

## The Coherence of the Principle of Patient Autonomy in the English Medical Law: A Re-evaluation

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### ABSTRACT

*By comparing and contrasting four specific areas within English medical law – informed consent, mental capacity of adults, mental capacity of children, and mental health – this essay observes a fundamental shift from medical paternalism towards patient autonomy in the UK. The general position is that a competent adult with capacity has an almost absolute right to informedly consent to or refuse medical treatment, while those not qualifying as such are assisted so far as practicable in enabling them to make choices concerning their medical treatment in the most autonomous way possible. However, this commitment to patient autonomy lacks coherence. This essay identifies three main reasons for this. Firstly, a degree of unjustified paternalism remains even with regard to competent adults – especially in the case of mentally ill patients. Secondly, by viewing autonomy in predominantly individualistic terms, the law disregards how patients' interdependences and relationships may be constitutive – not destructive – of their autonomy. Thus, it unfairly subjects those incapable of an individualised sense of independence to the 'best interests' test. Thirdly, the 'best interests' test is ill-equipped to uphold such patients' autonomy. This essay argues that re-envisioning autonomy in relational terms is a vital starting point to address the current incoherencies.*

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## INTRODUCTION

The rise of bioethics, challenging the ‘doctor knows best’ foundations of conventional medical ethics, is reflective of a fundamental shift in medical law from medical paternalism towards patient autonomy.<sup>1</sup> For the purpose of clarity, this essay defines autonomy as the ability of the patient to exercise self-determination with regards to their treatment, comprising three aspects: (1) agency: setting their own goals in life; (2) independence: acting free from the coercive influence of others; and (3) rationality: reasoning in accordance to one’s own values and desires.<sup>2</sup> Comparing and contrasting four areas within English medical law – informed consent, mental capacity of adults, mental capacity of children, and mental health – this essay identifies a clear rise in recognition of patient autonomy. Informed consent law relates to the ability of a competent patient to make autonomous decisions regarding their own treatments. In contrast, mental capacity law of adults and children sets a threshold to determine the level of competency and understanding patients need to display before being allowed to make such decisions. Mental health law deals with similar issues but does so specifically with mentally ill patients in mind. A comparative analysis of these four areas in the English medical law shows that the general position is that a competent adult with capacity has an almost absolute right to informedly consent to or refuse medical treatment. Those that do not qualify as such – whom we will refer to as ‘the vulnerable’ – are assisted so far as practicable in enabling them to make choices concerning their medical treatment in the most autonomous way possible.

Unfortunately, a close analysis demonstrates that this shift towards patient autonomy lacks coherence. Firstly, even with regard to competent adults, a degree of unjustified paternalism remains – blatantly so in the case of the mentally ill. Secondly, protection of patient autonomy is envisaged predominantly in individualistic terms. This disregards the ways in which patients’ interdependences and relationships may be constitutive, *not* destructive, of their independence, and

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<sup>1</sup> Helga Kuhse and Peter Singer, *A Companion to Bioethics* (first published 1998, Blackwell 2013).

<sup>2</sup> Genevra Richardson, ‘Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions’ [2002] MLR 65, 5.

thereby their autonomy.<sup>3</sup> By generally not viewing autonomy relationally, the law seems to categorise patients artificially as ‘the autonomous’ and the ‘vulnerable’, thereby subjecting those incapable of an individualised sense of independence, i.e. the latter, to the ‘best interests’ test.<sup>4</sup> Thirdly, this matters because the autonomy of ‘the vulnerable’ under this test, while now assuming greater recognition, is not adequately protected.

## I. THE ADULT WITH CAPACITY: AN ABSOLUTE RIGHT TO MAKE DECISIONS ABOUT THEIR TREATMENTS?

The patients’ right to make decisions about their treatments is essentially a negative right, involving the right to give informed consent or competent objection to treatment. Both informed consent and mental capacity law reflect the dominance of patient autonomy by recognising that such decisions are no longer automatically determined by medical opinion, but are rather made by *individual* patients exercising a choice based on their own values and preferences

The landmark case on informed consent, *Montgomery v Lanarkshire*,<sup>5</sup> demonstrates this. It establishes that healthcare professionals owe a duty of care to disclose to patients “material” information about their treatment, where the test for materiality is “whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particularly patient would be likely to attach significance to it.”<sup>6</sup> This significantly departs from the precedent of *Bolam v Friern Hospital Management Committee*,<sup>7</sup> which held that healthcare professionals’ duty of disclosure would be discharged if they acted in a way “accepted as proper by a responsible body of skilled medical men.” Bolam’s position is a blatant manifestation of paternalism, where the starting

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<sup>3</sup> Roy Gilbar, ‘Family Involvement, Independence, and Patient Autonomy in Patient,’ [2011] MLR 19, 2.

