letting us make the decision for ourselves did not really understand us very well.

Even in cases where a person makes a decision on their immediate desire rather than deeper value, the person does have capacity. They have used the information to make the decision, even if we suspect it fits badly with their deeper values. The question in such scenarios from an autonomy perspective is how to treat these competing decisions: the more settled considered response and the immediate desire.⁴⁴ Antonia Cronin suggests that

Autonomy is the capacity of persons to reflect critically upon their first order preferences, desires, wishes and so forth and then readiness to accept or attempt to change these in the light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning to their lives and take responsibility for the kind of person they are.⁴⁵

42. Ibid.

43. The Bible, Romans 7:15.

44. Arguably, the supported decision model advocated in, for example, the UN Convention on the Rights of Persons with Disabilities would enable, although not require, a more diachronic approach to decision making that would more sensitive to the first-order and second-order desires.

45. A Cronin 'Transplants save lives, defending the double veto does not: a reply to Wilkinson' (2007) 33 J Med Ethics 219 at 220.

An example from the case-law can demonstrate this. In *Re MB*,⁴⁶ a woman was in the late stages of pregnancy and needed to be given a caesarean section operation, without which her life and that of the foetus were in danger. She needed an injection, but had needle phobia and refused to consent to the injection. The Court of Appeal authorised the giving of the injection without her consent. They justified this on the basis that she lacked the capacity to refuse the injection because her panic about needles meant she could not weigh up the information to make a decision.

A clearer account is to say that in this case there exist two competing wishes: to be given the caesarean and not to be given the injection. Both of these wishes cannot be satisfied (as they are mutually exclusive) and it must be decided which is more richly autonomous; in other words, which most reflects the settled decision of the person. In this case, we might say that in fact it is better to respect the wishes of the woman to override her refusal and give her the caesarean (and the accompanying injection).⁴⁷

Consider a further example where a person's beliefs, values, goals and wants may lack 'authenticity', that of anorexia nervosa. Tony Hope and others suggest that '[f]or many, anorexia nervosa was seen as separate from the real self'.⁴⁸ In such instances, there is a conflict between two sets of first-order desires: weight gain and weight loss. The language of 'the real self' implies that the desire to obtain a healthy weight is the authentic desire (and the desire for thinness lacks authenticity). The suggestion here is that when someone with anorexia nervosa acts out of a desire to be thin, their action is motivated by an inauthentic preference, goal or value, and is therefore not an autonomous action.

In some even more problematic cases we may determine that although a person has used their values to make a decision, these values are not their own. The values are not ones they have thought through and adopted for themselves, but ones that have been imposed upon them by others. That in part may be why young children are typically not treated as having capacity, even if they articulate values. These values simply reflect those of their parents or others; the child has not yet had the time to appropriate values for themselves.

Identifying these cases, however, can be extremely difficult. We are all inevitably influenced by our family and broader society. How we view ourselves and what we value in life are conceptions of the values that are influenced, caused or constituted by our social relationships and social conditions. Social-relational factors are essential in the development of our capacity for autonomous decision making.⁴⁹ We are probably overconfident, if anything, of actually being capable of shaking off the shackles of our relational and social context to form values genuinely "of our own". This is why we are somewhat sympathetic to great thinkers of the past who express views that, while orthodox in their day, now seem misguided or even offensive. We recognise that even the greatest thinkers to some extent adopt the values of their day.

However, even accepting human limitations, there may be cases where the ability to adopt and take on values for one's self has not been undertaken. Social relationships or social conditions can undermine our capacity for autonomous decision making by

46. [1997] EWCA Civ 1361.

47. J Herring 'The caesarean section cases and the supremacy of autonomy' in M Freeman (ed) *Law and Medicine* (Oxford: Oxford University Press, 2001).

48. Hope et al, above n 33, at 31.

49. J Herring *Relational Autonomy and Family Law* (Cham: Springer International, 2014).

influencing the content and impairing the authenticity of our affective attitudes.⁵⁰ When we engage in practical reasoning, we assign weight to our own preferences and desires. Although how our decisions impact us may not exhaust the considerations that feature in our practical reasoning, our own preferences, desires and goals are nonetheless treated as directly relevant. This follows from our attitudes of self-worth, self-respect or self-esteem, which suggest that our experiences and goals matter.⁵¹ Where this sense of self-worth is impaired, a person is vulnerable to deferring excessively to the preferences and desires of others. When the excessively deferential person makes a decision, such a decision may be motivated by a set of desires and preferences that are not their own desires and preferences.⁵² Autonomous decision making therefore requires the affective attitude of self-worth, in order for a decision to be aligned with authentic desires, preferences and goals.

