

In whose best interests? Childbirth choices and other health decisions*

Introduction

When it came into force in 2007, the Mental Capacity Act 2005 (MCA) was applauded by some for, amongst other things, placing the common law tests for capacity and for best interests into statute, as well as clarifying the status of advance decisions.¹ Since then, however, there has been disquiet about its use in practice, and in 2013 a House of Lords Select Committee considered whether the Act was working as Parliament intended and found that its implementation left much to be desired.² The Committee noted that (i) capacity was not always assumed as required (section 1(2)), (ii) capacity assessments were not always carried out, (iii) supported decision-making was ‘not well embedded’ (section 4(4)), (iv) best interests decision-making was ‘often not undertaken in the way set out in the Act: the wishes, thoughts and feelings of P are not routinely prioritised. Instead, clinical judgments or resource-led decision-making predominate’ (section 4(6)), and (v) the least restrictive option was ‘not routinely or adequately considered’ (section 1(5)).³ Similar concerns were raised in the Law Commission’s

* Thanks go to Rob Heywood, José Miola, Alexandra Mullock, John Murphy, and Suzanne Ost for comments on earlier drafts, and to colleagues at the Universities of Bristol, East Anglia, Strathclyde and Manchester, where I presented my developing thoughts on this matter.

¹ Some of the issues with these matters were summarised in the Law Commission’s consultation papers in the 1990s on the introduction of a Mental (In)Capacity Act: Law Commission, Mentally Incapacitated Adults and Decision-Making: An Overview Consultation Paper 119 (HMSO, London: 1991); Law Commission, Mentally Incapacitated Adults and Decision Making: Medical Treatment and Research Consultation Paper 129 (HMSO, London: 1993); Law Commission, Mentally Incapacitated and Other Vulnerable Adults: Public Law Protection Consultation Paper 130 (HMSO, London: 1993); Law Commission, Mental Incapacity Law Com No 231 (HMSO, London: 1995).

² House of Lords, Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: post-legislative scrutiny, Report of Session 2013-14, HL Paper 139, para 103. Other critiques of the Act and its use include P. Case, ‘Dangerous liaisons?: Psychiatry, language and law in the Court of Protection - Expert discourses of ‘insight’ in mental capacity’ (2016) 24 Medical Law Review 360; J. Coggon, ‘Mental capacity law, autonomy, and best interests: An argument for conceptual and practical clarity in the Court of Protection’ (2016) 24 Medical Law Review 396; B. Clough, ‘New legal landscapes: (Re)Configuring the boundaries of mental capacity law’ (2018) 26 Medical Law Review 246; R. Heywood, ‘Lost voices in research: Exposing the gaps in the Mental Capacity Act 2005’ (2019) 19 Medical Law Review 81.

³ House of Lords, n 2 above at para 104.

consultation on mental capacity and the deprivation of liberty provisions in the 2005 Act,⁴ and one of the relevant recommendations in their 2017 report was that section 4(6) of the Act was amended so that ‘particular weight’ was given to P’s wishes and feelings.⁵

In this article, I explore the concerns noted above in relation to a series of cases which involve women who are in labour or near-to-delivering, are within the remit of the Mental Health Act 1983 (MHA), and seek to resist the mode of childbirth recommended to them. Seven such cases have been reported since 2012,⁶ and they are reminiscent of the eight childbirth cases reported between 1992 and 2002 (pre-MCA).⁷ I am interested in three matters. First, whether the MCA has changed how capacity and best interests assessments have been employed with regard to the childbirth choices of such women. Secondly, whether best interests is the most appropriate test to apply in this situation and, finally, whether different approaches to best interests assessments are identifiable between childbirth and other health cases. My third and overall concern is that, given the mental health status of these women, there will only ever be one answer to questions about mode of childbirth which are framed around best interests: to deliver in whatever way is deemed to be medically most appropriate regardless of the woman’s wishes. This may be appropriate in some cases, but I argue that it ought not to be an approach that is

⁴ Law Commission, Mental Capacity and Deprivation of Liberty: A Consultation Paper Consultation Paper No 222 (TSO: London, 2015).

⁵ Law Commission, Mental Capacity and Deprivation of Liberty Law Com No 372, HC 1079 (HMSO: London, 2017), Recommendation 40. This recommendation was not included in the subsequent Mental Capacity (Amendment) Act 2019.

⁶ Re: AA [2012] EWCOP 4378 (AA); In the matter of P [2013] EWHC 4581 (COP) (P); Great Western Hospitals NHS Trust v AA [2014] EWHC 132 (Fam) (Great Western); NHS Trust 1, NHS Trust 2 v FG [2014] EWCOP 30 (FG); The NHS Acute Trust, The NHS Mental Health Trust v C [2016] EWCOP 17 (C); United Lincolnshire Hospitals NHS Trust v CD [2019] EWCOP 24 (CD); Guys and St Thomas’ NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R [2020] EWCOP 4 (R). I have not included cases where it is not stated in the judgment that the woman was under the Mental Health Act 1983 (MHA).

⁷ Re S (Adult: Refusal of medical treatment) [1992] 4 All ER 671 (S); Tameside and Glossop Acute Services Trust v CH [1996] 1 FCR 753 (Tameside); Norfolk and Norwich Healthcare (NHS) Trust v W [1997] 1 FCR 269 (Norfolk); Rochdale Healthcare (NHS) Trust v C [1997] 1 FCR 274 (Rochdale); Re L (Patient: Non-consensual treatment) [1992] 2 FLR 837 (L); Re MB (Medical treatment) [1997] 2 FLR 426, CA (MB); St George’s Healthcare NHS Trust v S; R v Collins, ex parte S [1998] 3 WLR 936, CA (St George’s); Bolton Hospitals NHS Trust v O [2003] 1 FLR 824 (O).

universally and automatically applied, for if it were it would negate the point of applying the MCA's best interests test to these women.

In order to address these matters, in the first section I will provide some of the key background details of the pre and post-MCA childbirth cases, to give some context to my arguments in the rest of the article. In sections two and three, I compare how capacity and best interests assessments were performed in these cases, and so address matters one and two above. In section four, I explore how best interests assessments have been approached in other health post-MCA cases and so address my third concern. I then draw together my analysis and provide some concluding thoughts.

Before proceeding as explained, there are two methodological limitations to acknowledge. First, my arguments are based solely on the publicly available reported judgments and, as Rosie Harding has suggested, '[a]s is always the case when only the judgment is available for academic scrutiny, we cannot be clear as to the ways that the various submissions were framed'.⁸ Indeed, in one of the pre-MCA childbirth cases, there were significant issues about the veracity of the information presented to the court.⁹ In one of the post-MCA cases, a report of the 'Proceedings' is included at the end of the judgment, and I draw on statements made therein where relevant.¹⁰ Secondly, as Paula Case has noted, '[t]here are ... methodological limitations to research which uses judgments as a lens through which to assess the dynamics of court proceedings', including the fact that in an emergency application the judge has to produce a reasoned decision under time pressures, and P's actual involvement might not be reflected in the judgment.¹¹

I An overview of the pre- and post-MCA childbirth cases

A Pre-MCA

⁸ R. Harding, 'The rise of statutory wills and the limits of best interests decision-making in inheritance' (2015) 78 *Modern Law Review* 945 at 962.

⁹ *St George's* n 7 above.

¹⁰ *AA* n 6 above.

¹¹ P. Case, 'When the judge met P: The rules of engagement in the Court of Protection and the parallel universe of children meeting judges in the Family Court' (2019) 39 *Legal Studies* 302 at 310.

Eight cases involving childbirth choices were reported prior to 2007 and each case was presented to the court as ‘urgent’,¹² although it is questionable whether this was correct for some of the cases.¹³ In one of the urgent cases, Tameside, was P¹⁴ within the remit of the MHA, and was held to lack the capacity to decide for herself but she had consented to a caesarean section if one was required.¹⁵ Nevertheless, a declaration was sought ‘in anticipation’ of her changing her mind and the situation becoming an emergency.¹⁶ Perhaps because of the urgent nature of the cases, most judges had a limited amount of time to hear and decide them. Thus, in four cases the judge had less than half an hour to decide the case,¹⁷ at least an hour in another case,¹⁸ and in MB the Court of Appeal heard the appeal just over an hour after the first instance judge had granted the declaration. The urgency with which these cases came to court might also explain why it was rare for P to instruct her own legal representative,¹⁹ although the Official Solicitor (OS) was involved in six cases.²⁰ Two of the cases were heard by the Court of Appeal, MB and St George’s, and in these cases the Court produced guidelines for use in future childbirth cases, including that cases should not be left to become emergencies before being brought to court.²¹

B Post-MCA

Four of the seven post MCA MHA cases were also presented to the court as ‘urgent’,²² and two of these cases involved anticipatory and contingent declarations, as occurred in

¹² S at 672; Tameside at 756, 757, 761; Norfolk at 270; Rochdale at 275; L at 838; MB at 429- 430; Bolton at [2]-[3], all n 7 above.

¹³ Tameside at 758, 763-764; St George’s at 947, both n 7 above.

¹⁴ I will follow the practice in the Court of Protection (COP) and use ‘P’ to refer to the woman who was the subject of proceedings for cases both pre and post the Mental Capacity Act 2005 (MCA): Court of Protection Rules 2017, SI 2017 No. 1035, r 2.1.

¹⁵ Tameside n 7 above at 757, 758, 763-764.

¹⁶ ibid at 757.

¹⁷ S, Rochdale, L, and MB. In order to hear Rochdale, the judge interrupted his hearing of Norfolk: Rochdale n 7 above at 275.

¹⁸ Norfolk.

¹⁹ At first instance and in the Court of Appeal in MB (at 428, 430), but only in the Court of Appeal in St George’s at 942, 947-948. P declined the opportunity to be represented in Bolton at [11], all n 7 above.

²⁰ As amicus curiae in S, Norfolk, L, MB; guardian ad litem in Tameside; the Deputy OS represented P in Bolton.