<sup>4</sup> Jonathan Herring, ‘Forging a relational approach: Best interests or human rights?’ [2013] MLI 13, 1.

<sup>5</sup> [2015] UKSC 11.

<sup>6</sup> *ibid* at [11].

<sup>7</sup> [1957] 1 WLR 583.

point is what the reasonable *doctor* considers relevant to disclose to the patient.<sup>8</sup> Even the subsequent jurisprudence re-focusing on the patient such as in *Pearce and Pearce v United Bristol Healthcare NHS Trust*,<sup>9</sup> where Lord Woolf held that the risk significant to a *reasonable patient* should be disclosed, is inadequate in terms of protecting patients' autonomy.<sup>10</sup> It assumes that patients are objectively reasonable, while in fact they may not be;<sup>11</sup> what they regard as a 'significant risk' varies with their own values and life goals. The importance of *Montgomery*<sup>12</sup> lies in recognising, and challenging this, refocusing on what the *specific* patient would regard as material. This aligns the law closely with the ethical guideline in General Medical Practice (GMC), which suggests that doctors should "work in partnership" with the individual patient to "maximise patients' opportunities...to make decisions for themselves."<sup>13</sup> Indeed, only with the knowledge of risks material to them can patients make fully autonomous decisions.

The overarching principle in *Montgomery*,<sup>14</sup> that while healthcare professionals may advise patients on medical matters, the latter retain the ultimate choice to accept or refuse treatment based on their own priorities, is similarly reflected in mental capacity law. It requires that an adult patient should, by default, be able to determine their own treatment due to the presumption of capacity in s 1(2) Mental Capacity Act 2005 ("MCA").<sup>15</sup> This presumption can only be rebutted with the satisfaction of a diagnostic threshold of "impairment of, or a disturbance in the functioning of, the brain" in s 2(1) *and* the refutation of the patient's cognitive capabilities in s 3(1). The latter establishes a low threshold, such as the ability to understand the relevant information in s 3(1)(a), interpreted generously as requiring only a general understanding of the risks and benefits of the treatment in *Heart of England NHS Foundation Trust v JB*.<sup>16</sup> This ensures that patients are not easily denied the autonomy to determine their treatment just because they cannot

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<sup>8</sup> Robert Heywood and Jose Miola, 'The changing face of pre-operative medical disclosure: placing the patient at the heart of the matter' [2017] LQR 133.

<sup>9</sup> [1996] EWCA Civ 878

<sup>10</sup> Emily Jackson, *Medical law* (4th edn, Oxford University Press 2016)

<sup>11</sup> Emma Cave, 'The ill-informed: Consent to medical treatment and therapeutic exception' [2017] CLR 26.

<sup>12</sup> *Montgomery* (n 5) 88.

<sup>13</sup> Heywood (n 8).

<sup>14</sup> *Montgomery* (n 5) 88.

<sup>15</sup> Mental Capacity Act 2005, s 1(2).

<sup>16</sup> [2014] EWHC 342.

or do not understand everything about their condition/treatment. Thus, competent patients are allowed to make decisions contrary to their best interests (*Airdale NHS Trust v Bland*<sup>17</sup>), in contrast to the position of incapacitated adults and children, as explained below. This is enshrined in legislation in s 1(4), which allows patients to make “unwise” decisions, and is depicted in *Kings College NHS Foundation v C*,<sup>18</sup> where the competent individual was allowed to reject life-saving treatment as she thought her life, characterised by alcohol, men and glamour had lost its “sparkle”.<sup>19</sup> As MacDonald J. stated, while the decision may be regarded as “unreasonable, illogical or even immoral”,<sup>20</sup> it is a manifestation of her autonomy *per* her own priorities. As in *Montgomery*,<sup>21</sup> this protects autonomy not in the thin sense of *self-determination* - patients simply doing what they want - but in a thicker sense as *rational self-determination*,<sup>22</sup> thus allowing patients’ *agency* to determine their own values, and to *rationalise* accordingly. This is welcome: deontologically, it allows patients choices regarding their own bodies; consequentially, it lends them greater control, and thereby responsibility, regarding their own treatments.

### Paternalism: Disappearing and Reappearing

Nevertheless, while both informed consent law and mental capacity law operate parallel to each other to foster patient autonomy, the introduction of a ‘therapeutic exception’ (“TE”) in *Montgomery*<sup>23</sup> inserts a level of paternalism akin to that in *Bolam* which stands at odds with the patient-empowering ethos of the MCA. The TE entitles a “doctor...to withhold information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient’s health.”<sup>24</sup> On the face of it, TE can be easily justified. As Deavey and Holm argue, extensive medical expertise and knowledge of healthcare professionals means that it is important to allow them to withdraw information

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<sup>17</sup> [1993] AC 789.

