**Negotiating the Domain of Mental Capacity: Clinical Judgement or Judicial Diagnosis?**

**Abstract**

‘*The decision on capacity is one for the judge to make’*.[[1]](#footnote-1)

Deciding whose voices matter in the assessment of someone’s decision making capacity raises issues of social and legal policy. Despite legal judgments explicitly asserting that the law has the upper hand in mental capacity assessment, both statute and judgments from the Court of Protection have to some extent endorsed capacity as largely the domain of medical expertise. Academics have claimed that the courts have historically adopted a ‘deferential’ or even ‘medicalised’ approach to expert evidence on this issue. Yet it is vital that the Court of Protection exercises rigorous scrutiny of capacity assessment, for whilst human rights discourse constructs ‘objective medical expertise’ as a safeguard against the arbitrary forfeiture of decision making power, excessive deference can transform medical opinion from safeguard to a form of arbitrariness in its own right. This short socio-legal study combines quantitative and qualitative approaches to probe this suggestion of deference, drawing from a sample of over 60 Court of Protection judgments where the issue of capacity was examined in some detail. In the course of undertaking this task, the paper interrogates the notions of ‘deference’ and ‘medicalisation’ to explore the intertwining of medical and legal domains on the issue of mental capacity.

**Introduction**

Mental capacity is a social construct[[2]](#footnote-2) which does not belong exclusively to any particular discipline, whether law, sociology, philosophy or medicine. Yet a number of academics have hinted that they perceive a deferential approach by the courts to the opinion of medical experts when dealing with the issue of decision making capacity. Professor Donnelly, for example, has observed that *‘*[i]n the case law prior to the [Mental Capacity Act 2005], when uncontradicted expert evidence was presented to the court, the court’s ultimate decision almost invariably accorded with that of the medical expert.*’*[[3]](#footnote-3)The broad aim of this article is to interrogate the suggestion that the concept of mental capacity has been treated as part of the medical domain in cases which have been brought before the Court of Protection (‘CoP’).[[4]](#footnote-4) First, the paper outlines the importance of assiduous scrutiny of assessments that ‘P’ (as the protected party in these proceedings is known) lacks decision making capacity in the context of decisions about her health or welfare.[[5]](#footnote-5) This provides the backdrop to a ‘black letter’ analysis of the statutory test for incapacity, with particular attention being paid to the role given to medical evidence, before examining judgments from the CoP. The paper concludes by assessing the utility of the concept of medicalisation in understanding how the concept of capacity is constructed in the courtroom and underscoring the implications of overreliance on psychiatry, or indeed any discipline, in the business of assessing capacity. These conclusions include an observation of the need to embrace epistemic diversity on this issue – a finding which is potentially incompatible with the drive towards increased efficiencies in the CoP, in particular by reducing the number of experts or even relying on a single joint expert. First, however, it is necessary to outline the significance of findings on whether P has mental capacity to make health and welfare decisions.

**A. The Magnitude of Legal Determinations on Mental Capacity**

The Mental Capacity Act 2005 (‘MCA’) governs decision making for those without capacity and provides the principles for determining how capacity is assessed. The MCA is based on a binary model, whereby those *with* capacity have a robust right to decide for themselves which is fiercely protected[[6]](#footnote-6), and those judged *not* to have capacity are subjected to a regime of decision making by others according to P’s ‘best interests’[[7]](#footnote-7). The arguments for the law adopting a rigorous, robust approach to capacity assessment which embraces ‘epistemic diversity’[[8]](#footnote-8) (used here to mean an inclusive approach drawing from the evidence and perspectives of non-medics and also non-experts, such as P and P’s family) hardly needs stating. A finding that P lacks the capacity to make decisions for themselves on medical treatment, residence or care is of grave and sometimes devastating import. In legal terms, a determination of *incapacity* is the trigger for exposing P to decision making by others and to the powers of the CoP which, in the words of Justice Hedley, can be ‘invasive and draconian’[[9]](#footnote-9), as they can include, for example, the authorisation of detention, sedation or other forms of restraint or force whilst treatment or care is provided.[[10]](#footnote-10) In this respect, a finding of incapacity has been usefully described as a ‘cliff edge off which one falls into the clinging embrace of paternalism’.[[11]](#footnote-11)

The import of a finding of incapacity therefore requires that the capacity/incapacity boundary must be vigilantly patrolled. Suggestions that the assessment of capacity has been medicalised provoke real concern, not least because of the tendency of medical opinion to be portrayed as objective fact, leaving little room for argument and reducing the scope for challenge.[[12]](#footnote-12) Foster and Miola argued recently that in respect of key issues in medical law where the nature of the decision is ethical, ‘the law is not just entitled but is obliged to be the final arbiter.’[[13]](#footnote-13) It is argued here that mental capacity assessment occupies one of these primarily ‘ethical’ domains. It is not ‘purely technical’; its position as a process which suspends P’s decision making autonomy and opens the door to ‘best interests’ decision making by professionals means that the issue of P’s capacity will very often comprise value judgements,[[14]](#footnote-14) inevitably informed by the decision maker’s perspective on where the line between protecting P’s autonomy and surrendering P to ‘best interests’ decision making should be drawn.