There is a tension here. Relationships are key to our identity. As Catriona Mackenzie argues, ‘as *agents*, our practical identities and value commitments are constituted in and by our interpersonal relationships and social environment’. At the same time, those relationships can undermine our sense of self. This need not unduly worry a relational theorist; indeed, it can highlight the significance of relationships to the nature of the self, and reveal what is particularly wrong about the misuse of a relationship to manipulate another.⁵³ How, though, can we distinguish between a relationship that establishes identity and one which controls? Mackenzie helpfully suggests that ‘self-trust’ and ‘self-worth’ are key. Relationships that build these up are compatible, even essential, to full autonomy. She explains:

to claim normative authority over her life an agent must have a conception of herself as the legitimate source of that authority; as able, and authorized, to speak for herself. What underwrites this self-conception ... are certain affective attitudes toward oneself – attitudes of self-respect, self-trust, and self-esteem.⁵⁴

In addition, even when someone views themselves as someone of worth, they may nonetheless adapt their preferences and desires because of the social conditions in which they live. The adaption of (first-order) preferences and desires is not problematic provided that it is accompanied by the (second-order) critical reflection about one’s own preferences, desires, goals, values and so on.⁵⁵ The concern is that some social conditions may impair this self-reflective capacity to endorse (or identify with) one’s apparent preferences and desires. We nonetheless note the difficulty with formulating this concern while avoiding the ‘infinite regress of ever-ascending orders of

50. Given the emphasis placed on supported decision making in the UN Convention on the Rights of Persons with Disabilities, this may be particularly significant.

51. T Grovier ‘Self-trust, autonomy and self-esteem’ (1993) 8 *Hypatia* 99.

52. C McLeod *Self-Trust and Reproductive Autonomy* (Cambridge, MA: The MIT Press, 2002).

53. See J Herring ‘The serious wrong of domestic abuse and the loss of control defence’ in A Reed and M Bohlander (eds) *Loss of Control and Diminished Responsibility* (Aldershot: Ashgate, 2011).

54. C Mckenzie ‘Relational autonomy, normative authority and perfectionism’ (2008) 39 *J Soc Phil* 512 at 513.

55. D Meyers ‘Decentralizing autonomy: five faces of selfhood’ in J Christman and J Anderson (eds) *Autonomy and the Challenges to Liberalism* (Cambridge, UK: Cambridge University Press, 2005).

reflection'⁵⁶ and the difficulty in differentiating between constructive and destructive components of relational autonomy.

Capacity requires the mere understanding and use of relevant information. Autonomy requires much more: a person makes an autonomous decision where the person is able to identify *with* the affective attitudes that are motivating the decision. A person may be vulnerable to making decisions that are inauthentic because of heightened fears or anxiety, medical conditions that separate 'the self' from the 'real self' or social conditions that undermine a person's sense of self-worth. They key point here is that this vulnerability is outside the apparatus of the MCA. Having established this particular gap between capacity and autonomy, we now turn to our third and final category.

(c) Process and context

In this section, we will explore the way in which the courts, in interpreting the MCA test for capacity, have held that (at least in some contexts) the test for capacity must be applied in relation to the issue at hand outside the context of a particular situation. So, for example, capacity to engage in sex is assessed in the abstract, rather than asking whether a person can consent to sex with person X in situation Y. We will argue that this approach opens up a further gap between capacity and autonomy.

The exercise of autonomy, the decision making process that aligns the outcomes of a decision with one's own beliefs, values and commitments, does not exist in a vacuum. The factors that motivate a decision, and the outcome of a decision, form part of the context of the decision making process. It is because of the importance of context to the decision making process that the courts, in some circumstances, focus on the specific circumstances of the decision when assessing whether the person has the capacity to make the decision. In recognition of this concern, McFarlane LJ in *York CC v PC* found that in determining that the test for the capacity to cohabit was situation specific:

the effect that removing the specific factual context from some decisions leaves nothing for the evaluation of capacity to bite upon.