²¹ MB at 445; St George’s at 968-970, both n 7 above.

²² AA, Great Western, CD, R

Tameside.²³ In the remaining three cases, declarations were sought ‘in anticipation’ of problems arising during labour,²⁴ indicating that the MB guidelines were being followed – to some extent at least.²⁵ As with the pre-MCA cases, the urgency in some of the cases is unclear or unexplained,²⁶ while in two cases time played a different role as the Trust wanted the matters to be decided while P had capacity so that the declaration would apply in the event that she no longer had capacity once her waters had broken (CD) or was in labour (R).²⁷ In the other cases, the pressure on the court to hear and determine them in a short period of time was minimised because they were brought before the court in advance of an emergency arising.²⁸

P did not instruct her own counsel in any of the post-MCA MHA childbirth cases, but was represented by the OS in three cases and the OS was P’s litigation friend in three other cases.²⁹ Only in R was P not represented and the OS acted as Advocate to the Court, which ‘involves very different obligations and is not to be conflated with the role of the Official Solicitor as litigation friend’.³⁰ Involving the OS follows the Court of Appeal’s guidelines in MB,³¹ and in FG, Keehan J also produced guidelines to ‘prevent the need for urgent applications to be made to the out of hours judge’, and ensure that Trusts appropriately relied on the provisions in section 5 of the MCA.³² These guidelines apply to four specific ‘categories’ where a pregnant

²³ CD, R.

²⁴ P, FG, C.

²⁵ MB n 7 above at 445.

²⁶ AA n 6 above at Note by Mr Justice Mostyn.

²⁷ CD at [3]; R at [2], both n 6 above.

²⁸ P, FG and C.

²⁹ Represented – P, Great Western and C; litigation friend – AA, FG and CD. Note that (i) when the application for an interim order was heard in Great Western, P was not represented and the Official Solicitor (OS) was unable to attend because of the timescale. At the full hearing the following day, the OS represented P; (ii) as litigation friend, the OS’s role is not to advocate for P but to represent her best interests. For discussions of this see A. Ruck Keene, P. Bartlett, N. Allen, ‘Litigation friends or foes? Representation of ‘P’ before the Court of Protection’ (2016) 24 Medical Law Review 333; A. Ruck Keene, Guidance Note: Acting as a litigation friend in the Court of Protection (2014) at <http://www.39essex.com/wp-content/uploads/2015/01/Acting-as-a-Litigation-Friend-in-the-Court-of-Protection-October-2014.pdf> (visited 13 May 2020).

³⁰ R n 6 above at [5].

³¹ MB n 7 above at 445.

³² FG n 6 above at [83].

woman lacks or may lack the capacity to make decisions about her obstetric care because of a diagnosed psychiatric illness,³³ but to date they have only been referred to in R.³⁴

II Determining capacity and best interests pre-MCA 2005

A health professional who intentionally or recklessly touches a patient without her consent commits both the crime and the tort of battery. To be insulated from such liability, the health professional must either have the valid consent of the patient, that of someone who is authorised to consent on the patient's behalf (such as, someone with parental responsibility in relation to that child), or the defence of necessity must apply.³⁵

A Capacity and best interests at common law

At common law capacity was to be presumed,³⁶ and the test for capacity was set out in Re C [1994]: 'there are three stages to the decision (1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs'.³⁷ If a patient had capacity, then their consent to or refusal of treatment had to be complied with,³⁸ but if they did not, then treatment could be provided if it was in their best interests to receive it.³⁹ Initially, best interests was viewed via a medical lens using the Bolam test (would a responsible body of medical opinion view the suggested treatment as being in the best interests of the patient?),⁴⁰ but in a number of cases in the early 2000s there was a shift in emphasis such that best interests came to be viewed other than in terms of purely medical best interests. For example, Dame Butler-Sloss P in Re A said that best interests 'encompasses medical, emotional and all other welfare interests',⁴¹ and in Re S that it involved 'broader ethical, social, moral and welfare considerations'.⁴²

³³ ibid at Annex [2]-[3].

³⁴ R n 6 above at [14]-[16].

³⁵ Consent must be provided voluntarily by someone who has capacity and has received sufficient information: Re T (Adult: Refusal of treatment) [1992] 3 WLR 782, CA; MCA 2005; Montgomery v Lanarkshire Health Board [2015] UKSC 11.

³⁶ Re T n 35 above at 796.

³⁷ Re C (Adult: Refusal of treatment) [1994] 1 WLR 290 at 292.

³⁸ Re T n 35 above.

³⁹ Re F (Mental patient: Sterilisation) [1990] 2 AC 1, HL.

⁴⁰ Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

⁴¹ Re A (Male sterilisation) [2000] 1 WLR 549, CA at 555.

⁴² Re S (Adult patient: Sterilisation) [2000] 3 WLR 1288, CA at 1299.

B Capacity assessments in childbirth cases

Capacity was assessed in all of the pre-MCA childbirth cases, bar the first to be reported (S) - perhaps because no doubts were raised concerning her capacity - although the nature and extent of the assessments varied, as well as who conducted them. In three cases, a consultant psychiatrist undertook the assessment, in two a consultant obstetrician, and in Tameside, the pre-MCA MHA case, two consultant obstetricians and gynaecologists and a consultant psychiatrist assessed P's capacity.⁴³ Where assessed, P was deemed to lack capacity by the assessor,⁴⁴ and the court held that P lacked the capacity to make childbirth choices. In five cases this was because P did not meet the Re C test,⁴⁵ while in Bolton, Dame Butler-Sloss P reiterated her statements from MB that P could temporarily lack capacity in one situation but not another.⁴⁶ In St George's P's capacity was only minimally considered at first instance.⁴⁷ On appeal, it was suggested that this was because P's capacity had been assumed,⁴⁸ but that the Court of Appeal should review the evidence on capacity because the psychiatrist had changed her opinion.⁴⁹ This argument was rejected and the Court held that P 'knew perfectly well what she was doing', and that 'however the question is tested, there is no sufficient evidence from which to conclude that her competence on 26 April was in question'.⁵⁰

There are two matters worthy of note relating to capacity assessments in the pre-MCA childbirth cases. First, in three cases the court relied on notions of 'temporary incapacity' to find that P lacked the capacity to consent to treatment.⁵¹ For example, in Rochdale Johnson J

⁴³ Psychiatrist – Norfolk, MB, St George's; obstetrician – Rochdale, L. It is not clear who assessed capacity in Bolton.

⁴⁴ With the caveat 'subject however to her extreme needle phobia': L n 7 above at 839.

⁴⁵ The Re C test was not directly cited in Norfolk or Rochdale but Johnson J relied on the test set out in Tameside, which was, in fact, the Re C test: Norfolk at 614; Rochdale at 275, both n 7 above. In MB Butler-Sloss LJ said that Hollis J had found that P was 'not really capable of considering matters lucidly so operation should be performed' (sic): n 7 above at 431. Note that lucidity was not part of the Re C test.

⁴⁶ MB at 437-438; Bolton at [17], both n 7 above.

⁴⁷ It was noted that P had been admitted under section 2 of the MHA for 'ongoing' assessment and that 'moderate depression' had been diagnosed: St George's n 7 above at 947.

⁴⁸ ibid.

⁴⁹ ibid at 948-949.

⁵⁰ ibid at 948.

⁵¹ Rochdale, Re MB, Bolton, all n 7 above.

said that a patient ‘in the throes of labour with all that is involved in terms of pain and emotional stress’, was not able to weigh up information as was required in Re C.⁵² And in MB, Butler-Sloss LJ relied on Lord Donaldson’s statement in Re T that ‘temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment’ may affect capacity.⁵³ The notion of being ‘temporarily’ without capacity due to such factors is problematic for many reasons,⁵⁴ and the parameters of temporary incapacity were not really explored or clarified in MB. Capacity assessors were thus seemingly handed a blank cheque. Notably though, judicial manipulation of the concept of capacity in these cases was criticised by Hayden J in R, the latest reported post-MCA MHA childbirth case.⁵⁵

Secondly, in Rochdale and MB even though a declaration was granted on the basis that P lacked the capacity to consent, the court noted that P had changed her mind and so delivering by caesarean section occurred with her ‘consent’.⁵⁶ How P lacked capacity when she was disagreeing with the recommended mode of delivery but capacitous when she agreed with it, was not explained. Nevertheless, in Rochdale at least, P was seemingly with and without capacity at the same time because as the Trust was in court arguing that P lacked capacity to consent and after Johnson J issued a declaration on that basis, he was informed that ‘in the time it had taken Mr. Leigh to come to the court the patient had changed her mind and given her consent to the procedure. Accordingly, the operation was in fact performed with her consent’.⁵⁷

On a different but related point, in considering P’s capacity in St George’s and concluding that there was ‘no sufficient evidence’ to question it, Judge LJ said ‘[t]hat conclusion is reinforced by the decision to make one last effort to obtain her consent to treatment at 20.35: if she was not thought competent at that stage, the exercise was a complete waste of time’.⁵⁸ Thus, continuing to seek consent in St George’s was taken as evidence that P was thought to have

⁵² Rochdale n 7 above at 285.

⁵³ Re T n 35 above at 796.

⁵⁴ On the use of temporary incapacity see, for example, S. Fovargue and J. Miola, ‘Policing Pregnancy: Implications of the Attorney-General’s Reference (No. 3 of 1994)’ (1998) 6 Medical Law Review 265.

⁵⁵ R n 6 above at [56].

⁵⁶ Rochdale at 275-276; MB at 430, 439, both n 7 above.

⁵⁷ Rochdale n 7 above at 275-276, emphasis added.