<sup>18</sup> [2015] EWCOP 59.

<sup>19</sup> *ibid*.

<sup>20</sup> *ibid* at [97].

<sup>21</sup> *Montgomery* (n 5) 88

<sup>22</sup> Alasdair Maclean, ‘Autonomy, Informed Consent, and Medical Law: A Relational Challenge’ (2009) Cambridge Law, Medicine and Ethics.

<sup>23</sup> *Montgomery* (n 5) 88.

<sup>24</sup> *Montgomery* (n 5) 88.

from patients in exceptional cases where it would be necessary to do so.<sup>25</sup> Indeed, the Court was insistent that this was only a “limited exception” that did not intend to “subvert that principle [of disclosure].”<sup>26</sup> This is reflected in the terminology change from “therapeutic *privilege*” to “therapeutic *exception*”.<sup>27</sup> Thus, initially, TE, with its emphasised exceptionality, seems to strike a desirable balance between protecting patient autonomy in general and maintaining a degree of deference to the expertise and knowledge pertaining to the medical judgment.<sup>28</sup>

Despite this, the lack of exploration of its scope potentially allows a pathway for paternalism to creep in through the backdoor. As Cave argues, this generates a dangerous possibility that TE might be utilised to prevent patients making ‘irrational’ decisions which would put them in serious harm.<sup>29</sup> If so, this sits incoherently with the MCA whose benchmark for autonomous decisions is not irrationality, but rather capacity.<sup>30</sup> Of course, the actual dissonance between TE and the MCA is contingent on the practical implementation of the MCA’s autonomy-enhancing ethos. The MCA might be similarly incapable of supporting competent patients’ ‘unwise’ decisions if measures are not taken to alter the findings of the House of Lord Select Committee in 2014 to the effect that that the dominance of patient autonomy in the MCA, through features such as the assumption of capacity, is not well-understood or implemented *in practice* by healthcare professionals. As the vast majority of capacity decisions taken by these professionals and are rarely disputed in court,<sup>31</sup> this seriously compromises patient autonomy. We could contend that abolishing TE and raising awareness concerning the MCA is necessary to address these incoherencies.

### **The limitations of an individualistic focus**

In both informed consent and mental capacity law, the protection of autonomy is understood predominantly in individualistic terms. In informed

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<sup>25</sup> Sarah Devaney and Soren Holm ‘The Transmutation of Deference in Medicine: An Ethico-Legal Perspective’ (2018) *Medical Law Review* 26, 2.

<sup>26</sup> *ibid* 91.

<sup>27</sup> Cave (n 11).

<sup>28</sup> Devaney and Holm (n 25).

<sup>29</sup> Cave (n 11).

<sup>30</sup> *ibid*.

<sup>31</sup> Jackson (n 10).

consent law in *Montgomery*,<sup>32</sup> the focus is solely on the doctor-patient relationship, assuming that patients make decisions on the basis of 'material' information alone and independently of others. Hostility towards relatives/friends influencing patients' decisions is depicted in *Re T (Adult: refusal of medical treatment)*<sup>33</sup> where the refusal of the patient in question to accept a blood transfusion was held to be a decision not autonomously arrived at but influenced by her mother.<sup>34</sup> Surely, where there is a coercive force of others amounting to undue influence which mitigates consent, this *cannot* enhance (relational) autonomy.<sup>35</sup> Nevertheless, it is of paramount importance to distinguish between relationships that are coercive and relationships that are merely influencing. The latter should not be rejected automatically: as many patients explain, their interdependencies are vital components of their own personhood and identity, and thus, are often not destructive but constitutive of their autonomy.<sup>36</sup> This, however, seems not to be reflected in the current law. For example, Gilbar suggests that *Re T* depicts an individualistic bias.<sup>37</sup> As she suggests, the Court's judgement did not adequately deal with the possibility that the patient agreed with her mother's view because the patient's relationship with her mother is a crucial part of her own identity.<sup>38</sup> Indeed, it might be that a relational (though of course, qualified) view of autonomy could have led to a different conclusion. Given this possibility, *Re T* represents an example of how the court's (overly-)individualistic interpretation of autonomy might sometimes lead to a denial of autonomous choice to the patient.

The individualistic approach towards autonomy is also still predominant in capacity law. By allowing an almost unlimited legal right to individuals to refuse life-saving treatment in cases like *Kings College*, law ignores the impact patients' decisions can have on people surrounding them - to whom they have *moral* obligations.<sup>39</sup> The gap between patients' legal rights and moral obligations might mean that while law protects *rational* self-determination, it does not ensure *moral*

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<sup>32</sup> *Montgomery* (n 5).