The ability to make an autonomous decision depends on deliberation. Yet deliberation requires an assessment on the effects and consequences of a decision. As we have seen, the exercise of autonomy is not simply a matter of comprehension: it is also a matter of evaluative judgement and self-respect. The difficulty is that we cannot make sense of affective attitudes, self-trust and self-respect without reference to the specific context in which these values are applied. It is only possible to understand and assess these attitudes and conceptions of value with reference to the substance of the decision and the context in which the decision takes place.

The problem is that the application of the MCA often directs the court to bracket or sideline the specific context of a decision. Recall how ss 2 and 3 MCA set out a 'diagnostic test' and a 'functional test'.⁵⁷ Under the 'functional test', it is enough to satisfy the requirements of capacity that particular inputs, specifically the 'relevant information', form part of the decision making process. It is therefore possible to assess whether

56. C Mackenzie 'Critical reflection, self-knowledge, and the emotions' (2002) 5 Phil'l Expl'ns 186 at 190; see also C Mackenzie 'On bodily autonomy' in SK Toombs (ed) *Handbook of Phenomenology and Medicine* (Dordrecht: Kluwer Academic, 2001) p 430.

57. [2013] EWHC 2322 (COP).

someone has capacity without reference to the content or outcome of the particular decision.⁵⁸ Provided that the person's ability to include the relevant information in their reasoning process is not impaired by a mental health condition, the person will have the capacity to make the particular decision.

The problem, as we see it, is that the functional test under the MCA does not provide the apparatus to assess whether a person is acting autonomously, because it forces the courts to bracket the substance and context of the decision. This bracketing occurs in two main instances: first, where the court is determining what counts as 'relevant information'; and secondly, where the court is reviewing evidence of whether a person has the ability or inability to understand and use relevant information.

Relevant information

To be autonomous, one must understand the relevant information. The MCA contains the same requirement. However, much depends here on what constitutes 'relevant information'. That in turn will often depend on how one interprets the question to be decided.

Consider, for example, the question in *A Local Authority v Mr and Mrs A*⁵⁹ of whether Mrs A had capacity to make a decision about contraception. This could be phrased in a number of ways: Did she have capacity to consent to become pregnant or give birth or raise a child? Did she have capacity to take the pill? In the case-law, this issue has particularly focused on a debate over whether the question is posed in general terms or person-specific terms – and so, for example, whether in relation to consensual sex the question is 'Does P have capacity to consent to sex as a general matter?' or 'Does P have capacity to consent to sex with X?'⁶⁰ In truth, the law has struggled to find a coherent approach. Marriage, for example, has been found to use a general test, while cohabitation is a person-specific test. So P may have capacity to marry X, but not to cohabit with X.

It is, perhaps, surprising that the courts have not stuck with a person-specific test. It is difficult to make sense of the question whether, as a general matter, P has capacity to consent to sex. Inevitably, it all depends upon the individual, the circumstances and situation. The idea you can consent to sex ignores the huge variation in understandings, even for a particular person, about the meaning of sex acts in different contexts.⁶¹ Sex may be a moment of fun, an expression of commitment, a physical release and/or an act of spiritual union, at different times for different people (or for the same person at different times, or for different people at the same time). Asking whether a person can consent to sex assumes that we have a monolithic understanding of sex. This is laid bare by the test for capacity for consenting to sex, which focuses on the essential physical aspects – as in *A Local Authority v H*,⁶² where Hedley J explains that to have capacity to consent to sex, a person needs to understand:

- The 'mechanics of the physical acts' (para 23).
- 'That vaginal intercourse may lead to pregnancy' (para 23).

58. 'What matters is [the] ability to carry out the processes involved in making the decision – and not the outcome': Department of Constitutional Affairs 2007, Code of Practice, s 4.2.

59. [2010] EWHC 1549 (Fam).

60. *IL v LM* [2014] EWCA 37 (Civ).

61. J Herring 'Mistaken sex' [2005] Crim L Rev 511.

62. [2012] EWHC 49 (COP).

- ‘Some grasp of sexual health’, although that only need to be rudimentary and it would, ‘suffice if a person understands that sexual relations may lead to significant ill-health and that those risks can be reduced by precautions like a condom’ (para 23).
- That she does have a choice and that she can refuse (para 25).