⁵⁸ St George’s n 7 above at 949.

capacity, otherwise there was no point in seeking it. This must surely be correct, and replicates the point made by Heilbron J as long ago as 1976 in Re D. In that case, a consultant paediatrician and consultant gynaecologist sought to ascertain 11 year old D's consent to sterilisation and Heilbron J said that, as she lacked capacity, 'One would have thought that they must have known that any answer she might have given, or any purported consent, would have been valueless'.⁵⁹

C Best interests assessments in childbirth cases

Once a court has decided that P lacks the capacity to consent to or refuse the suggested mode of delivery, the court must consider whether it is in P's best interests to deliver as recommended. However, in most of the pre-MCA childbirth cases, minimal attention was paid to best interests, with no mention of them in two cases.⁶⁰ For example, in S, although P's capacity was not considered, at the end of the case report it is stated that 'Declaration that a Caesarian section ... was in the vital interests of the patient and her unborn child'.⁶¹ Similarly, 'best interest(s)' was mentioned only once in three cases,⁶² and in MB Butler-Sloss LJ said that it was 'implicit' in Hollis J's judgment at first instance that a caesarean was in P's best interests'.⁶³ The Court of Appeal itself in MB, however, dedicated two paragraphs to best interests and they were mentioned elsewhere in the judgment too,⁶⁴ as they were in Tameside, mainly in terms of the court's ability to declare that, where P was unable to consent for herself, a procedure was lawful and in her best interests.⁶⁵

(i) The basis of best interests assessments

a) Medical evidence

⁵⁹ In re D (A minor) (Wardship: Sterilisation) [1976] Fam 185 at 193.

⁶⁰ Bolton, St George's (the Court of Appeal's summary of the first instance decision), both n 7 above. Best interests did not feature in the judgment of the Court of Appeal itself in St George's, probably because the Court held that P did not lack capacity to consent and so her best interests were irrelevant. They were, however, noted in two places: at 951, 970.

⁶¹ S n 7 above at 672.

⁶² Norfolk n 7 above at 616. The second mention of 'best interests' has not been counted as it was in a quote from Lord Brandon in Re F n 39; Rochdale at 275; L at 840, both n 7 above.

⁶³ MB n 7 above at 439.

⁶⁴ ibid at 438-439, Also, 432-434, 437, 445.

⁶⁵ Tameside n 7 above at 761. Also, 762.

Best interests assessments must be based on evidence and in three cases, as per the Bolam test which applied at the time, medical best interests appeared to prevail, with physical health taking centre stage in Norfolk and Rochdale.⁶⁶ Mental health was the focus in Tameside,⁶⁷ and there were no physical risks to P if her pregnancy continued or the foetus died in utero.⁶⁸ Rather, any physical risks came from labour being induced or a caesarean being performed. By contrast, in L and MB, where P was refusing a caesarean because of her needle phobia,⁶⁹ medical and other evidence were used in the best interests assessments. In L, the evidence was that without intervention the foetus would die, and P had agreed ‘in principle’ to a caesarean but was unable to consent to any procedure involving a needle because of her ‘extreme needle phobia’.⁷⁰ If P was not safely delivered of the foetus, ‘her own health and well-being would be put in jeopardy’.⁷¹ Physical and mental health considerations are also evident in MB, where P was in labour and a caesarean was recommended because, without one, the risk to the foetus ‘was assessed as 50%’.⁷² While there was ‘little physical danger’ to P, the psychiatric evidence was that P would suffer ‘significant long-term damage’ if she did not deliver via caesarean and the child was harmed or died, but ‘would not suffer lasting harm from the anaesthesia being administered to her to achieve a desired result of the safe delivery of her child’.⁷³

b) P’s wishes

In MB, Butler-Sloss LJ stated that ‘Best interests are not limited to best medical interests’,⁷⁴ and this wider interpretation of best interests was emphasised in other cases in the early 2000s, as I noted earlier.⁷⁵ In L and MB, it can be argued that this interpretation was employed in the sense that P’s wishes were noted in the judgments.⁷⁶ These decisions contrast with the earlier

⁶⁶ Norfolk at 616; Rochdale at 275, both n 7 above.

⁶⁷ Tameside n 7 above at 757, 759, 764.

⁶⁸ ibid at 757-758.

⁶⁹ MB at 430; L at 838, both n 7 above.

⁷⁰ L n 7 above at 838.

⁷¹ ibid at 838-839.

⁷² MB n 7 above at 429.

⁷³ ibid.

⁷⁴ ibid at 439.

⁷⁵ See n 41-42 above.

⁷⁶ L at 839-840; MB at 429, 431, 439, both n 7 above.

cases, where P's wishes were either not included in the judgment or there was minimal mention of them,⁷⁷ perhaps because, as noted in section I above, P was not represented in court.⁷⁸

In L it was said that P 'wished to be safely delivered of her child', but that her fear of needles was the obstacle.⁷⁹ Similar comments were noted in MB,⁸⁰ and P wanted (and had requested) a caesarean 'subject only to her needle phobia'.⁸¹ Thus, performing a caesarean, even without her consent, could be seen as adhering to some aspects of P's wishes and giving her what she wanted. In these cases then, the court could be seen to be taking a more holistic perspective to best interests, by, at the very least, including P's wishes and feelings in its decision-making process. And even though best interests were not directly addressed in Bolton, P's views were included a number of times in the judgment.⁸² P also spoke to Dame Elizabeth Butler-Sloss P over the telephone and, following that conversation and in authorising the caesarean section, she said that P 'wants me to make this order because she wants the operation to go forward. She wants the decision, effectively, taken out of her hands'.⁸³ Again, the court was seemingly giving P what she wanted, complying with her wishes.

c) Others' wishes

The limited space given to P's wishes is mirrored with regard to the wishes of those close to her, as these were only noted in two cases. In S it was noted that P's refusal to consent to deliver via a caesarean was supported by her husband,⁸⁴ and in MB it was said that both P and her partner had requested (and were 'in favour of') a caesarean, with the necessary use of needles the issue.⁸⁵ Both of them also 'wanted this child to be born alive'.⁸⁶ The language in this phrase

⁷⁷ No reason given – Norfolk; P's wishes mentioned once – Rochdale at 275, S at 672; Tameside at 761, all n 7 above.

⁷⁸ S, Norfolk, Rochdale, Tameside.

⁷⁹ L n 7 above at 838.

⁸⁰ MB n 7 above at 435.

⁸¹ ibid at 429, 439, respectively.

⁸² Bolton n 7 above at 14.

⁸³ ibid.

⁸⁴ S n 7 above at 672.

⁸⁵ MB n 7 above at 429-430.

⁸⁶ ibid at 439.

is worth noting because while the ‘unborn child’ or ‘unborn baby’⁸⁷ and/or the ‘foetus’⁸⁸ clearly cannot express wishes, their very presence in the reports of the pre-MCA childbirth cases is in marked contrast to the largely absent views of both P and those close to her. Furthermore, the life of the ‘unborn child’ was explicitly used in S to justify authorising a caesarean section without a capacitous’ P’s consent.⁸⁹

D Summary of the pre-MCA position

Prior to the MCA, if a woman’s childbirth choice was questioned, the case was likely to come before the court as an urgent application and the court would necessarily have a limited amount of time (and information) to consider it.⁹⁰ P’s capacity might have been assessed, but that assessment would not always be an in-depth one or be conducted by a psychiatrist. If P was found to lack capacity, her best interests were likely to be minimally assessed, medical best interests would predominate, and P’s wishes and those of others would receive limited attention. By contrast, the unborn child/unborn baby/foetus would be present in the judgments. This assessment of the pre-MCA case law may seem unduly cynical, but it is supported by Thorpe LJ, who, writing extra-judicially at the time, said that ‘It is unnecessary to dwell on best interests in the context of cases involving Caesarean section. Obviously if the patient lacks capacity, the obstetrician proceeds towards the goal of successful delivery in the exercise of his clinical judgment’.⁹¹ He also suggested that the Court of Appeal’s decision in St George’s created ‘undoubted difficulty’ for the professionals involved, especially the consultant was is responsible for the life of the mother and ‘the being on the verge of independent existence’.⁹² He said that it was also ‘hard for the first-instance judge to suppress his every instinct to avert tragedy’, and that it might be ‘easier for appellate judges to define the principles than for first-

⁸⁷ ‘Child’ – S at 672; Tameside at 755, 757-760, 763-764, 766; Rochdale at 274; Norfolk at 273; L at 838-840; Bolton at [1], [13]. ‘Baby’ - Tameside at 757-761, 764, 766; Norfolk at 270, 273; MB at 430, 435, 438; Bolton at [2]-[4], [12], [14], all n 7 above. The position or status of the unborn child/baby/foetus was specifically noted in S at 672; Norfolk at 616; MB at 439-444.

⁸⁸ Tameside at 756-758, 760, 763; Norfolk at 270, 272-273; Rochdale at 275; MB at 428-429, 434-435, 440-444, all n 7 above.

⁸⁹ S n 7 above at 672.

⁹⁰ For a critique of the element of time in these cases see J Harrington, Towards a Rhetoric of Medical Law (Oxford: Routledge, 2017) 81-82.

⁹¹ Thorpe LJ, ‘Consent for Caesarean Sections: Part 2 - Autonomy, Capacity, Best Interests, Reasonable Force and Procedural Guidelines’ (1999) 5 Clinical Risk 209 at 210, emphasis added.

⁹² ibid at 211.

instance judges to apply them’ – and ‘to apply the principles retrospectively’.⁹³ Given all of this, Thorpe LJ suggested that ‘[s]ome may perceive the judges as more confident in defining the principle of autonomy than in applying it to a mother and fetus for whom death is at the door.’⁹⁴ These are prescient words when we consider how the courts have applied the provisions of the MCA to pregnant women who are within the remit of the MHA.

III Determining capacity and best interests post-MCA 2005

The common law concepts of capacity and best interests were transferred into statute in the MCA,⁹⁵ and the Act has not altered the significance of a finding of capacity; consent to or refusal of treatment by an adult with capacity, which is provided voluntarily and is informed, must be respected.

