

Capacity and Consent in England and Wales: The Mental Capacity Act under Scrutiny

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The Mental Capacity Act 2005 came into force in England and Wales in 2007. Its primary purpose is to provide “a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves.”¹ Examples of such people are those with dementia, learning disabilities, mental health problems, and so on.² The Act also gives those who currently have capacity a legal framework within which they can make arrangements for a time when they may come to lack it. Toward this end, it allows for them to make advance decisions (in effect, refusals of consent to certain forms of treatment) or to appoint proxy decision makers with lasting powers of attorney. Such attorneys must always act with regard to the incapacitated person’s best interests. Of course, where no such arrangements have been put in place, the Act insists that all decisions made on behalf of an incapacitated person, such as those made by healthcare professionals, must also be carried out in her best interests. In cases in which there is disagreement about precisely what constitutes those interests or where clarification of the legality of a proposed course of action is needed, a newly instituted Court of Protection is empowered to make the required judgments. The court may also appoint a deputy to make decisions on the incapacitated person’s behalf.

Although much commented upon, the Act has until recently received comparatively little in the way of distinctively philosophical attention. This is in some ways surprising, especially because, as will become clear, it has at its heart a distinctive notion of decisionmaking capacity that is likely to be of some interest to bioethicists. In this short report, I outline and briefly comment on the Act’s central principles before summarizing some recent original work on the Act that has been carried out by colleagues from my own organization, the International School for Communities, Rights and Inclusion at the University of Central Lancashire.

The Mental Capacity Act 2005: Key Principles

In the very first paragraph of the Act, five key principles are listed, which are to be taken as underpinning and guiding all its provisions:

- 1) A person must be assumed to have capacity unless it is established that he lacks capacity.
- 2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- 3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

- 4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- 5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.³

The first principle, which we might call the principle of the presumption of capacity, aims to avoid anybody's being taken to lack capacity in certain areas of decisionmaking, simply because of her age, appearance, physical or mental condition, and so on.⁴ The Act emphasizes, too, that capacity or its lack is, so to speak, decision-context dependent: a person's lacking the capacity to make decisions of one type does not entail that she lacks the capacity to make decisions of another type. It may also be that the capacity to make one specific type of decision is subject to fluctuation over time; under certain circumstances, a person may be perfectly capable of making a type of decision that, under other circumstances, she would not be able to make. This stress on the decision-context dependence of capacity and the consequent shift from characterizing individuals as capable or incapable *tout court* would appear to have much in common with Tom Beauchamp and James Childress's belief that it is more useful in biomedical ethics to talk of the autonomy or otherwise of *acts*, rather than of *persons*:

Even autonomous persons who have self-governing capacities ... sometimes fail to govern themselves in particular choices because of temporary constraints caused by illness, depression, ignorance [and so forth]. ... Similarly, some persons who are generally incapable of autonomous decision making can at times make autonomous choices.⁵

Therefore, whenever the Act makes use of the notion of a person's lack of capacity, that lack should be understood as existing relative to particular types of decision in particular contexts only. And, it is clear, given the first of the five principles, that no judgment of such a lack can legitimately be made in the absence of a proper assessment of a person's capacity.

What is more, as the third principle makes clear, we are not to assume that a person lacks the capacity to make a certain type of decision just because she makes a decision of that type that is unwise. Clearly, this principle acts as a check on paternalism. Equally clearly, it mirrors the distinction between substantive autonomy (determined by reference to the *output* of a piece of practical reasoning, i.e., by reference to the decision itself) and procedural autonomy (determined by reference to the nature of the reasoning that underlies a decision).

Though I have not seen this concern raised anywhere, it seems to me that there may be some tension between the fourth and the fifth principles. If both are to be followed, then when someone needs to make a decision for an incapacitated patient (perhaps an agent to whom has been granted lasting powers of attorney, perhaps a deputy appointed by the Court of Protection, or perhaps a healthcare professional charged with the care of a patient), that decision must *both* be concerned with the patient's best interests and be the least restrictive possible of the person's rights and freedoms. However, it seems conceivable that some proxy decisions that are in a patient's best interests may not be the least restrictive possible; conversely, the decision that is least restrictive in a particular circumstance

might fail to be in the patient's best interests. For situations such as these, we need to know whether it is the patient's best interests or her rights and freedoms that ought to be given greater weight and so which ought to act as a constraint on the other. Do we decide first what is in her best interests and then choose the available course of action, out of those in her best interests, which is least restrictive? Or do we decide first what course of action is least restrictive and then act not in the patient's *overall* best interests but in her best interests compatible with, and limited by, a recognition of her rights and freedoms?