The irony is that few capacious people in deciding to have sex will place much weight on the mechanics of the acts or the risks of health. For Munby LJ (para 87):

A woman either has capacity, for example, to consent to ‘normal’ penetrative vaginal intercourse, or she does not. It is difficult to see how it can sensibly be said that she has capacity to consent to a particular sexual act with Y whilst at the same time lacking capacity to consent to precisely the same sexual act with Z.

But that seems very odd. If the woman is in an abusive relationship with Z, or suffers delusions about Z, or knows facts about Y but not Z are all factors that could well mean that she could have capacity to consent to sex with Y but not Z. While, of course, Munby LJ would not for a moment countenance the ‘rape myth’ – that a woman who is willing to consent to sex with A will be happy to have sex with any man – his reasoning is in danger of lending some support to that, by suggesting that there are no extra factors that play a part in autonomous decision making when a woman consents to sex with Y rather than Z.

It is understandable that the courts wish to avoid person-specific tests in relation to sex or marriage. One cannot envy a judge being required to rule whether a person understood sufficient information to engage in sex with a particular person.⁶³ However, the difficulty of applying a test is not an adequate reason for not using it. Child protection issues raise similar issues of difficulty, but no one suggests that we should avoid asking if this child is at risk from this parent, simply because it raises sensitive issues.

Evidence of capacity

The approach under the MCA also brackets the context and substance of the decision by narrowing the evidential focus of the ss 2 and 3 test. Philosophers do not need to worry themselves about how to prove whether a person is autonomous. Lawyers do not have that luxury. Tests for capacity have to be usable by clinicians making the necessary assessment and capable of providing proof if challenged before a court. The MCA itself does not have much to say about proof of capacity, save this provision:

A person is not to be treated as unable to make a decision merely because he makes an unwise decision.⁶⁴

At first sight, this seems an eminently sensible provision. If a person could be found to lack capacity simply by virtue of the fact that their decision was seen as unwise by someone else, the protection for autonomy in the MCA would become meaningless. If we agreed with the person’s decision then they were capacitous, while if we disagreed that they would be treated as lacking capacity, either way they would end up doing what we thought best. That would be paternalism, not autonomy.

However, the problem is that assessing whether a person has used and weighed information is difficult, if not impossible, without looking at the outcome of the

63. Indeed, this appears to have influenced the Court of Appeal in *IL v LM* [2014] EWCA 37 (Civ) to support an act-specific test.

64. Mental Capacity Act 2005, s 1(5).

decision reached. For instance, the Court of Appeal in *PC v York* found the expert evidence (of Dr Payne) to be ‘less than reliable ... because of the clear potential for [Dr Payne] to have focused upon the “outcome” rather than PC’s functional ability in general’.⁶⁵ As a result, Hedley J’s finding that PC lacked the capacity to consent to cohabit with a particular person was unsustainable. The irony is that since the MCA requires a decision-specific assessment, evidence of capacity or incapacity must be evidence of the capacity or incapacity to make the specific decision (including, in this case, the characteristics of the cohabiter), yet any such evidence cannot focus on the content of the decision. But what is a clinician to do if a person with mental impairment makes an irrational decision and is unable to provide an explanation for it? They have nothing to go on in deciding whether the person made the decision with capacity, apart from the outcome of the decision itself. It puts clinicians in an impossible position if they are forbidden from using the outcome as the basis for an assessment. Of course, a highly articulate individual might be able to set out in detail the exact reasoning behind their decision, and from this we might be able to see that they have appropriately weighed and used the information – even if they subsequently reached a decision that the clinician thinks unwise. But if, as is much more likely, the individual cannot articulate the precise weighing that is to take place, what is the clinician to do, save to look to the wisdom of the decision?

It is important in this context to have regard to the wording of s 1(4), which only requires that the clinician does not treat a person as lacking capacity *merely* because they have made a decision that the clinician deems unwise. That does not prevent a clinician using the lack of wisdom of a decision as part of an overall assessment. Nor is it objectionable that the evidence refers to the content of the decision, along with other evidence to make an assessment of capacity.⁶⁶ Yet, despite all this, the current approach of the courts is to treat evidence that is ‘focused on the final content of the decision’ as being ‘less than reliable’.⁶⁷

First, notice, there is a normative decision that is made in determining what information is needed to make the decision – such that where it is held that a particular fact need not be understood, there is a normative assessment that a decision disregarding that factor is capacious.