A Capacity and best interests under the MCA

Five key principles are set out in section 1 of the MCA, including the assumption of capacity for those aged 16 and over, the presumption that the least restrictive alternative will be adopted if options are available, and that if someone cannot make a decision for themselves then the decision must be made in their best interests. The Re C capacity test is, essentially, placed on a statutory footing in section 3, which must be read with section 2. If a best interests assessment is required, a non-exhaustive list of relevant factors to be considered can be found in section 4.⁹⁶ These include that the person determining best interests ‘must consider all the relevant circumstances’; that is, those ‘(a) of which the person making the determination is aware, and (b) which it would be reasonable to regard as relevant’.⁹⁷ Furthermore, as far as is reasonably practicable, P should be permitted and encouraged to participate, or to improve their ability to participate, as fully as possible in any act done for them and any decision affecting them.⁹⁸ P’s

⁹³ ibid, emphasis added.

⁹⁴ ibid, emphasis added.

⁹⁵ For a fascinating telling of the story of capacity law, see M. Donnelly, ‘Changing values and growing expectations: The evolution of capacity law’ (2017) 70 Current Legal Problems 305.

⁹⁶ Further guidance on best interests assessments can be found in the Code of Practice which accompanies the Act: Department for Constitutional Affairs (DCA), Mental Capacity Act 2005 Code of Practice (London: TSO, 2007) at ch 5.

⁹⁷ MCA, ss 4(2), (11), respectively.

⁹⁸ MCA, s 4(4). On participation and the MCA see, for example, C. Kong, J. Coggon, M. Dunn, P. Cooper, ‘Judging values and participation in mental capacity law’ (2019) 8 Laws 3 at <https://doi.org/10.3390/laws8010003>

past and present wishes and feelings, beliefs and values that would be likely to influence their decision if they had capacity, and other factors that they would be likely to consider if they were able to do so, must be considered ‘so far as is reasonably ascertainable’.⁹⁹ Thus, ‘P’s perspective and values have some normative status (however indeterminate) in any judicial decision-making that affects P’s life’.¹⁰⁰ Additionally, in deciding what would be in P’s best interests, the decision-maker must also take into account the views of certain people, including anyone named by P as someone to be consulted and anyone engaged in caring for P or interested in their welfare, if it is practicable and appropriate to consult them.¹⁰¹

Questions about what is in P’s best interests have been considered by the courts, but they actually occupy little of the Court of Protection’s (COP) time.¹⁰² As these are fact specific and first instance decisions, they are not precedents although statements within them may have relevance beyond the immediate case. Notable, and oft-cited, statements include Munby J’s reiteration, in Re MM (An adult), of Butler-Sloss LJ’s comments from the early 2000s about the wide scope of best interests assessments,¹⁰³ and that in those assessments ‘One of the most important factors to be taken into account is the vulnerable adult’s wishes and feelings. The fact that MM lacks the relevant capacity does not mean that her wishes and feelings simply fall out of account’.¹⁰⁴ Indeed, ‘The nearer to the borderline the particular adult, even if she falls on the wrong side of the line, the more weight must in principle be attached to her wishes and feelings’.¹⁰⁵ And while the weight to be attached to P’s wishes and feelings ‘will always be case-specific and fact-specific’,¹⁰⁶ in Re M, ITW v Z Munby J set out some of the relevant circumstances which regard should be had to when considering the weight and importance to be attached to P’s wishes, including ‘the strength and consistency’ of P’s views, and the extent

(last visited 13 May 2020); M. Donnelly, ‘Best interests, patient participation and the Mental Capacity Act 2005’ (2009) 17 Medical Law Review 1.

⁹⁹ MCA, s 4(6).

¹⁰⁰ Kong et al n 97 above.

¹⁰¹ MCA, s 4(7).

¹⁰² A. Ruck Keene, N.B. Kane, S.Y.H. Kim, G.S. Owen, ‘Taking capacity seriously? Ten years of mental capacity disputes before England’s Court of Protection’ (2019) 62 International Journal of Law and Psychiatry 56 at 60.

¹⁰³ See n 41-42 above; Re MM (An adult) [2007] EWHC 2003 (Fam) at [99].

¹⁰⁴ Re MM n 102 above at [121]. Also, Re M, ITW v Z [2009] EWHC 2525 (Fam) at [35].

¹⁰⁵ Re MM n 102 above at [124].

¹⁰⁶ Re M n 103 above at [35].

to which P's wishes and feelings 'are, or are not, rational sensible, responsible and pragmatically capable of sensible implementation'.¹⁰⁷

Aintree University Hospitals NHS Foundation Trust v James was the first case under the MCA to come before the Supreme Court. Lady Hale delivered the judgment of the Court and said that P should be seen as an individual with their own values, likes and dislikes, and that their best interests should be considered in 'a holistic way'.¹⁰⁸ Thus, the best interests of 'this particular patient at this particular time' were to be considered, looking at 'welfare in the widest sense, not just medical but social and psychological'.¹⁰⁹ Beyond this, decision makers must:

- consider the nature of the treatment in question, what it involves, its prospects of success;
- consider the likely outcome of the treatment for the patient;
- try and put themselves in the place of that patient - what their attitude to the treatment is or would be likely to be;
- consult others who are looking after the patient or who are interested in their welfare – particularly their view of what the patient's attitude would be.¹¹⁰

Lady Hale then set out the purpose of the best interests test, in a lengthy but important paragraph which merits full replication:

The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament ... But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are

¹⁰⁷ ibid.

¹⁰⁸ Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 at [26].

¹⁰⁹ ibid.

¹¹⁰ ibid at [39].

a component in making the choice which is right for him as an individual human being.¹¹¹

This decision was delivered in October 2013 and pre-dates all the post-MCA MHA childbirth cases bar AA,¹¹² and so there is no reason why the approach to best interests enunciated in Aintree should not be evident in subsequent cases.

B Capacity assessments in childbirth cases¹¹³

The statutorily protected presumption of capacity was only referred in three of the seven post-MCA MHA childbirth cases.¹¹⁴ Capacity was, however, assessed in all of the cases and, as with the pre-MCA cases, varying degrees of explanation and/or evidence as to the basis for the assessment were provided in the judgments. In a change from the pre-MCA cases, only in FG was capacity assessed by a consultant obstetrician and gynaecologist rather than a psychiatrist, and in all cases bar CD and R, where anticipatory and contingent declarations were sought while P had capacity, P was deemed to lack capacity by both the capacity assessor and the judge.¹¹⁵ Relevant sections of the MCA were referred to in all judgments apart from Great Western and CD,¹¹⁶ although from his discussion of the evidence of the consultant psychiatrist

¹¹¹ ibid at [45], emphasis added.

¹¹² AA was heard on 23 August 2012; P on 11 December 2013; Great Western on 28 January 2014 (the interim hearing was the day before); FG on 20 and 22 May 2014; C on 29 February and 1 March 2016; CD on 4 July 2019; R was heard on 30 August 2019 but Hayden J received further written submissions on the jurisdictional issues on 25 October 2019 and the case was not reported until 29 January 2020.

¹¹³ On capacity assessments generally post-MCA see P. Case, 'Negotiating the domain of mental capacity: Clinical judgement or judicial diagnosis' (2016) 16 Medical Law International 174; P. Skowron, 'Evidence and causation in mental capacity assessments: PC v City of York Council [2013] EWCA Civ 478' (2014) 22 Medical Law Review 631; M. Donnelly, Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism (Cambridge: Cambridge University Press, 2010) at ch 4.

¹¹⁴ P at [10]; FG at [30]; C at [47], all n 6 above.

¹¹⁵ Williams J criticised evidence of capacity being provided by 'a clinician other than a consultant psychiatrist or psychologist, particularly where it is known that JP is known to a psychiatric team' in NHS Trust v JP [2019] EWCOP 23 at [25].

¹¹⁶ MCA, ss 1(5) and/or s 2 - AA at [2]-[3], R at [19]; MCA, s 3 - P at [10] (where Jackson J incorporated the presumption of capacity in section 1(2) of the MCA into his description of section 3), R at [20]; MCA, ss 1-3 - FG at [30]-[31], C at [47]-[49], all n 6 above.

in Great Western, it is clear that Hayden J was aware that the tests in sections 2 and 3 were to be applied in a capacity assessment.¹¹⁷

Three matters relating to capacity merit attention here. First, in AA Mostyn J commented that ‘I am struggling to envisage a circumstance where a patient detained under section 3 as an inpatient with a diagnosed mental illness has got capacity’.¹¹⁸ The OS helped the judge to understand how this might be possible,¹¹⁹ but without that intervention a judge in the COP would have been operating under the misapprehension that detention under the MHA automatically connotes incapacity under the MCA. This is disturbing. Beverley Clough has also noted this surprising exchange, and commented that ‘it is imperative the judiciary grapple with and closely scrutinise assessments of capacity which rely heavily on clinical judgement, particularly when core rights are at stake’.¹²⁰ Such scrutiny is particularly essential when P is a pregnant woman under the MHA, because she seems to be in a precarious situation - legally and medically.

Secondly, in C the court and the medical and psychiatric teams agreed that P’s capacity should be kept ‘under active review’ by the clinicians involved,¹²¹ in consultation with her partner and her mother.¹²² Thus, the determination that at the time the court heard the case P lacked capacity to make childbirth choices herself, was not seen to be the end of the matter. Rather, because P’s mental health condition was ‘of a relapsing remitting nature’¹²³ and her compliance with medication fluctuated,¹²⁴ Theis J recognised the reality of P’s situation and the fact that she may retain/regain the ability to decide for herself. This is to be commended.

The final matter is linked to that noted above. In CD, Francis J was asked to make an anticipatory and contingent declaration while P had capacity because, ‘based on her history,

¹¹⁷ Great Western n 6 above at [19].

¹¹⁸ AA n 6 above at Proceedings 6.

¹¹⁹ ibid at [2], Proceedings 4.

¹²⁰ B. Clough, “‘People like that’: Realising the social model in mental capacity jurisprudence’ (2014) 23 Medical Law Review 53 at 57.

¹²¹ C n 6 above at [12], [35].

¹²² ibid at [35].

¹²³ ibid at [15].