<sup>33</sup> *Re T (Adult: refusal of medical treatment)* [1992] 4 All ER 649.

<sup>34</sup> Gilbar (n 3).

<sup>35</sup> Herring (n 4).

<sup>36</sup> Gilbar (n 3).

<sup>37</sup> *ibid.*

<sup>38</sup> *ibid.*

<sup>39</sup> Maclean (n 22).

rational self-determination.<sup>40</sup> While moral obligations may initially be viewed as detrimental to the individual patient's autonomy, in a Kantian framework, one's autonomy can only be realised through moral actions.<sup>41</sup> The latter perspective envisages autonomy in relational terms, as one which can only be attained in the context of our relationships with others. Yet, the current law's individualistic focus wholly disregards patients' moral responsibilities towards others, fostering a selfishly limited conception of autonomy.

Therefore, the individualistic protection of autonomy is limited in two ways: firstly, it can deny patients the right to make influenced but still autonomous choices, and secondly, it neglects patients' moral obligations towards others. Moreover, it is also problematic because it leads to an unjust distinction between those considered capable of being 'autonomous' and the others - 'the vulnerable'.

## **II. INCAPACITATED ADULTS AND NON-ADULTS, *LES MISERABLES*: (MIS)DRAWING THE BOUNDARIES**

In contrast to competent adults deemed worthy of the right to autonomy stand others, children, incapacitated adults and mentally ill patients (*Les Miserables*) are allowed only a restricted level of autonomy.<sup>42</sup> Indeed, if such groups are unable to fulfil the three-fold requirements of autonomy, giving them the right to determine their treatment will not uphold their autonomy, and can even be harmful. Yet, there are two reasons why the invisible line drawn between 'the autonomous' and 'the vulnerable' can be unfair.

Firstly, the law's aforementioned reliance on an unrealistic image of an independent, rational and free patient categorises others engaged in interdependent relationships, such as children, incapable of autonomous decisions. This is problematic, because the autonomy of such groups is protected to a far lesser extent, even if they may be just as capable of autonomous decisions as those deemed competent under the s 3(1) of the MCA. The legal distinction child capacity law draws between children's right to consent to or reject treatment demonstrates this. On one hand, *Gillick v West Norfolk*<sup>43</sup> aligns child capacity law

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<sup>40</sup> *ibid.*

<sup>41</sup> *ibid.*

<sup>42</sup> Herring (n 4).

<sup>43</sup> [1986] AC 112.



closely with adult capacity law, holding that a mature minor having reached a sufficient understanding has a right to *consent* to treatment, even if parents oppose treatment. This criterion separates *Gillick*-competent children from other young minors. Lord Scarman's judgement is particularly radical, suggesting that parents' right to consent to any treatment is *extinguished* when a child reaches a sufficient level of maturity and understanding.<sup>44</sup> Such an approach resonates with the functional approach of Mental Capacity Law, where protection of autonomy is contingent on patients having established a certain level of understanding. Nevertheless, a degree of incoherency exists, as the recognition of the right to consent to treatment is not matched by a right to refuse treatment. Judges display particular reluctance in finding children who refuse treatment to be *Gillick*-competent, such as in *Re E (A minor)*.<sup>45</sup> In that case, Ward J. found that to be *Gillick*-competent, a 15-year-old child refusing a blood transfer needed to understand the manner of his ensuing death and the extent of his family's consequent suffering. As Jackson suggests, this is an "excessively demanding test";<sup>46</sup> even "most adults do not fully understand what it is like to die".<sup>47</sup> Such a stringent approach is also at odds with the much lower threshold for (adult) capacity in s 3(1) of MCA (above). The rhetoric of *Gillick* is further rebuffed in *Re R (A Minor)*<sup>48</sup> which holds that the refusal of the *Gillick*-competent mature minor of treatment can be trumped by the consent of the parent or the court. This substantially compromises the *Gillick* right to autonomy on the part of children.

Arguably, this reluctance to allow children to refuse life-saving treatment is partly justified on the grounds of 'transitional paternalism'.<sup>49</sup> Adults have obligations towards young people to ensure that they become self-governing in the future. Indeed, overriding children's *present* autonomy to make decisions which could harm themselves can be seen as protecting their *future* autonomy to reconsider such decisions at a more mature level. This partially explains the inconsistency between adult and children capacity law. However, there remains a group of children who are of sufficient capacity to make their own decisions. The

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<sup>44</sup> *ibid.*

<sup>45</sup> [1993] 1 FLR 386.

<sup>46</sup> Jackson (n 10).

<sup>47</sup> *ibid.*

<sup>48</sup> [1992] Fam 11 CA.