Secondly, to use an example first given by Natalie Banner:⁶⁸

I were to tell a person standing at a set of traffic lights that a lorry was hurtling along the road ignoring red lights, and I have every reason to believe he understands my utterances. He then proceeds to step directly into the lorry’s oncoming path.

She argues that she would judge that the person had either not understood the information or had not weighed it. And she says that this conclusion flows because, ‘he did not respond to that information in the way that he ought to’. She explains that when we say that someone has failed to weigh or use information, we are implicitly saying that they have failed to use or weigh the information as they ought to. This is not as strong a prescription as it sounds. It recognises that there may be a range of reasonable decisions that could be reached or a range of ways in which the information might be used, but also a range of decisions that mean that inadequate weight was given. For example, if a patient said that they did not attach any weight to the race of a surgeon when

65. *PC v York*, at [59].

66. Department of Constitutional Affairs *Mental Capacity Act: Code of Practice* (London: TSO, 2007) para 2.7.

67. *PC v City of York* [2013] EWCA Civ 478, [59]; see J Herring and J Wall ‘Capacity to cohabit: hoping “everything turns out well in the end”’ [2013] *Child & Fam L Q* 417.

68. N Banner ‘Unreasonable reasons: normative judgements in the assessment of mental capacity’ (2012) 18 *J Eval Clinical Prac* 1038 at 1039.

deciding whether to consent to treatment, we would not question the capacity of the patient at all. The patient certainly should not be giving any weight to that factor. The fact that the particular factor was not considered would point clearly in favour of capacity, but that is based on a normative assessment of what is relevant.

The test for capacity under the MCA requires an assessment of whether a person is able to undertake the process of decision making. This calls for evidence for or against a person's ability to undertake the process (of understanding and using the relevant information). But by removing too much of the content and context of the actual decision, it 'leaves nothing for the evaluation of capacity to bite upon' and limits the evidence that can be introduced to show that a person has or does not have capacity. In essence, it reduces social activities that have huge variation in understandings into activities of monolithic meaning, whereas the exercise of autonomy will always depend on the context-specific meaning of the activity. As such, 'capacity' under the MCA is a much narrower category than 'autonomy'.

This gap is particularly significant given the particular role that capacity has to play in the law (as highlighted earlier). Capacity is relevant in the legal context to determine whether the person can give consent to justify a *prima facie* unlawful act. To provide consent, and justify a *prima facie* wrong, the person ought to be richly autonomous in the sense we have described.

3. THE INHERENT JURISDICTION OF THE COURT OF PROTECTION

So far in this paper, we have highlighted the fact that some people assessed as having capacity under the MCA will not be genuinely autonomous. This raises the concerning possibility that a court would determine that, because a person has been found to have capacity, it cannot intervene to protect them (despite genuine concern as to their autonomy). This is precisely what happened in *PC v York*.⁶⁹ Despite the expert views that if PC were to cohabit with her husband she would be at risk of serious violence, Lewison LJ concluded:

I well understand that all the responsible professionals take the view that it would be extremely unwise for PC to cohabit with her husband. But adult autonomy is such that people are free to make unwise decisions, provided that they have the capacity to decide ... We must leave PC free to make her own decision, and hope that everything turns out well in the end.⁷⁰

Such a conclusion, that a person found to have capacity cannot be protected from harm, would be unpalatable, particularly given the arguments made above that Lewison LJ's assumption that a person with capacity is acting autonomously is ill founded. In particular, it would amount to a failure of the legal system to comply with its obligations under the Human Rights Act 1998 and the European Convention on Human Rights, were it to not take reasonable steps to protect vulnerable adults from violence and harm. We will not here provide the detail of.⁷¹ We will focus instead on how the law might respond to this situation.

69. [2013] EWCA Civ 478.

70. *Ibid*, para 64.

71. For more on these requirements, see Herring and Wall, above n 67, at 417.

REDEFINING CAPACITY

One response to the gaps we have identified between capacity and autonomy is to re-define capacity to bring it in line with the notion of autonomy. This clearly has attractions, but brings with it difficulties. For instance, to develop a definition of capacity that covered all the issues raised above would prove complex and would probably be unusable in a clinical setting. The practical requirements for finding capacity in patients necessitates that doctors are able to use it in a clinical setting. Straightforwardness is particularly important if a doctor is to be held to account if they have failed to meet the legal standards.