A finding that P lacks mental capacity which then forfeits P’s right to make her own decisions has human rights dimensions. It can constitute an interference with her Article 8 rights to respect for ‘privacy and family life’ under the European Convention of Human Rights (ECHR). Whilst it is rare for the CoP to explicitly reference Article 8 in its judgments, it is clear that the jurisprudence of Article 8 underpins P’s right to self-determination.[[15]](#footnote-15) Imposing medical treatment or decisions about where P should live and receive care without P’s consent can violate her Article 8 rights.[[16]](#footnote-16) Article 8 jurisprudence emphasises that the boundary between capacity and incapacity is to be subject to strict scrutiny (such scrutiny presumably to be proportionate to the interests at stake) and the denial of capacity should be reserved for ‘exceptional circumstances’.[[17]](#footnote-17)

Allegations of deference in capacity assessment take on even greater significance in light of the UK’s commitments under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Although the Convention is not currently incorporated into domestic law, the UK is a signatory which signals a pledge to develop our legal frameworks in a way which better protects Convention rights.[[18]](#footnote-18) The CRPD has also been referenced as an aid to construction of the ECHR.[[19]](#footnote-19) Article 12(2) of the CRPD expresses the principle of universal legal capacity which requires that persons with disabilities should ‘enjoy legal capacity on an equal basis before the law’. Legal capacity exists at two levels; ‘legal standing’ (referring to being recognised as a person before the law as a holder of rights and duties) and ‘legal agency’ (meaning the ability to exercise those rights).[[20]](#footnote-20) The concept of ‘legal capacity’ is therefore distinct from that of ‘mental capacity’. CRPD *General Comment No. 1* includes a resounding rejection of medical models of capacity. Paragraph 14 disapproves of attempts to equate legal capacity with mental capacity, observing of the latter that it is not ‘as is commonly presented, an objective, scientific and naturally occurring phenomenon’ but rather mental capacity is ‘contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.’[[21]](#footnote-21) This suggests that heavy reliance on medical opinion to determine capacity conflicts with CRPD values, in that it further entrenches a medical model of capacity which the CRPD regards as inherently discriminatory.[[22]](#footnote-22) It also suggests that the future of the concept of mental capacity in UK law is precarious. There are signs that CoP jurisprudence is inching closer to CRPD principles by a deliberate ‘softening’ of the mental capacity/incapacity distinction. To this end, a number of judgments have signalled greater importance being attached to P’s wishes and feelings in the ‘best interests’ calculation,[[23]](#footnote-23) and mental incapacity is not to be treated as ‘an off switch for P’s rights and freedoms.’[[24]](#footnote-24) However, many view the CRPD as requiring a more radical deconstruction of the binary MCA framework and a jettisoning of the concept of mental capacity as we know it.[[25]](#footnote-25) Such radical reshaping of medical law is unlikely to be imminent,[[26]](#footnote-26) and in the meantime the judiciary is tasked with the job of remoulding existing structures so as to bring them closer to CRPD values such as non-discrimination against those with physical or mental disabilities.[[27]](#footnote-27)

The first step in identifying whether the construction of capacity in the courtroom has been medicalised is to explore how the law defines incapacity and to what extent, if at all, medical expertise is given prominence in the application of this test. The answer to this question will vary from case to case, but it is nonetheless possible to broadly specify general principles regarding the epistemic competence of medicine on the issue of capacity assessment.

**B. Negotiable Spaces in the Business of Mental Capacity Assessment and the Prominence of Clinical Judgement**

Although the health and welfare cases which come before the CoP give rise to issues of ECHR and CRPD compliance, CoP judgments generally engage explicitly only with domestic law. The MCA sets out the ‘intellectual framework’[[28]](#footnote-28) for assessing mental capacity, but is silent on whose evidence matters in the cases which come before the CoP. As such, the Act generates substantial negotiable territory regarding how its provisions are to be interpreted and applied. The starting point is the presumption that P has decision-making capacity.[[29]](#footnote-29) The universality of this starting point is a crucial device in combating discrimination against those with disabilities. Thereafter, sections 2 and 3 of the Act set out the test to be applied where P’s capacity has been called into question. Starting with s.2(1), a person lacks capacity if they are ‘unable to make a decision’ on the issue at hand and that ‘inability’ is caused by an ‘impairment or disturbance of the mind or brain.’ The ‘functional’ criteria for being ‘unable to decide’ for the purposes of s.2 are unpacked in s.3(1) and require the identified ‘impairment or disturbance’ to cause P to be unable to do one of the following: *understand* the information relevant to the decision; *retain* that information; *use or weigh* the information to arrive at a decision or *communicate* the decision.