Having said that, the conception of best interests appealed to in the Act appears to differ in some ways from that most commonly employed in, for example, the bioethical literature. So, in Part 1, Section 4 of the Act we read that in considering an incapacitated person's best interests, someone making decisions on his behalf must consider, insofar as it is possible,

- a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- c) the other factors that he would be likely to consider if he were able to do so.⁶

Now, suppose that we are reasonably certain that the incapacitated person would, had he possessed capacity, have made an unwise decision. This account of best interests seems to license us to make an unwise decision on his behalf. And yet an unwise decision is usually understood precisely as being one which runs counter to the decision maker's best interests. It may seem odd, then, to hold, as the Act implicitly does, that just such a decision can be in the patient's best interests. In fact, it simply demonstrates that the Act's understanding of the notion of best interests is a slightly idiosyncratic one, insofar as it covers acts that would typically be taken to be *against* a patient's best interests.

It might be argued that, though potentially confusing in its divergence from standard usage, the Act's understanding of best interests is nonetheless perfectly innocuous. And this may well be the case, so long as the idiosyncratic usage is borne carefully in mind. Even so, dangers lurk in any attempt to collapse respect for patient autonomy (or, in this case, a simulacrum of respect for autonomy, as the patient lacks autonomy in the relevant sphere) into a concern with a patient's best interests. The collapse remains safe so long as judgments about what is good for the patient are subordinated to a determination to do what she would herself choose. But if the collapse is, so to speak, effected in the opposite direction, so that what she would choose is understood solely in terms of what is good for her—and so in terms of her best interests as traditionally understood—then the specter of paternalism begins to loom.

The Deprivation of Liberty Safeguards

To close what has come to be known as "the Bournemouth gap," the Act was augmented by the specification, in the Mental Health Act 2007, of a range of Deprivation of Liberty Safeguards (DoLS). The Bournemouth gap is a legal loophole that has allowed incapacitated but compliant patients to be informally admitted to settings such as hospitals or care homes. Such patients, being

compliant, have made no attempt to resist admission or to leave settings once admitted.

One such patient, a severely autistic man known as HL, was admitted to Bournwood hospital in the early 2000s. Given his compliance, there was held to be no need formally to detain him under the Mental Health Act, which allows patients who constitute a risk to themselves or others to be detained against their wishes. HL expressed no desire to leave, but, crucially, had he tried to, he would have been prevented. It was this fact that led eventually (after some legal wrangling in the U.K. courts) to the European Court of Human Rights declaring the deprivation of HL's liberty to constitute a violation of his human rights, despite its being instituted in his best interests (and note that the expression "best interests" has here its customary sense). It was this ruling that led eventually to the development of the DoLS.

The safeguards, and the procedures that are triggered in accordance with them whenever it is deemed necessary to deprive a patient of his or her liberty, are complex and elaborate.⁷ Their aim, however, is to provide a legal framework wherein, among other things, it is possible to appeal against decisions to treat incapacitated but compliant patients and to ensure that the patients in question really do lack capacity to decide whether they are to stay in a setting or not.

The Mental Capacity Act and Cultural Sensitivity

Having outlined some of the main points of the Mental Capacity Act and the DoLS, I want in the remaining sections to consider, all too briefly, some of the critical evaluation to which colleagues in the International School for Communities, Rights and Inclusion have subjected them.

One of the main constituencies to which the Mental Capacity Act applies is that of elderly sufferers from dementia. In England and Wales, a not inconsiderable proportion of such sufferers will be members of Black and minority ethnic (BME) groups. In an editorial in the journal *Age and Ageing*, Ajit Shah (himself a consultant psychiatrist) and Chris Heginbotham have noted some important implications that this fact has for the practical application of the Act. Chiefly, these concern the ways in which the decisionmaking capacity of some BME elders is to be assessed. For example, as Shah and Heginbotham point out:

A successful assessment of the DMC [decisionmaking capacity] and the application of the MCA [Mental Capacity Act] are contingent upon the assessor's fluency in the subject's language, subject's fluency in English, accuracy of interpretation services and availability of appropriate vocabulary in the subject's language for concepts discussed during the assessment.⁸