¹²⁴ ibid at [18].

her clinicians are agreed that there is a substantial risk that she may become incapacitous in relation to such decisions at a critical moment in her labour'.¹²⁵ Francis J noted that the application raised an issue which had not otherwise been reported, and he was referred to an unreported decision from 2009 where the then McFarlane J 'made contingent declarations as to the circumstances in which P would lack capacity and her best interests in that event'.¹²⁶ Francis J thus held that 'in exceptional circumstances, the court had the power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c) [of the MCA]'.¹²⁷ The use of such a declaration is of concern, not least because it is questionable whether the circumstances were, in fact, 'exceptional'. Francis J said that if he did not 'address the matter now I could put the welfare and even the life, of CD at risk', as well as that of 'her yet as undelivered baby'.¹²⁸ However, it is difficult to see how the facts in this case were different to other cases which have been (or might be) deemed to be 'urgent'. Indeed, there is no indication in the judgment that a decision had to be made on that day or within a certain timescale; rather, there was a concern that P might not have capacity when her waters broke and that at that point 'there would almost certainly be insufficient time to make a renewed application to the court'.¹²⁹ Why this natural event in the labour process would affect her capacity and necessitate an application to court is not explained, beyond the statements that 'it is possible that during labour her delusional beliefs may affect her judgment and she may again lose capacity to make decisions about the delivery for herself',¹³⁰ and that those treating P considered it 'very likely' that she would lose capacity in the future.¹³¹ This is reminiscent of the idea of temporary incapacity which was used in some of the pre-MCA childbirth cases,¹³² with the idea that being in labour necessarily affects a woman's capacity.

Furthermore, in determining P's best interests while she had capacity appears to contravene the rationale behind the MCA. Capacity is supposed to be issue, time and fact-specific,¹³³ with best

¹²⁵ CD n 6 above at [3].

¹²⁶ See further n 6 to para 1.483, as cited in ibid at [16] v).

¹²⁷ CD n 6 above at [16] iii).

¹²⁸ ibid.

¹²⁹ ibid at [3].

¹³⁰ ibid at [6], emphasis added.

¹³¹ ibid at [13].

¹³² See p 00 above.

¹³³ MCA, s 2(1); DCA n 96 above at para 4.4. Also, CC v KK and STCC [2012] EWHC 2136 (COP).

interests similarly time and context dependent.¹³⁴ Yet, in CD, and in R discussed below, Francis J was able to determine P’s best interests in advance of her being assessed as lacking the capacity to decide for herself. Thus, without knowing how and why P would be so assessed and her particular circumstances at the time of that assessment, Francis J was still able to decide what would be in her best interests at that unknown point in the future.

Within about six weeks of this decision, a second anticipatory and contingent declaration relating to childbirth choices was granted by Hayden J. In R, there was said to be a ‘substantial risk’ that P’s mental health would deteriorate so that she would lose capacity while in labour, and also that she might require a caesarean ‘for the safe delivery of her baby but might resist’.¹³⁵ The reasons for these concerns were not explicated in the judgment, because ‘[i]t is unnecessary for me to identify the particulars of that evidence here, other than to say it was well established by R’s earlier behaviours’.¹³⁶ Whether the particulars of the case were such that it fell within Keehan J’s ‘exceptional circumstances’ is unclear; however, Hayden J said that ‘many cases’ that come before the COP judges ‘may properly be described as exceptional ... The cases frequently present issues of medical, moral, legal complexity’.¹³⁷ This wide interpretation of ‘exceptional’, was qualified thus:

The jurisdiction is highly case or fact specific. Against this backdrop it is easy to see that the concept of “exceptional” is vulnerable to being corroded i.e. interpreted as having wider application than that which the Court might intend. The right of all individuals to respect for their bodily integrity is a fundamental one. It is every bit the right of the incapacitous as well as the capacitous.¹³⁸

¹³⁴ MCA, s 4. Discussed further in in S. Fovargue, ‘Anticipating issues with capacitous pregnant women: United Lincolnshire NHS Hospitals Trust v CD [2019] EWCOP 24 and Guys and St Thomas’ NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R [2020] EWCOP 4’ (2020) Medical Law Review, forthcoming.

¹³⁵ R n 6 above at [2].

¹³⁶ ibid at [4].

¹³⁷ ibid at [48].

¹³⁸ ibid, emphasis in original.

While this might be so, Hayden J confirmed in R that anticipatory and contingent declarations can be made under section 15 of the MCA in relation to someone who currently has capacity,¹³⁹ so we now have a route via which the childbirth choices of women with capacity can be challenged. All labouring or near-to-delivering women are thus now within laws gaze because we know from the pre-MCA childbirth cases that women may be at ‘high risk’ of losing capacity during labour¹⁴⁰ because they are in ‘the throes of labour with all that is involved in terms of pain and emotional stress’.¹⁴¹

C Best interests assessments in childbirth cases

Given the statutory codification of best interests assessments in section 4 of the MCA, it might be expected that such assessments would be more common and comprehensive in the post-MCA childbirth cases than in the pre-MCA ones. While best interests were mentioned in all of the former cases, only in AA were they noted throughout the judgment,¹⁴² although the law relating to best interests was acknowledged in all but two cases,¹⁴³ with section 4 set out in full or mentioned in three cases,¹⁴⁴ and the provision in section 1(5) (to make decisions which are in the person’s best interests), set out in full or referred to three cases.¹⁴⁵ As I explore below, although the best interests assessments varied in these cases, in all of them the principle that the court must have regard to the principle of least restriction was acknowledged,¹⁴⁶ with options (available and theoretical) considered in five cases.¹⁴⁷ Alternatives were also included

¹³⁹ ibid at [32], [35]-[36]. Anticipatory declarations were also discussed by Cobb J in Wakefield Metropolitan District Council, Wakefield Clinical Commissioning Group v DN and MN [2019] EWHC 2306 (Fam).

¹⁴⁰ ibid at [3].

¹⁴¹ Rochdale n 52 above.

¹⁴² In five of the nine paragraphs and twice in the Note from Mostyn J at the start of the case report: AA n 6 above.

¹⁴³ Great Western, CD. In Great Western, there appears to have been some confusion as to whether the case was heard under the inherent jurisdiction of the High Court or the MCA. This might explain the limited reliance on the latter: Great Western n 6 above at [1], [21]. In CD, P had capacity at the time the case was heard and so a best interests assessment was not in issue, although Francis J said it was ‘common ground that every possible step should be taken to act in the best interests of CD and to promote her welfare’: CD n 6 above at [4].

¹⁴⁴ P at [15]; FG at [32]; R at [62], all n 6 above.

¹⁴⁵ FG at [30]; C at [47]; AA at [3], all n 6 above.

¹⁴⁶ AA n 6 above at [3].

¹⁴⁷ Available - P at [17]. Also, [3], [4], [12]; FG at [36], [42], [49], [54]; C at [35], [58]; CD at [16] iv). Theoretical - Great Western at [10]. All n 6 above.

in the order itself in three cases,¹⁴⁸ and in C the court and the medical and psychiatric teams agreed that the court-authorized methods of delivery were to be kept ‘under active review’ by the clinicians,¹⁴⁹ in consultation with P’s partner and her mother.¹⁵⁰ This was as well as continually reviewing P’s capacity.¹⁵¹ Thus, if P’s mental health improved such that a caesarean section was not required, one would not be performed. Obtaining the declarations sought were, therefore, not seen as the end of the matter; rather, the reality of P’s situation was acknowledged. As her mental health condition was ‘of a relapsing remitting nature’¹⁵² and her compliance with medication fluctuated,¹⁵³ she may regain and retain capacity throughout labour and birth. A different approach to best interests is thus identifiable in this case, as well as the least restrictive alternative principle being in evidence.¹⁵⁴ However, the Supreme Court’s decision in Aintree was not cited in any of the post-MCA childbirth cases; although in Great Western Hayden J said that ‘a best interests decision requires a broader survey of the available material’, and ‘Best interests declarations are never grounded exclusively in medical issues: the wider context is frequently just as illuminating’.¹⁵⁵

(i) The basis of best interests assessments

a) Medical evidence

As in the pre-MCA cases, evidence relating to medical (physical) or psychiatric health were relied on as the basis of the best interests assessments in four cases. In two of those cases physical best interests predominated, and in P it was declared lawful to attempt to deliver without surgical intervention and only move to such intervention if P’s health and/or that of the foetus required it.¹⁵⁶ In this in anticipation case, Jackson J was clear that granting the

¹⁴⁸ P at [3]; EG at [17]; CD at [16], all n 6 above. The precise content of the declaration in R is unknown because an obstetric care plan was annexed to the order but was not included in the judgment: n 6 above at [7]. However, alternatives might not have been included in the declaration because the OS was not able to speak with P, and so it was not possible to obtain ‘greater clarity’ about her wishes and feelings, which was needed ‘if nothing more, to help craft a declaration which kept options open for her and her unborn child’ at [58].

¹⁴⁹ ibid at [12], [35]. Also, [5], [9], [43], [58]-[59].

¹⁵⁰ C n 6 above at [35].

¹⁵¹ See n 120-121 above.

¹⁵² C n 6 above at [15].

¹⁵³ ibid at [18].

¹⁵⁴ Section 1(6) of the MCA was also set out in full: ibid at [47].

¹⁵⁵ Great Western n 6 above at [16], [17], respectively.

¹⁵⁶ P n 6 above at [12]. Also, [14].

declaration ‘gives her a good chance of having a normal labour, but will provide her with safety if it were to be necessary’.¹⁵⁷ Similarly, in Great Western Hayden J evaluated the clinical alternatives ‘keeping her medical interests in focus’,¹⁵⁸ before concluding that delivering via caesarean section was in P’s best interests.¹⁵⁹ By contrast, psychiatric evidence was the basis of the best interests assessment in C and appears to have been in FG too. In that case, no medical reasons for intervening in the birth were included in the judgment but it does not seem that P’s physical health, or the foetus’, were at risk.¹⁶⁰ Rather, P’s mental health was of concern as she was refusing her medication, not co-operating with staff, and believed that the health teams were part of a conspiracy to kill her.¹⁶¹ Similarly, in C there were no medical risks to P of delivering vaginally, but her mental health condition meant that this mode of delivery would ‘be very difficult to manage safely’.¹⁶² It was thus in O’s best interests to deliver via caesarean section under general anaesthetic. This declaration was not, however, the end of the matter, and I discuss this further below.