*‘Stage 1’ – the diagnostic threshold –* In requiring an identifiable ‘impairment or disturbance’ of mental function as a separate requirement from characteristics manifesting an inability to decide, the MCA introduced what is known as a ‘diagnostic threshold.’ The MCA *Code of Practice* identifies this ‘diagnostic threshold’ as ‘stage 1’ in the process of assessing P’s capacity.[[30]](#footnote-30) It will *usually* (but not always) be the case that the identified ‘impairment or disturbance’ is constituted by the diagnosis of a condition (whether mental disorder, learning disability or brain damage).[[31]](#footnote-31) The inclusion of this diagnostic component, and its positioning as ‘stage 1’ of the process might be predicted as encouraging a deferential approach to medical evidence. Certainly, medical evidence is generally conclusive on the impairment issue. Once P is regarded as suffering from an impairment (based on the medical evidence) the inclination to pathologise aspects of P’s behaviour and assume that P lacks capacity because of that impairment is strong. The judgment in *Re AA* where Mostyn J confessed to be ‘struggling to envisage a circumstance where a patient detained under section 3 [of the Mental Health Act 1983] as an inpatient with a diagnosed mental illness has gotcapacity’ (sic) would seem to lend some substance to this prediction.[[32]](#footnote-32) These dangers are also identified by Sir Nicholas Wall in *RT v LT & Anor* where he references the tendency to assume that incapacity follows pathology as ‘the trap.’[[33]](#footnote-33) If the non-discrimination provisions of the CRPD are to be achieved, it is vital that the courts demonstrate resilience in resisting the inclination to pathologise the decisions of anyone who meets ‘stage one’ of the test. Otherwise, the non-discriminatory potential of the presumption of capacity is lost.

In the domain of unfitness to plead in criminal cases, the Law Commission recently concluded that a statutory test modelled on the MCA should be introduced but refused to endorse the inclusion of a diagnostic threshold.[[34]](#footnote-34) This seems to have been at least in part due to the objections of a number of consultees commenting on its potentially discriminating effects and consequent incompatibility with the principle of universal legal capacity in the CRPD.[[35]](#footnote-35)

*‘Stage 2’ – the functional criteria -* Although ostensibly descriptive, these criteria, particularly the requirement that P must be able to ‘use’ and ‘weigh’ the information to reach a decision, necessarily involve a degree of normative judgement in their application.[[36]](#footnote-36) Thus, although the judges regard the tests as ‘clear,’ Foster identifies a host of questions arising in the consideration of s.3 alone.[[37]](#footnote-37) These questions leave ample room for competing interpretations and space for negotiation as to the exact meaning and proper application of the concept of capacity.

The ‘functional’ criteria are identified in the MCA *Code of Practice* as ‘stage 2’ of assessing capacity, and it is in this negotiable space that the CoP has been eager to claim supreme authority. Speaking of the functional criteria, Munby J (as he then was) in *A Local Authority v A* observed: ‘*only the court has the full picture. Experts are neither able nor expected to form an overview.’*[[38]](#footnote-38) These sentiments were reiterated by Baker J in *ST v CC* with the words‘…it is the court alone that is in the position to weigh up all the evidence as to the functional test and thus it is the court that must make the ultimate decision’[[39]](#footnote-39) and were later echoed in *London Borough of Islington v QR* in the assertion that ‘[t]he decision on capacity is one for the judge to make’.[[40]](#footnote-40) These dicta clearly recognise that mental capacity should *not* be treated as falling exclusively within the medical domain and that the court is the ultimate arbiter on this issue. Nevertheless, the evidence of psychiatrists is generally sought not only on whether P is affected by impairment, but also on whether the functional criteria have been fulfilled.[[41]](#footnote-41)

*Causation: the ‘inferential gap’ -* Describing the tests by reference to ‘stages’ 1 and 2 has served to underplay a key component of capacity assessment, namely the necessity of demonstrating that the impairment is *causing* the ‘inability to decide.’[[42]](#footnote-42) This causal component of the test for incapacity represents further negotiable territory, which might be thought to sit within psychiatry’s area of expertise. Long before the MCA was passed, Silberfeld and Checkland identified a shortage of relevant expertise on the causal dimensions of incapacity.[[43]](#footnote-43) Their paper referred to this problem as ‘the inferential gap;’ psychiatry’s expertise generally lay in the area of which therapies worked for which mental health problems, but was ill-equipped to answer whether an identified mental illness was truly responsible for a particular style of decision making.[[44]](#footnote-44) In the absence of any real expertise on this aspect of capacity, assessors must draw an inference as to whether P’s apparently flawed decision making is *caused by* their impairment.