<sup>49</sup> Faye Tucker, 'Developing Autonomy and Transitional Paternalism' (2016) *Bioethics* 30, 9.

consistency of the boy's decision in *Re E*, demonstrated by his refusal of treatment at the age of 18 and his consequent death,<sup>50</sup> perhaps exemplifies this. Yet, the binary approach drawn between consenting and rejecting treatment based not on the child's capacity in functional terms but rather their *status* as a child leads to an almost *automatic* denial of autonomy with regards to the latter. This is at odds with s 2(3) MCA which states that lack of capacity cannot be established based on a person's age alone. Thus, unlike Montgomery's emphasis on patient autonomy for competent adults, the (limited) autonomy granted to children appears not an end in itself, but merely instrumental in allowing doctors to treat children without incurring liability. This inconsistency occurs because law expects patients to be independent and free in order to uphold their autonomy, automatically classifying those who cannot fit this idealised image as vulnerable and unable to decide for themselves.

Secondly, the law employs a medicalised understanding of disability used to identify 'the vulnerable' which is overly restrictive.<sup>51</sup> This means that the law over-relies on medical information when determining what constitutes disability. This is evident in both the MCA and the Mental Health Act 1963 ("MHA").<sup>52</sup> The diagnostic threshold, "impairment of, or a disturbance in the functioning of, the main or brain" outlined in s 2(1) MCA 2005 and an almost identical provision in s 1(2) MHA, provides the basis for interfering with patient autonomy, to force treatment, or even detain individuals against their will. The diagnostic focus ignores the impact of the wider context relationally affecting their capacity for autonomy, and overlooks the extent to which these groups' disabilities may be socially constructed.<sup>53</sup> For example, the repeated findings of incapacity in anorexia cases, such as *Re E*,<sup>54</sup> *Re L*,<sup>55</sup> and *NHS Foundation Trust v Ms X*,<sup>56</sup> on the basis that the obsessive fear of gaining weight deprives those concerned of the competence to weigh up their choices and to make a competent decision as required by s 3(1)(c) displays a continuing insensitivity towards the broader social and political

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<sup>50</sup> Jackson (n 10).

<sup>51</sup> Beverley Clough, "People Like That": Realising the Social Model in Mental Capacity Jurisprudence' (2016) *Medical Law Review* 24, 3.

<sup>52</sup> Section 1(2) Mental Health Act (MHA) 1983.

<sup>53</sup> *ibid*.

<sup>54</sup> *Re E (Medical treatment: Anorexia)* [2012] EWCOP 1639.

<sup>55</sup> *The NHS Trust v L* [2012] EWHC 2741 (COP).

<sup>56</sup> [2014] EWCOP 35.

context surrounding anorexia.<sup>57</sup> This is exemplified in *Ms X*,<sup>58</sup> where Ms X was held to lack the capacity to make decisions regarding her anorexia, but not her alcoholism. The court distinguished her alcoholism from anorexia, holding that with the former she made an active *choice* to drink alcohol. Nevertheless, such a choice may not be freer than one exercised in relation to anorexia: in both cases, the act – the decision to drink or the decision not to eat – is not wholly unwilling in the sense of absence of control over it, but compelled, in that she has severe difficulties in controlling it.<sup>59</sup> Thus, the Court’s conclusion perhaps reflects societal attitudes towards the two conditions: while anorexia is considered an illness and consequently not the sufferer’s fault, alcoholism is regarded as morally repulsive and blameworthy. Again, this ignores the wider social context in which alcoholism occurs.<sup>60</sup> In fact, medicalisation of disabilities can be used to shift the focus away from the state’s obligations under the UNCRPD Article 12(2) to ensure that disabled people “enjoy legal capacity on equal basis with others in all aspects of life,”<sup>61</sup> despite the UK being a signatory to it. It overlooks the extent to which these groups’ disabilities may be socially constructed. Thus, categorisations (‘the vulnerable’ and ‘the autonomous’), predominantly informed by an individualistic and ‘medicalised’ understanding of autonomy, are not always reflective of one’s ability to exercise autonomy.

Consequently, it is predominantly the individualistic approach towards autonomy which leads to potential mis-categorisations, overlooking the way in which patients’ autonomy can be fostered or restricted by their relationships and their context. The extent to which these categorisations matter depends on the extent to which ‘vulnerable’ patients’ autonomy is fostered within the best interests test.

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<sup>57</sup> Beverley Clough, ‘Anorexia, Capacity, and Best Interests: Developments in the Court of Protection Since the Mental Capacity Act 2005’ 2 (2016) *Bioethics* 30, 9.

<sup>58</sup> *Ms X* (n 56).