Blurring the capacity/non-capacity line

John Coggan, in a highly instructive article,⁷² distinguishes three meanings of autonomy. The first conception of autonomy, 'Ideal desire autonomy':

Leads to an action decided upon because it reflects what a person should want, measured by reference to some purportedly universal or objective standard of values.

As we have discussed above, a person may lack 'autonomy' where they assign unreasonable or irrational normative weight to a particular fact, do not assign the appropriate epistemic weight to a relevant fact or do not arrive at decisions through the consideration of their own self-worth. Their autonomy is impaired because their affective attitudes fall below an 'objective standard of values'.

Coggan's second conception of autonomy, 'Best desire autonomy':

Leads to an action decided upon because it reflects a person's overall desire given his own values, even if this runs contrary to his immediate desire.

We have also argued here that a person may lack autonomy where their values, wishes and desires lack authenticity. Their autonomy is impaired when they are unable to act on their 'overall desire' but, instead, are motivated by an 'immediate desire', where the 'immediate desire' may not be a desire that they 'identify with'.

Coggan's third conception ultimately aligns with the concept of 'capacity' under the MCA. 'Current desire autonomy':

Leads to an action decided upon because it reflects a person's immediate inclinations, i.e. what he thinks he wants in a given moment without further reflection.

According to this conception, provided that a person understands the relevant information, and the information is used in the decision making process, an 'autonomous' person may make a decision based upon their immediate inclinations.

As can be seen from Coggan's analysis, some decisions are richly autonomous: they reflect a genuine part of the person's life vision, and are made with a full understanding of the consequences. Other decisions are only weakly autonomous: they represent no more than a whim or casual preference and may not involve a careful consideration of the consequences. While both are autonomous decisions and both deserve respect, they do not justify the same level of respect. That is important in relation to cases involving consent to medical treatment. In such cases, we must weigh up the respect

72. J Coggan 'Varied and principled understandings of autonomy in English law: justifiable inconsistency or blinkered moralism?' (2007) 15 Health Care Analysis 235.

due to the decision of the patient with the benefit or harm that the treatment (or its absence) will bring. With a richly autonomous decision, we can justify respecting the person's decision, even where doing so will risk death or serious harm. Where, however, it is a weakly autonomous decision, we may decide to attach less weight to the decision and it cannot justify the individual being caused serious harm. In legal terms, it may be that the weak notion of autonomy is insufficient to amount to a legally effective refusal of treatment.

Coggan argues that all three can be justified as forms of autonomy. Although autonomy is often understood by lawyers to refer to what he calls current desire autonomy, he argues that in fact best desire autonomy is generally the preferable version when serious decisions are at stake.

Herein lies our concern with the current legal approach. The law is asked to adjudicate on matters of capacity in anticipation of a *prima facie* wrongful action (an action that may be harmful, that engages legally protected interests or that otherwise calls for an explanation). The wrongfulness of the anticipated action, the extent of harm or the type of interest varies substantially depending on the type of action and circumstances. The law (rightly) calls for an explanation, and often it is P's decision or consent that acts as a justification for the otherwise wrongful act involving P. However, the same standard of explanation, 'capacity' or 'current desire autonomy', serves to justify a host of different *prima facie* wrongful actions. It is our contention that there are some decisions that are more serious, harmful or wrongful and call for a more robust explanation than the mere 'capacity' or 'current desire autonomy' provides.

To put it another way, we should not assume that autonomy is an 'all-or-nothing concept'. A richly autonomous decision requires full protection and the patient has the right to have their refusal respected, however serious the consequences. Where, however, the decision is only marginally autonomous, then it may be sufficient to deserve respect in cases where what the patient wants to do something that is not particularly harmful. A weakly autonomous decision may, therefore, not be sufficient to justify doing an act that will lead to serious harm. Hence, we can see that a patient whose decision is only weakly autonomous may still have his or her decision to consent to medical treatment respected, but not a decision to refuse treatment.⁷³

There is much that might appeal to such an analysis. However, it would require a complete reworking of the MCA.⁷⁴ Any resulting statutory formulation would become remarkably complex. A better way forward has already been found by the courts and that is their use of the inherent jurisdiction to protect vulnerable adults. It is our suggestion that the Court of Protection has the inherent jurisdiction to 'calibrate' the seriousness of the decision with the adequacy of the explanation.