In the remaining three cases, including the two most recently reported ones where anticipatory and contingent declarations were granted, the best interests assessments were based on both medical and psychiatric evidence.¹⁶³ In AA and CD, there were risks to P’s physical health if she delivered vaginally,¹⁶⁴ although in CD the consultant obstetrician and gynaecologist said that if the physical risks eventuated, ‘the risk to CD is mostly about the psychological impact of the emergency and the risk that her baby will be damaged/die’.¹⁶⁵ The idea that a healthy baby equals a (mentally) healthy mother is also present in AA and R,¹⁶⁶ but it is not clear from the case report in AA what P’s mental health status was at the time of the hearing, how it fed into the best interests assessment, and there is also no discussion or explanation for Mostyn J’s conclusion that delivering via caesarean section was in her best interests. In R, however, the

¹⁵⁷ ibid at [18].

¹⁵⁸ Great Western n 6 above at [16]

¹⁵⁹ ibid at [10].

¹⁶⁰ FG n 6 above.

¹⁶¹ ibid at [38], [40], [44], [45], [51].

¹⁶² C n 6 above at [4]. Also, [25]-[32].

¹⁶³ AA, CD, R.

¹⁶⁴ AA at [4]-[5]; CD at [3], [8], both n 6 above.

¹⁶⁵ CD n 6 above at [9]. Also, at [4].

¹⁶⁶ AA at [5]; R at [42], [63], both n 6 above.

physical risk was different, because it was uncertain how the foetus was presenting, although there was said to be a ‘real risk’ that a caesarean would be required ‘for the safe delivery of the baby’ but that P might not co-operate or might resist.¹⁶⁷ Thus, it is questionable whether the physical risks which were the concern of the court related to P or the foetus. I return to this in section c) below.

b) P’s beliefs, wishes and feelings

P’s beliefs, wishes and feelings are one of the matters set out in section 4 of the MCA that best interests decision-makers must consider, and they were included (to varying degrees) in five of the seven judgments.¹⁶⁸ For example, P’s wishes (to deliver naturally and only to have a caesarean in an emergency) were noted throughout the judgment in C, perhaps indicating that P’s view was towards the forefront of Theis J’s thinking. By contrast, in R Hayden J noted that P was clear that a caesarean would not be required but because the case came to court as an urgent application, the OS was unable to speak with her and so ‘it was not possible ... to achieve greater clarity as to her wishes and feelings’.¹⁶⁹ This is notable because Hayden J also stated that although the ‘identified wishes of P will not in and of themselves be determinative, they will always be given substantial weight and are highly likely to be reflected in the order or declaration the Court has to make’.¹⁷⁰

P’s wishes were not mentioned in the judgments in AA and Great Western and so section 4 (6)(a) of the MCA 2005 might not have been complied with in these cases. P’s wishes might not have been sought because her mental health status was such that it was not possible to ascertain her wishes. However, under section 4(4) the best interests decision-maker must ‘so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him’.¹⁷¹ It is not clear whether this occurred in these cases, and in AA there is no indication of P’s mental health status at the time the case was heard so it is not known whether supported

¹⁶⁷ R n 6 above at [4].

¹⁶⁸ P at [15]; FG at [36]; C at [4,] [16], [40], [41], [58]; CD at [7]; R at [4], [12], [56], [65], all n 6 above.

¹⁶⁹ R n 6 above at [58].

¹⁷⁰ *ibid* at [33].

¹⁷¹ For guidance see Charles J, Facilitating participation of ‘P’ and vulnerable persons in Court of Protection proceedings (2016) at https://www.familylaw.co.uk/docs/pdf-files/Practice_Guidance_Vulnerable_Persons.pdf (visited 13 May 2020).

decision-making was, in fact, possible. Given that the views of those around P were also not included in this judgment, as required by section 4 (7) and discussed below, the omission of P's wishes in AA is particularly concerning. By contrast, and also discussed below, in Great Western the views of others were known but P's views were not,¹⁷² and she could not be supported to make a decision or participate in the decision-making process because of her mental health status at the time of the application ('it was almost impossible to engage AA or indeed to gain her attention at all to discuss concerns with her').¹⁷³

In terms of the beliefs and values that would be likely to influence P's decision if she had capacity (section 4(6)(b)), and the other factors that P would be likely to consider if she were able to do so (section 4(6)(c)), these are harder to identify in the cases, but can, perhaps, be seen in the comments in Great Western concerning P's desire to be pregnant.¹⁷⁴ As this was described as 'a wanted baby in a supportive unit',¹⁷⁵ the implication is that that P would want to deliver as safely as possible – a not unreasonable assumption. While the desire to be pregnant was not explicitly noted in the other cases, this does not mean that this assumption was not operating in those cases too. Indeed, in all the post-MCA MHA cases the pregnancies were at or near-to-term and this could be seen as an important justification for delivering as medically indicated.

Furthermore, comments such as 'I would have thought it was in her best interests ... that her child should be born alive and healthy',¹⁷⁶ and 'there is no doubt at all that it would be in the best interests of Mrs. P for her baby to be safely delivered',¹⁷⁷ might also indicate an underlying idea that these were matters that would be 'likely to influence' P's decision if she had capacity, or could be an 'other factor' that she would be likely to consider if she were able to. Indeed, in R Hayden J said that 'the delivery of her healthy unborn baby will be an intrinsic factor' in a best interests assessment.¹⁷⁸ Given that at issue in these cases are the childbirth choices of women who are in labour or are near-to-delivering, the idea that they want or would

¹⁷² Great Western n 6 above at [5], [9].

¹⁷³ ibid at [20].

¹⁷⁴ ibid at [2].

¹⁷⁵ ibid at [16].

¹⁷⁶ AA n 6 above at [5].

¹⁷⁷ P n 6 above at [17].

¹⁷⁸ R n 6 above at [62]. Also, [63].

want to deliver a healthy child in as safe a way as possible appears uncontroversial. But if this is so, it is important to question the purpose of undertaking a best interests assessment at in this context.

c) Others' beliefs, wishes and feelings

As well as P's wishes, the views of others caring for or interested in P's welfare as to what is in her best interests and as to her past and present wishes and feelings, should also be taken into account under section 4(7) of the MCA. However, this only seems to have occurred in three of the post-MCA MHA childbirth cases, with the views of P's partner and her parents included in two of the judgments,¹⁷⁹ and CD was the only case to include the views of a nurse and P's Independent Mental Capacity Advocate (IMCA)/Independent Mental Health Advocate (IMHA).¹⁸⁰ Including the views of others in best interests assessments and in the judgments not only complies with the provisions of the MCA, but also helps to give a sense that it was recognised that P was not an isolated being, but was situated within a network of relationships.

By contrast, where the views of others were not included in the judgments,¹⁸¹ P then appears to be an isolated individual, with no or limited context to her particular circumstances provided - beyond the medical or psychiatric evidence referred to in the judgments. This is of concern because, as will be shown in section IV below, '[o]ur significant others can help us give full expression to who we are and what we want, or undermine it through not hearing, not respecting or dismissing what is meaningful and significant to us'.¹⁸² Ironically, this was recognised by Hayden J in R, even though there was no mention of P's others in that case.¹⁸³

In the childbirth cases where the views of others were not included, this may have been because P was single and/or without family or any support from friends, but if that was so then an IMCA or IMHA should have been appointed for her, as occurred in CD. However, there is no

¹⁷⁹ Great Western at [16]-[17]; C at [6], [16], [58], both n 6 above.

¹⁸⁰ CD n 6 above at [5]. For information on the role of an Independent Mental Capacity Advocate (IMCA), see MCA, ss 35-36, DCA n 96 above at ch 10, and on an Independent Mental Health Advocate (IMHA), see MHA, ss 130A-130E, Department of Health, Mental Health Act 1983 Code of Practice (London: TSO, 2015) at ch 6.

¹⁸¹ AA, P, FG, R.

¹⁸² C. Johnston, N. Banner and A. Fenwick, 'Patient narrative: An 'on switch' for evaluating best interests' (2016) 38 Journal of Social Welfare and Family Law 249 at 253.

¹⁸³ R n 6 above at [66].

indication in these judgments that this possibility was explored. Yet, if P is not able to express views herself, it may be even more important that the views of those around her are sought, but this, of course, is not unproblematic. For example, the putative father could use this as a way of prioritising his wish to be (or not to be) a father, and, relatedly, his sense of the importance/value of the life of the foetus/baby, rather than presenting the views of P. Jonathan Herring has suggested that in any caring relationship it might be difficult to disentangle the interests of the care-giver and cared-for;¹⁸⁴ likewise, Hayden J has recognised that there is always a risk that the person consulted represents their own views and not those of P when they are asked what P's views are and/or were.¹⁸⁵

As with the pre-MCA childbirth cases, the presence of the 'unborn child'/'unborn baby',¹⁸⁶ and/or the 'foetus'¹⁸⁷ in all of the post-MCA MHA childbirth judgments is in marked contrast to the largely absent voices of those close to P about P's views. Of particular note are some of the comments made in the cases heard in 2019 where P had capacity and anticipatory and contingent declarations were sought. In CD, Francis J included the 'unborn child' in his best interests assessment and said that that it was 'common ground that every possible step should be taken to act in the best interests of CD and to promote her welfare and, as part of that process, to protect her unborn child'.¹⁸⁸ P's welfare was thus inextricably linked to that of the foetus. And in R, Hayden J said that 'risk to the health or life of the unborn child is ... rarely likely to be in the mother's best interests'.¹⁸⁹ In some respects these are not surprising statements, as we are concerned with women who are in labour or are near-to delivering and so it is not unreasonable for the foetus to remain within the view of the court. At the same time, the

¹⁸⁴ J. Herring, 'Losing it? Losing what? The law and dementia' (2006) 21 Child and Family Law Quarterly 3.