<sup>59</sup> Jillian Craigie and Ailsa Davies, ‘Problems of control: Alcohol dependence, anorexia nervosa, and the flexible interpretation of mental incapacity tests’ (2018) *Medical Law Review*.

<sup>60</sup> *ibid*.

<sup>61</sup> United Nations Convention on the Rights of Persons with Disabilities (“UNCRPD” or “CRPD”).

### III. CHILDREN AND INCAPACITATED ADULTS – ACCOMMODATING AUTONOMY WITHIN THE BEST INTERESTS PARADIGM?

While children and incapacitated adults are subjected to the best interests test, this does not mean an outright rejection of their autonomy – rather, the need to respect their autonomy is an integral part of the test. Under s1(a) of the Children Act (“CA”) 1989, children’s welfare has to be the court’s paramount consideration in any medical decision. Under both the welfare checklist in s1(3) and the Code of Practice (“CoP”), any assessment for the children’s best interests must include their views and wishes. Similarly, incapacitated adults are governed by the best interests test under s 1(5) MCA, which, as elaborated in s.4, require respect for patient autonomy, obligating the court to consider factors such as the patients’ beliefs and values (s 4(6)(b)) along with other factors important to them (s 4(6)(c)). The analogy between the legal rights of children and incapacitated adults is outlined by Munby J. in *Re X (A Child)*<sup>62</sup> that, while such people may lack the ability to exercise autonomy, judges should strive to attach “very considerable weight...[to] clear wishes and feelings.” Within adult capacity law, this is reflected in case law. A salient example is *Aintree University Hospitals NHS Foundation Trust v James*,<sup>63</sup> where Lady Hale claimed that “the purpose of the best interests test is to consider matters from the patient’s point of view” in order to allow them to make “the choice which is right to him as an individual human being.”<sup>64</sup> A similar trend in favour of upholding patient autonomy is evident in child capacity law as exemplified in *Gillick*. Thus, in both adult and child capacity law, respect for patient autonomy is one of the many factors judges should consider, and the case-law depicts an increasing level of importance attached to it.

Furthermore, both the law regarding children and incapacitated adults can potentially accommodate a relational analysis, which can offer a more realistic protection of autonomy. In *An NHS Trust v DE* (2013),<sup>65</sup> for example, the court held that undergoing vasectomy was in the incapacitated (adult) patient’s best interests: in addition to enabling him to have a long-term relationship with his girlfriend without having children (as he wanted), King J. also contended that the

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<sup>62</sup> [2014] EWHC 1871.

<sup>63</sup> [2013] UKSC 67.

<sup>64</sup> *ibid.*

<sup>65</sup> [2013] EWHC 2562.

treatment would greatly please his parents, thus conferring upon him the benefit of seeing them happy. This views welfare not only on individualistic terms, but as something which may be achieved in consideration of those surrounding us,<sup>66</sup> although importantly, his parents' happiness is taken into account only because this would make *him* happy. Still, the decision may uphold the patient's autonomy in the Kantian sense, taking into account the will of the patient in a way that does not disregard his moral duties towards others. Such an approach can reconcile the relational protection of autonomy with an individualistic protection. The ability to accommodate a relational view is similarly evident in children capacity law. Under s 1(3) CA, the welfare of the child is determined by factors including the capacity of his parents "for meeting his needs" (s 1(3)(f)), his "background or any characteristics of which the court considers relevant" (s 1(3)(d)) and the child's "emotional...needs". While these factors are relevant only to the extent that they affect the *child's* welfare, which is the court's sole consideration (*per* Lord Dermontt, *J v C*),<sup>67</sup> they demonstrate an acknowledgement of the importance of the child's relationships. For instance, in *Re T (A Minor) (Wardship: Medical Treatment)*,<sup>68</sup> while there was a unanimous agreement of the medical opinion that the child should receive life-saving treatment, the court refused to authorise it. This was because authorising the treatment in the face of his mother's opposition would adversely affect her, and thereby undermine his welfare which depended on his mother. Arguably, this relational approach towards *welfare* risks undermining the child's individual *autonomy*, as identifying the child's interests with his mother's as "one" in this "unusual case"<sup>69</sup> (*per* Butler-Sloss LJ) arguably hides the child's independent interests.<sup>70</sup> This difficulty with the relational approach, however, can be eliminated, by limiting relational approach to caring relationships, excluding abusive relationships (above). Still, a confusion remains. As both *DE* and *Re T* demonstrate, the protection of autonomy is conducted covertly within the umbrella of the 'best-interests' test, making it difficult to identify the actual weight attached to the child's autonomy. This undermines clarity in law because the protection welfare does not always intersect with the protection of autonomy. Children as well as adult capacity law should more explicitly protect relational

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<sup>66</sup> Herring (n 4).