The case of *Re M* provides a useful example of how important the causal nexus is, whilst also highlighting the dangers of deferring to medical evidence too readily.[[45]](#footnote-45) M, a 67 year old woman wishing to return home to her bungalow from a care home, was judged to lack capacity on the issue of her residence. The judgment relied heavily on the evidence of an independent psychiatrist that she was suffering from ‘mild depression’ (as evidenced by her being prescribed anti depressants) and that she was ‘unable to make a decision’ because her inability to appreciate her personal limitations meant that she had unreasonable expectations of being able to manage her physical illness (diabetes) at home. On the face of it, this judgment appears flawed on a number of fronts. In relying on ‘mild depression’ as the ‘impairment’ required for s.2(1), M was ensnared in a ‘catch 22.’ Anyone being told, as M was, that she could not return home to be with her partner of 30 years, but would need to move to residential care, would likely become mildly depressed. Moving on from the diagnostic threshold, Justice Peter Jackson stated that M was ‘unable to make a decision’ under s.3(1)(c) because:

*‘...a central component in that decision is an appropriate appreciation of the risks arising from the lower level of supervision of her diabetes management that a home placement entails compared with 24-hour professional oversight. M has an inflexible but mistaken belief that she can manage her own diabetes and consequently cannot weigh up the serious risks involved in a reduction in the level of supervision.’[[46]](#footnote-46)*

This assessment does not appear to comply with the MCA tests, and the disproportionate impact of the diagnosis rather than M’s decision making processes would seem to be in conflict with ECHR and CRPD principles. In particular, the scrutiny required where capacity is denied ought to be proportionate to the interests at stake. Yet there was scant evidence of any causal connection between M’s ‘impairment’ (mild depression) and her identified ‘inability to decide’ (inability to appreciate the risks of returning home).[[47]](#footnote-47) This looked like a clear case of M exercising her right to make an unwise decision,[[48]](#footnote-48) or minimising the risks to avoid the appearance of conceding territory in a disagreement about her care, rather than a decision affected by an inability to process the relevant information. What makes the outcome here seem even more anomalous, is the fact that the judgment accepted M’s decision making capacity was not affected in any other area of her life.[[49]](#footnote-49)

The prominence afforded to the diagnostic threshold suggested by the MCA Code of Practice facilitates, or even encourages, a deferential approach to medical evidence on capacity. However, uncertainties surrounding the functional criteria and the ‘inferential gap’ outlined above appear to leave open substantial negotiable territory. How are doubts about P’s capacity resolved? And to what extent are they resolved in ways which suggest medicalisation, or deference to medical opinion?

**C. Assessing Deference to Medical Views in the Court of Protection**

*Quantitative and qualitative markers of judicial ‘deference’ -* The term ‘deference’ is widely used in constitutional law to indicate ‘standards of review’ of lower court or public body decisions and broadly refers to the ‘weight attached’ to those decisions.[[50]](#footnote-50) This ‘doctrinal deference’ is to be distinguished from ‘epistemic deference’ which refers to the practice of paying respect to other decision makers by according weight to them.[[51]](#footnote-51) It is this latter application of deference which is frequently used in a pejorative sense in medical law to frame critique, with a focus on the scrutiny the court applies to particular sources of argumentation. As indicated above, Donnelly’s observation that the courts have been deferential to the opinion of medical experts when dealing with issues of mental capacity suggests that the low incidence of cases departing from medical evidence provides a preliminary indicator of such deference.[[52]](#footnote-52)Deference might therefore, at least in part, be measured by reference to quantitative, ‘outcome based’ indicators.[[53]](#footnote-53) Certainly, a quantitative approach can offer a useful starting point before embarking on a more detailed analysis of markers/indices of deference.