¹⁸⁵ Abertawe Bro Morgannwg University Local Health Board v RY and CP [2017] EWCOP 2 at [38]. Also, Justice Baker, 'A matter of life and death' (2017) 43 Journal of Medical Ethics 427 at 432; M. Donnelly, 'Best interests in the Mental Capacity Act: Time to say goodbye?' (2016) 24 Medical Law Review 318; H. Taylor, 'What are "best interests"? A critical evaluation of "best interests" decision-making in clinical practice' (2016) 24 Medical Law Review 176.

¹⁸⁶ 'Child' – AA at [1], [4]-[5]; P at [17]; C at [6], [8], [10], [16], [35], [58], [63]; CD at [4]; R at [42], [56], [58], [67]. 'Baby' – Great Western at [15], [19]; FG at [50], [53]; C at [6], [58]; CD at [4]-[6], [8]-[9], [13], [16]; R at [16], [59]-[62]. All n 6 above.

¹⁸⁷ Great Western n 6 above at [10], [15].

¹⁸⁸ CD n 6 above at [4], emphasis added. Also, [16] iii).

¹⁸⁹ R n 6 above at [42].

difference between its presence in the judgments and decision-making processes, and P's views and/or those of others around her are marked, given the requirements in section 4 of the MCA.

D Summary of the post-MCA position

It appears that the guidelines from the earlier childbirth cases and the MCA have had an impact on the post-MCA MHA childbirth cases. Only two of the latter cases came to court as urgent,¹⁹⁰ and P's capacity was assessed in all five cases where it was in issue,¹⁹¹ with that assessment undertaken by a psychiatrist in all but one of the cases.¹⁹² However, the statutory presumption of capacity was only noted in three of the seven cases.¹⁹³ The approach to the capacity assessment is particularly notable in one of those cases (C), where Theis J held that P's capacity was to be kept under review, despite granting the declaration sought. In this way, the reality of P's fluctuating mental health status was recognised.

In terms of the best interests assessments, P's beliefs, wishes and feelings were noted in all of the judgments, apart from the two urgent cases where capacity was at issue.¹⁹⁴ By contrast, the voices of others close to P were only included in two cases,¹⁹⁵ with the opinion of the IMCA/IMHA reported in CD; however, the foetus retains a constant presence in all of the post-MCA MHA childbirth cases. Medical factors (including psychiatric interests) continue to dominate best interests assessments. Having said that, in one case Hayden J took account of a number of matters in determining P's best interests, including her present circumstances, how she had acted in the past, and the views of others.¹⁹⁶ And in C, a recurrent theme was keeping P's situation under review, in consultation with those close to her.¹⁹⁷ Thus, different approaches to best interests assessments are possible but not common.

IV Best interests assessments in other health cases

¹⁹⁰ AA, Great Western.

¹⁹¹ Capacity was not in issue in CD or R.

¹⁹² FG.

¹⁹³ FG, P, C.

¹⁹⁴ AA, Great Western.

¹⁹⁵ Great Western, C.

¹⁹⁶ Great Western n 6 above at [7], [16].

¹⁹⁷ C n 148-149 above.

It is interesting that this is where an analysis of the post-MCA MHA childbirth cases leaves us because very different approaches to best interests assessments are identifiable in many other post-MCA health cases heard between 2014 and 2019.¹⁹⁸ For example, the importance of and weight to be attached to P's wishes, beliefs and feelings have been highlighted in other health post-MCA cases, including Wye Valley NHS Trust v B.¹⁹⁹ In this case, P was under the remit of the MHA 1983 and refusing a life-saving foot amputation. Notably, and because of 'the momentous consequences of the decision', Jackson J visited P in hospital in order to determine his wishes and he linked this with the duty to permit or encourage P's participation in section 4(4) of the MCA.²⁰⁰ This requirement to enable decision-making was also unusually directly addressed in University Hospitals of Derby and Burton NHS Foundation Trust v J, where Williams J held that because of P's learning disability '[t]here is no means by which she could currently be enabled to make a decision'.²⁰¹

In Wye Valley, Jackson J also said that it was 'of great importance' to give 'proper weight' to P's wishes, feelings, beliefs and values, and that the weight to be given to them would be case-specific and would vary.²⁰² Similar comments have been made in other health cases,²⁰³ and in A Clinical Commissioning Group v P and TD, MacDonald J, referring to Wye Valley, stated that if P's 'present wishes can be ascertained with reasonable confidence, they should not be undervalued'.²⁰⁴ And in a non-MCA case, Sir James Munby P said that '[a] child or incapacitated adult may, in strict law, lack autonomy. But the court must surely attach very

¹⁹⁸ For discussion of best interests under the MCA and a proposal to introduce rebuttal presumptions to guide decision-makers in their assessments, see E. Jackson, 'From "doctor knows best" to dignity: Placing adults who lack capacity at the centre of decisions about their medical treatment' (2018) 81 MLR 247.

¹⁹⁹ Wye Valley NHS Trust v B [EWCOP] 60.

²⁰⁰ ibid at [18]. For discussion of this decision see L. Series, 'The place of wishes and feelings in best interests decisions: Wye Valley NHS Trust v Mr B' (2016) 79 MLR 1101. COP judges have also met P in other health cases including in Imperial College Healthcare An NHS Trust v MB and Others [2019] EWCOP 30; A Local Authority v P, the NHS Trust and A Family Member [2018] EWCOP 10. For discussion of judges meeting P, see Case n 11 above.

²⁰¹ University Hospitals of Derby and Burton NHS Foundation Trust v J (Medical treatment: Best interests) [2019] EWCOP 16 at [30].

²⁰² n 199 above at [10], emphasis added.

²⁰³ Including Sheffield Teaching Hospitals NHS Foundation Trust v TH and TR [2014] EWCOP 4; A Clinical Commissioning Group v P and TD [2019] EWCOP 18.

²⁰⁴ A Clinical Commissioning Group n 203 above at [46 (ii)].

considerable weight indeed to the albeit limited qualified autonomy of a mother who in relation to a matter as personal, intimate and sensitive as pregnancy is expressing clear wishes and feelings, whichever way, as to whether or not she wants a termination'.²⁰⁵ All of these statements apply equally to women who are within the remit of the MHA and are in labour or close to delivering, and yet there is no sense in any of those decisions that P's views were deemed to be of great value or that she should meet the judge in order for her views to be ascertained.

Going further, in a number of cases the importance of seeking evidence of P's views from those who know her best has been emphasised. For example, in Sheffield Teaching Hospitals NHS Foundation Trust v TH and TR,²⁰⁶ P was in a minimally conscious state and at issue was whether he should be transferred from hospital to a specialist nursing home. P's ex-wife (TR) opposed this, as did his longstanding friend (GM), who wanted to care for him at home. TR told the court that P would 'loathe his present situation' and that 'he would find it a violation of his dignity'.²⁰⁷ Having heard from TR and GM in court, Keehan J said that 'it became clear ... what TR really wanted to do was to ensure that TH's voice was heard in this court room with her as the conduit for it'.²⁰⁸ TR was clear that P 'wishes to die, preferably as quickly and as painlessly as possible' and while she was in 'no doubt' that these were his wishes, they were not hers because she 'was "not ready to let him go", but she would be failing him, she thought, if she did not communicate what she was confident were his views to the court'.²⁰⁹ In his judgment, Keehan J highlighted P's presence in the courtroom because of TR's and GM's evidence,²¹⁰ and said that as P's friendships were 'enduring, faithful and lifelong', TR and GM were 'particularly qualifie[d] ... to convey to me TH's own authentic voice'.²¹¹ Indeed, 'If ever a court heard a holistic account of a man's character, life, talents and priorities it is this court in this case. Each of the witnesses has contributed to the overall picture and I include in that

²⁰⁵ In the matter of X (A child) [2014] EWHC 1871 (Fam) at [10], emphasis added.

²⁰⁶ Sheffield Teaching Hospitals n 203 above.

²⁰⁷ ibid at [8], emphasis in original.

²⁰⁸ ibid.

²⁰⁹ ibid.

²¹⁰ ibid at [38].

²¹¹ ibid at [39]. For similar sentiments see Briggs v Briggs, The Walton Centre NHS Trust and Wirral Clinical Commissioning Group [2016] EWCOP 53; M v Mrs N and others [2015] EWCOP 76; Re D [2012] EWHC 885 (COP).

the treating clinicians, whose view of TH seems to me to accord very much with that communicated by his friends'.²¹²

The importance of being 'rigorous and scrupulous in seeking out what P's views would have been', including via 'evidence from relatives and those who have cared for her about her wishes and feelings which may assist the Court to understand P as a person', was emphasised by MacDonald J in A Clinical Commissioning Group v P and TD.²¹³ And in Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG and Another, Cohen J agreed that, amongst other things, P's husband's and children's views on what P would have wanted constituted 'compelling evidence' that although in a vegetative state, P would want intubation to continue,²¹⁴ even though the health professionals thought that this was not beneficial.

Finally, the Court of Appeal's decision in Re AB (Termination of Pregnancy) is important because the Court discussed (and criticised) the issues raised by best interests assessments discussed in sections II and III above. In this case, P was described as having 'moderate learning disabilities', was over 22 weeks pregnant,²¹⁵ and her mother (CD) was 'implacably opposed' to a termination, with P having 'indicated on occasions that she likes the idea of having the baby'.²¹⁶ Lieven J held that it was in P's best interests to terminate the pregnancy, that her wishes and feelings were 'plainly a relevant consideration' but were not 'clearly expressed' and that P had 'no sense of what [it] means' to have a baby.²¹⁷ Given this, Lieven J could not 'give very much weight to those expressions of wishes and feelings', but if she

²¹² Sheffield Teaching Hospitals n 203 at [53]. Also PL v Sutton Commissioning Group and The Royal Borough of Kingston on Thames [2017] EWCOP 22; Salford Royal NHS Foundation Trust v Mrs P and Q [2017] EWCOP 23; Cumbria NHS Clinical Commissioning Group v S, D and T [2016] EWCOP 32; United Lincolnshire Hospitals NHS Trust v N [2014] EWCOP 16. On character in best interests determinations in minimally conscious state cases, see G. Birchley, '... What God and the angels know of us?' Character, autonomy, and best interests in minimally conscious state' (2017) 26 Medical Law Review 392.