The vulnerable adult jurisdiction

Much merit can therefore be found in the approach the courts have taken in developing a jurisdiction for vulnerable adults.⁷⁵ In *DL v A Local Authority*,⁷⁶ the Court of Appeal was clear:

... the inherent jurisdiction remains available for use in cases to which it may apply that fall outside the MCA 2005 is not merely arrived at on the negative basis that the

73. J Herring 'Losing it, losing what? The law and dementia' [2009] *Child & Fam L Q* 3.

74. It is possible that the courts could start again with a new way of interpreting the MCA, but it is hard to imagine the courts taking a complete *volte-face* at this stage.

75. B Hewson "'Neither midwives nor rainmakers'" – why DL is wrong' [2013] *Pub L* 451.

76. [2012] *EWCA Civ* 253.

words of the statute are self-limiting and there is no reference within it to the inherent jurisdiction. There is, in my view, a sound and strong public policy justification for this to be so. The existence of ‘elder abuse’, as described by Professor Williams, is sadly all too easy to contemplate. Indeed the use of the term ‘elder’ in that label may inadvertently limit it to a particular age group whereas, as the cases demonstrate, the will of a vulnerable adult of any age may, in certain circumstances, be overborne. Where the facts justify it, such individuals require and deserve the protection of the authorities and the law so that they may regain the very autonomy that the appellants rightly prize.⁷⁷

The Court of Appeal did not want to limit the ambit of the jurisdiction by producing a definition of the vulnerable adults caught by the jurisdiction. All they were willing to say was that it applied to people who, although having capacity under the MCA, had a ‘borderline lack of capacity’.⁷⁸

The benefit of this jurisdiction is that it provides the courts with flexibility to identify cases where even if a person has capacity within the meaning of the MCA, they lack the ability to form an autonomous judgement.

We can see this as the basis of some judgments to date. For example, in *DL v A Local Authority*, the parents, although they possessed the understanding of factual issues, were not able to apply their own values to the decision making. Similarly, in some of the cases involving forced marriage,⁷⁹ the women’s decision making was driven by overriding affective attitudes of fear. This meant that their decision to marry was not one they had made for themselves.

If the vulnerable adult jurisdiction is understood as providing protection for those deemed to have capacity, as understood by the MCA, but who clearly lack the ability to exercise autonomy, the jurisdiction is entirely supportable. Under this view, it becomes misguided to suggest that inherent jurisdiction is improperly interfering in people’s autonomy rights.⁸⁰ Quite the opposite, it is ensuring that only autonomous decisions are respected and that those who wish to do prima facie wrongful acts to others cannot rely on the ‘consent’ of a person that does not reflect that person’s autonomously expressed wish.

Indeed, it is most appropriate that the courts have said, in exercising inherent jurisdiction, that the primary role of the jurisdiction is to put the person in a position where they can exercise their autonomy. As Macur J put it in *BL v BYJ*:⁸¹

the relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions.

One final advantage to the use of the vulnerable adult jurisdiction is that the law is brought closely in line to the ideals in the United Nations Convention on the Rights of Persons with Disabilities. The ability to intervene and make decisions will discriminate less on the grounds of whether a person has a mental disorder and enable the law to provide a set of protective mechanisms for those who lack autonomy.

77. *DL v A Local Authority* [63].

78. *Ibid*, at [62].

79. *Re SA (Vulnerable adult with capacity: marriage)* [2005] EWHC 2942, [2006] 1 FLR 867.

80. Hewson, above n 75.

81. [2010] EWHC 2665 (Fam).

CONCLUSION

This paper has explored the gap between capacity and autonomy. We have sought to set out the circumstances in which a person may be said to have capacity under the MCA, but not to be autonomous. These include where a person misuses affective attitudes in making the decision; where a person's decision is not authentic to their values; and where the MCA prevents use of the context or outcome of the decision in assessing capacity. We have argued that the courts use of the inherent jurisdiction to protect vulnerable adults, which is currently somewhat under-analysed or justified, is the most appropriate response to the gap between capacity and autonomy.