*Collating the quantitative evidence -* In 2010 Donnelly also commented on the ‘dearth of reported decisions from the Court of Protection,’ this fact making it very difficult to assess the court’s approach to expert evidence on capacity post-MCA.[[54]](#footnote-54) Transparency reforms to the CoP in 2014 mean that the paucity of reported cases has, to an extent, been remedied.[[55]](#footnote-55) The publication of these judgments has been liberalised and in 2016 it was possible for the author to compile a database of well over 200 CoP judgments in order to assess post-MCA judicial responses to expert evidence on P’s capacity.[[56]](#footnote-56) From this dataset, 66 judgments were identified where P’s decision making capacity in health/welfare cases was explored in some *detail*, being of three further types;

i) the ‘*consensus* cases’ – 51 (77 per cent) of the 66 judgments were identified as ‘consensus cases’ where a consensus was reached amongst all the experts (or there was only one expert) *and* the court as to whether P had mental capacity on the particular issue(s) at stake[[57]](#footnote-57);

ii) the ‘*deviation* cases’ - just three out of the 66 judgments (4.5 per cent) (*CC v STCC,[[58]](#footnote-58)* *Re SB[[59]](#footnote-59)* and *Re Z & Others[[60]](#footnote-60)*) were observed in which the experts were in agreement (or there was only one expert) and the judge departed completely from conclusion of the expert evidence on the issue of P’s capacity[[61]](#footnote-61); and

iii) the ‘*conflict* cases’ - twelve out of the 66 judgments involved a conflict in the expert evidence which the judge needed to resolve.

Analysis of the 66 cases suggested that the majority of experts called to give evidence on capacity were doctors: 73 per cent of the witnesses providing expert evidence on capacity were from the medical profession (i.e. 55 per cent were psychiatrists and ‘other doctors’ made up 18 per cent of the sample). The remaining 27 per cent was made up of social workers (12.5 per cent), psychologists (9.5 per cent) and ‘others’ (5 per cent).[[62]](#footnote-62) In 24 per cent of the judgments the *only* expert evidence referred to on capacity came from psychiatrists. These statistics raise a number of interesting questions about the impact of the apparent dominance of medical evidence, and particularly psychiatric evidence, in the process of assessing P’s capacity: is the CoP as deferential to medical expert evidence on capacity as has been suggested was the case before the MCA? What role should quantitative criteria and qualitative indices play in measuring deference in this context? Finally, if the medical view is allowed to dominate capacity assessment in the courts, what are the social and policy implications?[[63]](#footnote-63)

**D. Deferring to clinical judgement or engaging in judicial diagnosis?**

Academics searching for signs of a non-deferential approach (referred to here as ‘forensic scepticism’) rather than deference to medical opinion, tend to require evidence of cases which demonstrate *both* explicit challenging of the medical evidence and an outcome which rejects that evidence.[[64]](#footnote-64) As outlined above, three judgments were identified in which the judge departed completely from a consensus of medical evidence on capacity: *CC v STCC, Re SB* and *Re Z.* Do the outcomes and tenor of these judgments equate to forensic scepticism in the court’s approach to medical evidence on capacity?

***i) Uncontested Expert Evidence on Capacity: the deviation cases***[[65]](#footnote-65)

The judgments in *CC, SB* and *Z* provide mixed evidence of the level of scrutiny applied to expert medical evidence. On first impressions they conform to what we might expect strong forensic scepticism to look like – the outcome in each case is ‘capacity affirming,’ in that it rejects the unanimous expert evidence to find that P does indeed have capacity to make the decisions under consideration. Further, in all three cases, it is evidence from lay witnesses, specifically, direct evidence from P herself, that is preferred to that of *all* the ‘experts’. In *CC,* Justice Baker found that P, an 82 year old woman with vascular dementia, had capacity to decide whether she should live in her bungalow or in a nursing home. P’s testimony in the courtroom had clearly made a significant impression:

*‘I note in particular that for a period earlier this year she elected not to go on her daily visits to the bungalow because of the inclement weather. This is, to my mind, clear evidence that she has the capacity to understand and weigh up information and make a decision. Likewise, I consider her frank observation that "if I fall over and die on the floor, then I die on the floor" demonstrates to me that she is aware of, and has weighed up, the greater risk of physical harm if she goes home.’[[66]](#footnote-66)*

In *Re SB* the CoP had to decide whether P, compulsorily detained under the Mental Health Act due to her bipolar disorder, had capacity to consent to a termination of her pregnancy. Reminiscent of the *CC* case, P gave evidence which ‘strongly asserted’ her capacity, as against ‘the very clear evidence’ of Dr T and the ‘equally strongly stated evidence’ of Dr Smith, both of whom regarded her as lacking capacity. The judge reflected that his assessment of the case had ‘been enormously illuminated by [P’s] attendance and by the considerable oral evidence which she has given.’[[67]](#footnote-67) The unsworn testimony of P in *Re Z* was also, according to Cobb J, ‘particularly valuable’.[[68]](#footnote-68)