Where it is necessary to utilize interpreters in an assessment of capacity, Shah and Heginbotham note that it is important to use professionals; lay interpreters (members of the patient's family, for example) may be emotionally involved with the person being assessed and, consequently, prone to bias. That bias, in turn, would be liable to infect their translations. But finding a suitable professional may, it is implied, be no easy matter. For example, different dialects of one and the same language may be spoken by members of different ethnic groups. In addition, the gender of the interpreter will be of significance for some BME

groups—elderly Indian women, for example, may require a female translator if they are reliably to supply sufficient information to allow for accurate assessment of their capacity.

The clearing of certain linguistic hurdles is not the only challenge facing those who would assess the capacity of BME elders, however. Wider cultural factors will need to be taken into consideration as well:

For example, elders practicing Hinduism and Jainism are expected to disengage from economic, social and domestic responsibility and, therefore, may indicate that any decision should be made by their eldest son. Also, elderly Indian women, in accordance with traditional cultural practice, may indicate that any decision should be made by their husband.⁹

The difficulty in this sort of case, according to Shah and Heginbotham, is that the Mental Capacity Act does not allow adult subjects to have other people consent on their behalf.

The general conclusion to which the authors come in their short piece is that “Policy-makers, service commissioners, service providers and assessors should be aware of these potential difficulties, and undertake measures to reduce them.”¹⁰ This is doubtless true, though, perhaps because of restrictions of space, Shah and Heginbotham do not dwell on the fact that they appear to have identified two very different types of difficulty in the application of the Act to BME elders. First, there are those difficulties that—despite practical implications of resourcing and so on—can, in principle, be met within the terms of the Act. Into this category fall the potential obstacles created by, so to speak, the existence of a linguistic gap between assessor and assessed. Second, however, are difficulties that the Act seems straightforwardly unable to accommodate. Let us assume that one can make an autonomous choice to hand over responsibility for decisionmaking to one’s eldest son or one’s husband and in doing so be acting with full decisionmaking capacity. It would appear that the Act quite simply neglects to recognize such autonomous acts, which effectively are intended to create a lasting power of attorney for a person *while she retains capacity*. If that is so, then in order for an autonomous decision of this sort to bear fruit, and so in order for the autonomous agent to get what she wants, she will first have to convince an assessor that she lacks capacity and thereby autonomy. Only then will others be allowed to make decisions on her behalf.

Assessment of Capacity and the DoLS

Ajit Shah returns to the topic of the Mental Capacity Act in a number of papers, including one that addresses what he calls the paradox of the assessment of capacity.¹¹ His argument for the suggested paradox takes as its point of departure the likelihood that clinicians in hospitals or care homes will, given the existence of the DoLS, adopt one of two cautious approaches when patients are admitted. The purpose of adopting these approaches will be to avoid “allegations that individuals may be deprived of their liberty without legal justification.”¹² The first approach would involve routine assessment of any patients not compulsorily detained under the Mental Health Act in order to determine whether they

possess the capacity to make decisions about staying at or leaving the setting. The second approach would involve automatic referral of anyone considered to be deprived of liberty to the relevant authorities in order to gain authorization for their being kept in the setting. This would be done regardless of whether or not they possess or fail to possess the relevant decisionmaking capacity.

Shah's worry is that either of these practices would breach the first of the Mental Capacity Act's key principles, that is, the principle requiring healthcare professionals to presume capacity on the part of their patients. His thought seems to be that if patients are routinely assessed for decisionmaking capacity, then such capacity is not being assumed, especially as the Act requires that assessments only be carried out if there is reason to suppose that capacity may be lacking. If, on the other hand, patients are automatically referred for authorization of their stay in the setting under the DoLS, again capacity is not being presumed. This is because the DoLS apply only to incapacitated patients.

The concerns expressed by Shah are challenged in an article by Peter Lucas,¹³ who suggests that the first approach—that of routine assessment of capacity—would not after all be incompatible with the Act's first principle. To suppose otherwise is to adopt the peculiar view that, before we can assess a patient's capacity, we must already know that she lacks it. That is, if we are required to presume capacity and to assess capacity is implicitly to assume its lack, then we cannot assess capacity unless we already know that it is lacking. But, of course, we could not know of a lack of capacity without first testing for it. The upshot of this would be that no one could ever legitimately be deemed to lack capacity.