²¹³ A Clinical Commissioning Group n 203 above at [46](ii).

²¹⁴ Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG and Another [2019] EWCOP 21 at [25]. Also, [24].

²¹⁵ Re: AB (Termination of Pregnancy) [2019] EWCA Civ 1215 at [1], [15].

²¹⁶ ibid at [2], [45]. Also, [51]-[52].

²¹⁷ An NHS Foundation Trust v AB and CD [2019] EWCOP 26 at [60].

thought P ‘had any understanding (albeit non-capacious ones) of the consequences of giving birth’ she would give them ‘a great deal of weight’.²¹⁸

Despite this, the Court of Appeal overturned Lieven J’s decision because she had not taken ‘sufficient account’ of P’s wishes and feelings in the best interests assessment,²¹⁹ nor had she included ‘the statutory consideration of the views of a carer’ in her list of matters that she identified as being relevant.²²⁰ Lieven J was ‘in error in failing to make any reference in her ultimate analysis to CD’s views about AB’s best interests when, the judge found, she knew AB better than anyone and had her best interests at heart’.²²¹ She also failed to give any weight to the opinions of P’s social worker or the OS,²²² and although she had ‘the expert evidence of the psychiatrists on the one hand and the views of those who know AB best on the other ... she did not weigh them up, one against the other’.²²³ It was ‘a significant omission’ not to mention P’s wishes and feelings, CD’s views, and those of the social worker and the OS.²²⁴ Ultimately, the Court held that Lieven J’s decision as to P’s best interests was ‘substantially anchored in the medical evidence ... that medical evidence, without more, did not in itself convincingly demonstrate the need for such profound intervention’,²²⁵ but ‘she gave inadequate weight to the non-medical factors in the case’.²²⁶ As well as mirroring the issues identified in other health post-MCA cases, these comments also echo some of the sentiments recognised by the Law Commission and in the House of Lords Select Committee’s report.²²⁷

V Concluding thoughts

²¹⁸ *ibid.*

²¹⁹ *Re: AB* n 215 above at [55].

²²⁰ *ibid* at [63].

²²¹ *ibid* at [64].

²²² *ibid* at [65], [67].

²²³ *ibid* at [66].

²²⁴ *ibid* at [75].

²²⁵ *ibid* at [73].

²²⁶ *ibid* at [79].

²²⁷ See n 4 and n 2 above.

Given the potential and enabling possibilities of the MCA 2005 and the fact that best interests assessors in other contexts have embraced at least some of these possibilities,²²⁸ it is disappointing that an holistic approach to these assessments, as mandated by the Supreme Court in Aintree,²²⁹ is not identifiable in the majority of the post-MCA MHA childbirth cases. The sample may be small (seven cases reported in eight years), but there is little sense of change or movement between the decisions in terms of the approach adopted to best interests assessments. If anything, the latest decisions (CD and R), which utilised anticipatory and contingent declarations for capacitous pregnant women, engender more not less concern.

Furthermore, in Tracey v Cambridge University Hospitals NHS Foundation Trust, the Court of Appeal held that health professionals have a duty to consult patients regarding decisions being made about them.²³⁰ Jonathan Montgomery has suggested that this could be seen as ‘a recasting of what respect for people’s rights requires – a move away from the transfer of information towards the opportunity to participate’.²³¹ This might hold true in other contexts but there is little evidence of it in post-MCA MHA childbirth cases, which is concerning because by explicitly including P’s preferences in best interests assessments, the MCA expressly introduced a subjective element into the objective assessment.²³² Having said that, applying the provisions of the Act to post-MCA MHA childbirth cases seems pointless if doing so will only lead to one conclusion – that delivering in the way recommended by the health professionals is necessarily in P’s best interests regardless of her wishes. And the evidence-to-date is that this is the likely result.

²²⁸ Reaching this conclusion in relation to P’s wishes and feelings see A. Ruck Keene and C. Auckland, ‘More presumptions please? Wishes, feelings and best interests decision-making’ (2015) 3 Elder Law Journal 293 at 299.

²²⁹ See n 108-111.

²³⁰ Tracey v Cambridge University Hospitals NHS Foundation Trust [2014] EWCA Civ 822. Also, Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB).

²³¹ J. Montgomery, ‘Patient no longer? What next in healthcare law?’ (2017) 70 Current Legal Problems 73 at 102.

²³² Donnelly n 112 above at 209.

One response could be that just because the health professionals' views have dominated so far, that does not mean that consulting P is pointless.²³³ Another could be that if P wishes to deliver a live and healthy baby, as she is likely to if she has reached or nearly reached her due date, then it does not matter whether a judge explicitly links their decision to her wishes and feelings. Of course, including P's wishes and feelings in a judgment does not mean that applying the best interests test is worthwhile, because '[c]ontrol remains with whoever is taken to be the authoritative interpreter of the person's wishes. This is not the person themselves. It is a wide range of professionals and, ultimately, a judge'.²³⁴ And if the key driver in the decision-making process is, as it appears to be, to approve the best way to secure the safe birth of a child, then medical interests will (always) dominate.

Others should also be consulted for their views about P's best interests, where it is practicable and appropriate to do so, and if this does not occur then the defence in section 5 of the MCA (that the decision-maker reasonably believes it will be in P's best interests for the act to be done) cannot be relied on.²³⁵ Section 4(9) would also not be complied with.²³⁶ A claim of battery and breach of Article 8 could thus be brought, because 'best interests is no defence to battery if the best interests decision was not reasonable because they or others were not properly consulted'.²³⁷

²³³ On the importance of involving P in decisions, particularly being involved in court proceedings, see J. Lindsey, 'Testimonial injustice and vulnerability: A qualitative analysis of participation in the Court of Protection' (2019) 28 *Social and Legal Studies* 450.

²³⁴ P. Skowron, 'The relationship between autonomy and adult mental capacity in the law of England and Wales' (2019) 27 *Medical Law Review* 32 at 52, reference removed.

²³⁵ *Winspear* n 230 above.

²³⁶ MCA, s 4(9): 'In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned', emphasis added. See DCA n 96 above at para 5.9: 'Section 4(9) confirms that if someone acts or makes a decision in the reasonable belief that what they are doing is in the best interests of the person who lacks capacity, then - provided they have followed the checklist in section 4 - they will have complied with the best interests principle set out in the Act', emphasis added.

²³⁷ E. Cave and C Purshouse, 'Think of the Children: Liability for non-disclosure of information post-*Montgomery*' (2020) *Medical Law Review*. Advance access at <https://doi.org/10.1093/medlaw/fwz023> (visited 13 May 2020).

While the post-MCA MHA childbirth cases show the ‘immense flexibility’ of the best interests standard, this flexibility has allowed ‘the indirect protection of the foetus’.²³⁸ Indeed, ‘despite the participative approach adopted by the Mental Capacity Act, the courts and doctors concerned have consistently diminished the value of the woman’s known wishes, demonstrating the low level of importance generally attributed to the subjective elements of the best interests determination’.²³⁹ Commenting on the childbirth cases in the 1990s, Margot Brazier suggested that, ‘[t]he way is left open to establish in a great many cases where women and doctors disagree about childbirth that the woman was incompetent so that what others consider her interests and her child’s interests require can lawfully be done’.²⁴⁰ We seem to be going even further now – where a woman has capacity and has a history of mental ill-health, then we can put in place provision to act in the event that she no longer has capacity during labour. And how might this be evidenced? - perhaps by her disagreement with medical advice. As best interests are conceptualised in terms of safe birth of the foetus, ‘it is almost unthinkable that obstetric intervention will not be authorised when the woman is deemed to lack the capacity to decide for herself and her clinicians are advocating intervention: the protection of the woman (and thereby the protection of the foetus) are prioritised over her autonomy’.²⁴¹ Indeed, the post-MCA MHA childbirth cases support Teresa Baron’s contention that ‘When foetal outcomes are the central concern of health professionals, the pregnant woman is no longer the primary patient. Often women’s autonomy is overlooked, and their subjectivity and active role in the birth process is seen as, at best, an inconvenience for the doctor “managing” their labour, and at worst, an obstacle to the safe delivery of the infant’.²⁴²

In the light of all of this, I reluctantly find myself returning to the conclusion of my case note on *Re MB* in 1998 that while foetal protection was not necessarily unwelcome, ‘when it occurs without an open and honest discussion, there is an uneasy feeling that a hidden agenda is being

²³⁸ S. Halliday, Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention (Oxford: Routledge, 2016) at 88.

²³⁹ ibid at 89.

²⁴⁰ M. Brazier, ‘Hard cases make bad law?’ (1997) 23 Journal of Medical Ethics 341 at 343.

²⁴¹ Halliday n 238 above at 90.

²⁴² T. Baron, ‘Nobody puts baby in the container: The foetal container model at work in medicine and commercial surrogacy’ (2019) 36 Journal of Applied Philosophy 491 at 498.

pursued, with the regulation and policing of pregnant women the ultimate goal'.²⁴³ Until the decision in CD, laws' focus appeared to be on the childbirth choices of women with a history of mental ill-health. However, the use of anticipatory declarations in CD, and in R, means that nearly 30 years after the decision in Re S, childbirth choices of all pregnant women (regardless of their capacity) may again be at risk of challenge.²⁴⁴

²⁴³ S. Fovargue, 'Re MB [1997] 8 Med LR 217, CA' (1998) 20 Journal of Social Welfare and Family Law 427 at 436, emphasis added.

²⁴⁴ Fovargue n 134 above.