The text of all three judgments also challenges (to varying degrees) the medical evidence and explicitly asserts that the functional test for incapacity is the law’s domain.[[69]](#footnote-69) The judgment in *Re SB* perhaps goes furthest here, in launching a normative challenge to the expert view on where the threshold of capacity ought to be pitched; a direct assertion of territory over the proper construction of the functional criteria. Whilst Justice Holman accepted the experts’ diagnoses of bipolar disorder as evidence that P suffered from an ‘impairment or disturbance’, on the issue of whether she had the ‘ability’ to make a decision, the experts had pitched the threshold for capacity too high. Termination of pregnancy was, according to Holman J, ‘…a profound and grave decision, … it [did] not necessarily involve complex issues.’[[70]](#footnote-70) The judgment also stressed that before a finding of incapacity could be made, the effect of the impairment must not be just to ‘impair’ decision making, it must render P ‘unable’ to make a decision.[[71]](#footnote-71) The judgment in *Re Z* is not explicitly critical of the expert’s assessment, but notes that whilst the expert had interviewed Z three times, the most recent update from the expert, two days before the hearing, comprised only a short email. The expert evidence was outweighed by the significance of the ‘other evidence’ (i.e. the testimony of Z herself) and the judge’s own interpretation of Z’s behaviour. The assertion of jurisdiction over the functional criteria is further underlined by the fact that the narrative of the judgment juxtaposes the ‘Expert assessment’ with the judge’s own ‘Assessment of Z’.[[72]](#footnote-72)

But perhaps a more significant aspect of the ‘deviation’ judgments concerns the court’s assertion of competence over the inferential gap. In reaching a finding that P had capacity, the court grapples directly with the inferential gap, in choosing to reject pathological narrative, and in offering a normalising, non-pathological explanation for P’s behaviour and style of decision making based on the judge’s own, non-clinical assessment. In *Re Z* Cobb J concluded that the behaviour reported by the expert was not to be construed as symptomatic of Asperger’s Syndrome and indicative of a lack of capacity, but instead was consistent with ‘naivety, immaturity, diffidence, or embarrassment.’[[73]](#footnote-73) In *Re SB* the experts focused on the effect of her persecutory beliefs preventing her from ‘understanding’ that her husband would be a caring and supportive father. Referring to this, Holman J commented that if he were to try to interrogate the truth of P’s views of her marriage as compared with those of her husband ‘as if this were a divorce hearing’ he would have been there a considerable length of time.[[74]](#footnote-74) In doing this he normalises P’s decision making by invoking a comparative evaluation with divorce petitioners.[[75]](#footnote-75)

However, some of the features which make these cases exceptional might also weaken the argument for saying that they provide clear examples of forensic scepticism in the courts’ approach to the expert evidence. First, P’s own evidence was clearly crucial in the courts’ decision to prefer a non-pathological explanation for P’s decision making, but if hearing directly from P really was the determinant factor in these cases, this is quite worrying. The experiences of P in *CC, SB* and *Re Z* are not replicated in most cases – a trawl through the dataset compiled by the researcher suggests that the direct participation of P in the proceedings had been ad hoc at best. Giving evidence to the House of Lords Select Committee on the MCA, one CoP judge thought that she had communicated directly with P in about 10 per cent of cases.[[76]](#footnote-76) The cases in this dataset suggested that direct participation had become more common, at least in health and welfare cases, with 16 of the 66 cases referring to direct communications between P and the judge.[[77]](#footnote-77) In the older cases in particular, however, P was frequently represented in the court’s judgment only through the judge’s narrative of the facts (often largely a potted medical history) and through the lens of capacity assessments submitted in evidence. As one of the principles underpinning the MCA is to maximise P’s involvement in decision making processes,[[78]](#footnote-78) it is absurd that historically P’s voice has been so frequently absent in CoP judgments.

Second, one of the ‘deviation’ cases, *Re SB,* was not a dispute arising out of P *refusing* the treatment or care being offered, rather the issue was, unusually, whether P had capacity to *consent* to a termination. It is well known that the assessment of P’s mental capacity is more likely to be triggered by a refusal of treatment,[[79]](#footnote-79) and that capacity to consent is usually more readily found than capacity to refuse suggested treatment.

Finally, of these three cases, it is *CC*[[80]](#footnote-80)which is probably the most striking case of departure from the medical evidence. This judgment, however, did not directly challenge the norms being applied by the experts. Instead, the judgment expressed doubt about the credibility of one expert’s evidence (due to the extent of repetition in his reports).[[81]](#footnote-81) In fact the exceptional outcome in *CC’s* case is perhaps attributable to the fact thatP was regarded as having litigation capacity. This meant that she had secured counsel - counsel who in this case who adopted an unusually strong adversarial approach to the evidence on capacity[[82]](#footnote-82). It was this approach which had resulted in aspersions being cast on the credibility of one of the expert witnesses.