Fortunately, however, at least according to Lucas, the Mental Capacity Act does not place us in this curious double bind. All that is required to license an assessment of decisionmaking capacity, according to the Act, is a rationally justified *doubt* that the person to be assessed lacks capacity. Certainly, the mere logical possibility of doubt is not enough legitimately to trigger assessment; there needs to be positive evidence underlying the doubt. Such evidence, as the Act says, may be provided by the patient's behavior or circumstances or by her having been diagnosed with some condition that affects the operation of her brain or mind.

Now, this suggests to Lucas a two-stage test for capacity. First, a reasonable doubt is raised as to whether the patient possesses decisionmaking capacity. The presence of this doubt triggers the second stage, in which capacity is fully assessed. Indeed, I think it might be more accurate not to call this a two-stage test, as the first stage does not really represent part of a test for capacity at all; instead, it fills a gatekeeping role, determining who will or will not be assessed for decisionmaking capacity.

Assuming that there is some reason for a person's being admitted to the psychiatric ward or care home, that reason is likely to be of the right sort also to provide a reasonable doubt about someone's possession of capacity:

All patients potentially falling within the scope of the DoLS will already have satisfied the first stage of the two-stage test, and will therefore legitimately be considered under stage two. And while the routine assessment of these individuals will undoubtedly involve the application of a standard different from that which we usually apply in ordinary life, it is nevertheless warranted, given that they have satisfied the first-stage test.¹⁴

I suspect that an analogy could be drawn between the picture that Lucas paints and that of a certain area of legal practice. People are only ever charged with criminal offenses (we naïvely hope, at least!) when there is some reason to doubt their innocence. Their innocence is then assessed through a legal trial; prior to and throughout that trial, their innocence is presumed. In just the same way, a reasonable doubt as to a person's decisionmaking capacity can trigger an assessment of that capacity. Nonetheless, at the time that the doubt is raised, and all through the process of her assessment, her capacity can be presumed.

This does not mean, though, that Lucas finds there to be no inconsistency at all between the Mental Capacity Act and the DoLS. In fact, he notes that each operates with a significantly different conception of capacity. These two conceptions, moreover, are mutually incompatible. That is, once a patient has been found not to possess the capacity to decide whether she ought to stay at a hospital or care home, that assessment is valid for a substantial amount of time:

A single assessment of capacity is held to be current for up to 28 days during the initial application for authorisation under the DoLS. Any subsequent authorisation, based (in part) on such an assessment, may be valid for up to a year.¹⁵

Lucas notes a considerable disparity between this picture of capacity, wherein lack of capacity is clearly thought of as capable of enduring for not inconsiderable periods, and the, as he puts it, "occasionalist" model that lies at the heart of the Act and its associated Code of Practice. He quotes from the Code as follows:

Whenever the term "person who lacks capacity" is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.

As Lucas puts it, then, judgments concerning lack of capacity, as they are understood in the Act, do not have the "temporal scope" seemingly required of the same judgments in the DoLS.

The worries expressed by both Shah and Lucas might seem to suggest that the DoLS need some refinement. It is worth mentioning, however, that Natalie Banner argues that the standards are not required at all. Between them, she thinks, the Mental Capacity Act and the existing Mental Health Act are quite capable of coping legitimately with all situations in which patients are deprived of their liberty in their best interests:

Where patients are deemed to lack capacity a decision will usually be taken in their "best interests" under the provisions of the MCA. The "best interests" assessment that occurs in the DoLS procedure is no different, so it is not clear what the additional DoLS provisions are intended to add to the clinical decision-making process over and above those contained within the MCA.¹⁶

The "Occasionalist" Model of Capacity and Unwise Decisions

As we have seen, enshrined in the Mental Capacity Act are the beliefs that (1) capacity is a thoroughly decision-context-dependent affair (that is, occasionalism,

as Lucas dubs it, is true) and (2) a person can have the capacity to make a certain type of decision on a particular occasion and yet still choose unwisely on that occasion. This latter claim ensures that a lack of capacity in a given area of decisionmaking cannot be straightforwardly inferred from an agent's making what might be deemed a poor or eccentric or irrational decision in that area. It is, as we saw earlier, an essentially antipaternalistic point.