<sup>67</sup> [1970] AC 668.

<sup>68</sup> [2017] 1 FLR 502.

<sup>69</sup> *ibid*.

<sup>70</sup> Jonathan Herring, *Family Law*, (8<sup>th</sup> edn, Pearson Education Limited 2017).

autonomy (in the qualified sense), as lack of clarity might often lead to obscuring it with (paternalistic) welfare considerations.<sup>71</sup>

#### IV. A STARK CONTRAST: MENTALLY ILL PATIENTS

While the autonomy of children and incapacitated adults is assuming importance within the welfare paradigm, the issue of patient autonomy is sorely neglected with regard to mentally ill patients.

Theoretically, this should not be so. The ordinary rules of consent (see above) apply to mentally ill patients with capacity. Therefore, where mentally ill patients are detained informally – the most common method of detention – their autonomy seems to be respected in two ways. Firstly, a patient can *choose* to be detained voluntarily. The Code of Practice for MHA states that consent should be based on sufficient knowledge of the purpose, nature and likely effects of treatments, paralleling a patient-focused autonomy model similar to that in *Montgomery*. Secondly, they are free to leave, which displays continuous, not just one-off, respect for patients' autonomy. Yet, this is not always the case when it comes to practice. Many patients consent to detention without being provided with adequate information on its implications, and only do so because they fear being otherwise detained under the stigmatic MHA.<sup>72</sup> This means that consent may be uninformed and actually not fully voluntarily. This stands in contrast to the emphasis on *informed* consent in *Montgomery*, which obligates providing patients not just all the “material” information, but also doing so in an emphatic manner which makes it comprehensible to the patient (*Lybert v Warrington Health Authority*).<sup>73</sup> The right to informed consent can therefore be seen as compromised in the case of the mentally ill. Furthermore, informally admitted patients may effectively be prevented from leaving a given facility. This is exposed in *R(L) v Bournewood Community and Mental Health NHS Trust*,<sup>74</sup> where the informally admitted patient was denied access to his carers due to a sense that such contact could lead him to want to leave. As the European Court of Human Rights

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<sup>71</sup> *ibid.*

<sup>72</sup> Benjamin Ian Perry, Swaran Preet Singh, David Hedley White, ‘Capacity Assessment and Information Provision for Voluntary Psychiatric Patients: a service evaluation in a UK NHS Trust’ (2016) *International Journal of Mental Health and Capacity Law* 22.

<sup>73</sup> [1995] 25 BMLR 91.

<sup>74</sup> [1999] 1 AC 458.

(“ECtHR”) held, contrary to the House of Lord’s (“HL”) judgement, this constitutes a deprivation of liberty, even if the patient is compliant and not actively attempting to leave, amounting to a violation of Art 5 in the absence of procedural safeguards stated in Art 5(4). The introduction of the Deprivation of Liberty Safeguards (“DoLS”) in response to this EctHR decision, however, still does not protect patient autonomy in a substantive sense. DoLS only introduces certain *procedural* safeguards when restricting patient autonomy.<sup>75</sup> It fails to promote the substantive protections for disability rights in the CRPD, which, in its guideline on Article 14, explicitly prohibits detention of people based on their disabilities.<sup>76</sup> The mismatch between law and practice, akin to that currently the case with the MCA, has adverse implications on the protection of autonomy.

With regards to formal detention and forced treatment under the MHA, there is an explicit conflict with the MCA. While the former respects the autonomy of adults with capacity, the MHA disregards this threshold, rendering it lawful to forcibly detain and treat competent adults. Under s 2, the patient can be detained to enable assessment for up to 28 days “if he is suffering from mental disorder of a nature or degree which warrants the detention of patient” and “he ought to be so detained in the interests of his own health or safety *or*...protection of other persons.” Such wording is problematic when discussing patient autonomy. Firstly, “nature *or* choice” runs contrary to the “least restrictive alternative” principle both in the MHA 1983 Code of Practice and s 1(6) and the MCA, because it may authorise the detention of a patient suffering from an illness the “nature” of which but not the “degree” of which necessitates detention<sup>77</sup>. This highlights not only an internal incoherency within Mental Health Law, but also in relation to Mental Capacity Law. Furthermore, the MHA authorises the detention of individuals not solely for their interests, but also to “protect” other people. In Millian terms, autonomy can be infringed justifiably in order to prevent harm to others.<sup>78</sup> Nevertheless, the notion that mentally ill people harm others rests on the erroneous assumption that mental illness diagnosis is an accurate reflector of

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<sup>75</sup> Jennifer Brown ‘The Changing Purpose of Mental Health Law: From Medicalism to Legalism to New Legalism’ (2016) *International Journal of Law and Psychiatry* 47.