It might therefore be concluded that collectively these judgments offer, at best, fairly weak evidence of forensic scepticism on the issue of P’s mental capacity. Given that there were only three cases in the dataset of the judge deviating from the medical consensus on P’s capacity, and that these cases feature unusual and distinct characteristics (strong adversarial representation and a decision to consent to treatment) rather than robust strategies of forensic scepticism, this would seem to support Donnelly’s hunch that even post the MCA, the courts are highly unlikely to depart from the medical evidence. It is far from clear, however, that the rarity of departure from medical evidence can be characterised as evidence of ‘deference’ per se. What of those cases where the medical evidence itself is not in agreement? Do these judgments tend to exhibit qualitative indicators of deference?

**ii) The ‘Conflict cases’ – stronger evidence of forensic scepticism?**

It is perhaps surprising that the stronger evidence of forensic scepticism came from the cases where medical evidence was in conflict, and therefore the court’s decision ultimately sided with one medical view rather than the other. In cases of conflicting evidence on capacity, deference can be examined by looking at the means deployed by the court to resolve that conflict.

***‘Capacity affirming’ judgments***

Amongst the 66 capacity cases there were twelve judgments where the expert evidence was in conflict and four of these resulted in a ‘capacity affirming’ decision.[[83]](#footnote-83) In these cases the court again asserted epistemic competence on the ‘inferential gap’ - determining that a medical construction was not to be applied to P’s behaviour, but rather that the pathological narrative on causality was to be rejected as it conflicted with legal norms at the heart of capacity assessment. Of these, five judgments, three again referred to detailed representations being made to the court by P. In *X v A Local Authority[[84]](#footnote-84)* the unsworn testimony of P himself appeared to weigh heavily – the judge commented of P’s representations:

*‘His thought process before me was reasonably logical. He has no problem in communicating a decision. He understands, in my judgment, the reasonably foreseeable consequences of his decisions …He may drink to excess again, but that, in my view, is an unwise decision rather than a sign of continuing incapacity.‘[[85]](#footnote-85)*

In *Wandsworth v IA*[[86]](#footnote-86) another decision concerned with capacity to decide residence and care after a long stay in hospital, IA had been ‘a regular correspondent with the court over … two or more years.’[[87]](#footnote-87) In a further example of asserting territory over the inferential gap, Justice Cobb construed IA’s ‘outbursts’ and ‘dogmatic pronouncements’ as attributable to his frustration at not being able to participate more in proceedings and at the slow progress being made, rather than symptoms of any impairment. In taking this view, he resisted the invitation to pathologise IA’s difficult behaviour and refused to accept the medicalised view of IA’s lack of co-operation. In a similar vein, In *A Local Authority v TZ,*[[88]](#footnote-88) a case concerning whether P had capacity to consent to sexual relations, the view of the court appointed expert was that P’s impairment[[89]](#footnote-89), particularly the symptoms of a tendency towards impulsivity, prevented him from properly ‘using and weighing’ the relevant information, including the potential emotional consequences of sexual relationships. The evidence of *TZ* himself, who spoke frankly in an informal discussion in the well of the court, was again key to the judge’s finding that he had capacity. As in *Wandsworth,* the judge chose to reject pathologisation of P’s decision making, saying that in fact most decision making in relation to sexual encounters was driven by impulsivity.[[90]](#footnote-90)

This subset of cases demonstrated that, occasionally, the lay evidence of P’s family could be instrumental in prompting the rejection of the majority of medical evidence. In *Kings College Hospital NHS Foundation Trust v C & Anor,*[[91]](#footnote-91)P had attempted suicide by taking 60 paracetamol tablets with champagne. After months of treatment in hospital, P persistently expressed the wish to refuse further life saving treatment, namely dialysis, saying she was ‘not prepared to wait for the possibility that my kidneys will get better.’[[92]](#footnote-92) Evidence on P’s capacity was conflicting, with two psychiatrists concluding that her decision making was affected by possible personality disorder which was causing her to lack capacity due to an inability to understand the possibility that she might have a positive prognosis. One psychiatrist concluded that the presumption of capacity had not been displaced. The judge went against the majority of medical opinion in finding that P had capacity to refuse treatment. Although C was too ill to attend court, the judge had the benefit of recorded interactions with medical staff in clinical notes. These notes were crucial in the judge’s finding that, contrary to the evidence of the experts, C *had* at various times clearly understood and taken on board information relating to her positive prognosis, she had simply not placed as much importance on it as others might have done. The rejection of the medical evidence this time was therefore on an issue of fact, rather than the product of any normative disagreement on the meaning of incapacity. In deference terms however, the most significant aspect of this judgment is the weight accorded to the lay evidence of C’s family (particularly C’s daughter) in providing the backdrop to the judge’s assessment of capacity.[[93]](#footnote-93) It was this evidence which persuaded the judge to reject the pathological causal narrative of the two psychiatrists, and choose instead to treat C’s decision as due to her strong will, stubborn character and highly egocentric views.[[94]](#footnote-94)