Tim Thornton, however, points out a tension between claims 1 and 2. The claims, he insists, are not inconsistent, to be sure. They can both be true. Nonetheless, the way in which we might naturally be tempted to explain the truth of claim 2 can, he thinks, be shown to be inaccurate. And once that inaccuracy has been highlighted, we are forced to conclude there are limits "on just how atomic our decision specific capacity can be."¹⁷

Thornton's arguments are subtle, and at least some familiarity with the work of the later Wittgenstein is useful if one is fully to grasp them. It is consequently difficult to do them full justice in a handful of paragraphs. However, the bare bones of the paper can usefully be set out as follows.

If we are to hold that a person has the capacity to make a particular type of decision and yet may still, in the exercise of that capacity, choose unwisely, then a particular picture of capacity is apt to suggest itself to us. That picture "suggests a notion of capacity which is distinguished from its outputs," because if the exercise of capacity "is not a matter of correct outputs, it must instead be the correct process."¹⁸ But if we cleave to an understanding of capacity as a process that can in principle be both characterized and determined independently of the decisions it produces, then we may be tempted to hold that that process is grounded in, or realized by, a mental mechanism. And Thornton wants to hold, on Wittgensteinian grounds, that the very idea of mental mechanisms that underlie, while remaining independent of, outputs such as decisions is profoundly flawed. As Wittgenstein holds, no such mechanism is ever consciously experienced (so introspection cannot reveal the existence of mental mechanisms), nor does the idea of such a mechanism have any explanatory power. So,

[b]oth kinds of argument count against the idea of mental mechanisms and thus count against this way of distinguishing between capacity and the making of wise decisions.¹⁹

The upshot of the failure of the "mental mechanism" model of capacity is that decisionmaking capacity cannot coherently be characterized independently of the outputs to which it leads. That, however, does not leave us in the unfortunate position of being totally unable to countenance the idea of unwise decisions reached with full decisionmaking capacity. But it does rather thwart any very robust form of occasionalism:

[T]he distinction between wisdom and capacity is provided by a partial independence of output from decision making process now construed without reference to mental mechanisms. Any individual decision could be unwise. But at the general level, a capacity reflecting ability to weigh information is an ability generally to make the right decision relative to the information.²⁰

In other words, we cannot make sense of the thought that a particular decision might be unwise and yet carried out with capacity, except against a backdrop of

the agent's generally being able to reason in ways that produce wise decisions. Whether this merely "partial independence of output from decision making process" is sufficiently strong for the purposes of the Mental Capacity Act is a question which, it seems to me, is worthy of further investigation.

Notes

1. *Mental Capacity Act 2005—Summary*. London: Department for Constitutional Affairs; 2005.
2. See note 1, *Mental Capacity Act 2005—Summary*. 2005.
3. *Mental Capacity Act 2005*. London: The Stationery Office; 2005:Part 1, Section 1.
4. See note 2, *Mental Capacity Act 2005*:Part 1, Section 2.
5. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 6th ed. New York: Oxford University Press; 2009:100.
6. See note 2, *Mental Capacity Act 2005*:Part 1, Section 4.
7. However, a lucid explanation is provided in Shah A. The paradox of the assessment of capacity under the Mental Capacity Act 2005. *Philosophy, Psychiatry, Psychology* (forthcoming).
8. Shah A, Heginbotham C. The Mental Capacity Act: Some implications for black and minority ethnic elders. *Age and Ageing* 2008;37:242.
9. See note 8, Shah, Heginbotham 2008:242.
10. See note 8, Shah, Heginbotham 2008:243.
11. See note 7, Shah (forthcoming).
12. See note 7, Shah (forthcoming).
13. Lucas P. Decision-making capacity and the deprivation of liberty safeguards. *Philosophy, Psychiatry, Psychology* (forthcoming).
14. See note 13, Lucas (forthcoming).
15. See note 13, Lucas (forthcoming).
16. Banner N. The "Bournewood Gap" and the deprivation of liberty safeguards in the Mental Capacity Act (2005). *Philosophy, Psychiatry, Psychology* (forthcoming).
17. Thornton T. Capacity, mental mechanisms and unwise decisions. *Philosophy, Psychiatry, Psychology* (forthcoming).
18. See note 17, Thornton (forthcoming).
19. See note 17, Thornton (forthcoming).
20. See note 17, Thornton (forthcoming).