<sup>76</sup> *ibid*.

<sup>77</sup> Jackson (n 10).

<sup>78</sup> Maclean (n 22).

violent behaviour.<sup>79</sup> As it is not always so,<sup>80</sup> the detention of mentally ill people on this basis is unjustified and discriminatory. Denying them the right to autonomy this way infringes Article 14 of the CRPD. Section 3, which authorises non-consensual admission for treatment for up to 6 months, displays the same two defects in a magnified form, given the length of the time during which patient's autonomy will be disregarded. It also allows forced treatment as long as "appropriate medical treatment is available for him." This replaces the previous treatability test, a change introduced in 2007 in order to facilitate the detention of the mentally ill people whose personality disorders may not be 'treatable'. As these sections are designed to facilitate the detention of (objecting) mentally ill patients, they run directly against the whole concept of patient autonomy.

A major exception to patient autonomy is s 63, which states that "the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering". This is "unusually inconsistent and discriminatory in the way it deals with questions of competence and patient autonomy with regards to mental disorder".<sup>81</sup> While this authorisation is limited to treatment regarding "mental disorder," it has been widely interpreted. An example of this is the force-feeding of anorexic patients in *Re KB (Adult) (Mental Patient: Medical Treatment)*.<sup>82</sup> The authorisation of force-feeding against the patient's wishes is not only medically counter-productive, but also severely destructive of the patient's will and autonomy.<sup>83</sup> Following the introduction of the Human Rights Act (HRA), courts have displayed greater reluctance to force treatment on someone with capacity, such as in *R (Wilkinson) v Broadmoor Special Hospital Authority and others*.<sup>84</sup> Nevertheless, the ECHR is not well-equipped to provide meaningful protection for patient autonomy. In addition to its limited procedural focus (above), it also displays significant deference to clinical judgement. In *Herzeggahy v Austria*,<sup>85</sup> the ECtHR held that treatments considered a "therapeutic necessity" cannot amount to inhuman/degrading treatment violating Article 3 of the ECHR. Similar to the problematic TE in *Montgomery*, this

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<sup>79</sup> Jackson (n 10).

<sup>80</sup> *ibid*.

<sup>81</sup> Richardson (n 2).

<sup>82</sup> [1994] 19 BMLR 144.

<sup>83</sup> Penney Lewis, 'Feeding Anorexic Patients Who Refuse Food' (1999) Medical Law Review 7.

<sup>84</sup> [2002] 1 WLR 419.

<sup>85</sup> ECHR 24 Sep 1992.



allows room for clinical paternalism to override patient autonomy. Many psychotropic treatments forced on individuals have side-effects such as obesity and the lessening of mobility, but mentally ill patients are not permitted to reject treatment by calculating its advantages and risks of their own volition.<sup>86</sup> We can contend that mentally ill patients' autonomy is very widely disregarded both in law and in practice, which is in stark contrast to informed consent and mental capacity law.

## CONCLUSION

The above discussions adumbrate an overall trend in favour of protecting patient autonomy, even with regard to groups considered 'vulnerable.' Nevertheless, such a pattern is hampered by the following incoherencies:

1. TE introduces the possibility of paternalistic qualifications within the context of an otherwise absolute right for competent adults to determine their treatment, in contrast to the approach in *Montgomery* and the patient-oriented ethos of the MCA.
2. There seems to be an implicit distinction between 'autonomous' and 'vulnerable' patients. The latter are excluded from the right to autonomy granted to competent adults.<sup>87</sup> This is problematic because such a distinction between the 'vulnerable' and the 'autonomous' depends on an unrealistic, individualistic and medicalised approach towards autonomy, resulting in unjustified binary distinctions.
3. The legal treatment of children and incapacitated adults is better able to accommodate a relational protection of autonomy which may be more meaningful and realistic in terms of patient autonomy. Nevertheless, this is not done explicit enough, and often obscured within a broad welfare paradigm.

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<sup>86</sup> Tony Zigmond, 'Pressures to adhere to treatment: Observations on 'leverage' in English mental healthcare' (2011) *British Journal of Psychiatry* 199, 2.

<sup>87</sup> Herring (n 4).

4. The mental health law presents us with a blatant exception to the primacy of patient autonomy. The authorisation of forceful detention and treatment of competent adults is clearly incompatible with the guiding principles of the MCA and informed consent law.

Consequently, the protection of autonomy has not been wholly coherent. By acknowledging that patients' autonomy is defined, fostered or limited by their relationships and context, the undesirable distinction drawn between 'the autonomous' and 'the vulnerable' can be effaced. This can perhaps be the starting point from which to address the current incoherencies.