Whilst the participation of P (or P’s family) certainly facilitates judicial scrutiny of the evidence, the same level of scrutiny is sometimes apparent in the absence of this lay involvement. In *Heart of England NHS Foundation Trust v JB[[95]](#footnote-95)*, despite a conflict in the evidence, and without the court hearing P’s narrative through letters or a court appearance, the court still preferred the minority expert view which supported P’s capacity to make her own decision on refusing a life-saving amputation. Not only did the judge interrogate the extent to which the content of the expert’s assessment reflected legal norms, such as the starting point of the presumption of capacity, but he went on to reject pathological constructions of P’s behaviour and again assert competence over the inferential gap. Justice Peter Jackson preferred the opinion of Mr Collin (surgeon) and Dr Prabhakaran (consultant psychiatrist) over the evidence of three other expert witnesses. In particular, he challenged the norms being applied by Dr B (consulting psychiatrist) and Dr O (community psychiatrist) as being inconsistent with the burden and standard of proof expressed by the MCA. In particular, Dr O’s evidence (that JB was "*unable to clearly show that she had considered the option"*of amputation and that she *"is unable to fully understand, retain and weigh information…"[[96]](#footnote-96))* was disapproved. This was presumably because the first statement seems to suggest it is for P to prove her capacity, and the second implies that ‘understanding’ must extend beyond the salient factors of the decision at hand.The evidence of the vascular surgeon who considered that *JB* lacked capacity, was also found to be at odds with legal norms on capacity, as indicated by the surgeon’s statement that *"…we now have a window of opportunity as she has become cooperative with her medical management and has consented to the operation.…"[[97]](#footnote-97)*  Justice Peter Jackson again suggested that this statement belied an approach incompatible with the legal norm that assessments of where P’s best interests lie should not influence assessments of her capacity. Such an approach underscored the danger that ‘the patient is regarded as capable of making a decision that follows medical advice but incapable of making one that does not.’[[98]](#footnote-98)

Having decided that a number of the assessments presented in court were based on a flawed understanding of the legal principles, a judicial diagnosis was undertaken of P’s behaviour. P’s indecision and reluctance to discuss the issues at times were not construed as symptoms of her schizophrenia, but represented fairly ordinary responses to stressful situations and difficult decisions: ‘Her tendency at times to be uncommunicative or avoidant and to minimise the risks of inaction are understandable human ways of dealing with her predicament and do not amount to incapacity.’[[99]](#footnote-99) The judgments in *Wandsworth v IA, C* and *JB* demonstrate a willingness by the judge to scrutinise medical evidence on whether the style of decision making was truly attributable to an impairment or to ordinary responses to difficult situations.

***‘Capacity denying’ judgments***

In the seven judgments where the conflict in expert evidence resulted in a finding that P *lacked* capacity, the judgments employed a range of heuristics to resolve the conflict. In such a small sample of cases no clear pattern is discernible from the reasons expressed by the court for preferring one expert view over another, but the following observations may be of interest, some of which might be viewed as consistent with a deferential approach. For example, in some instances, the judgment appeared to rely on the preponderance of expert evidence which favoured a finding of incapacity, without necessarily clearly spelling out how those assessments mapped onto the functional criteria.[[100]](#footnote-100) At other times, the judges seem keen to ‘reconcile’ the two contrasting viewpoints, thereby ‘smoothing out’ any conflict, rather than preferring one assessment over the other and spelling out the conflicting norms at play.[[101]](#footnote-101) One means of ‘reconciliation’ was to refer to the proximity of the assessment to the hearing or its duration. In *PH v A Local Authority,* although Dr Rickards was considered to be ‘appropriately objective and professional’ in his assessment, his report was described as:

*‘somewhat superficial. This may have been a reflection of the fact that he was basing his opinion on a single interview of ninety minutes. It would be an over­simplification to describe it as a snapshot but it is, to my mind, a disadvantage that the assessment was based on a single visit.’[[102]](#footnote-102)*

In *A Local Authority v A[[103]](#footnote-103)* the parties ‘strongly disagree[d]’ on the issue of capacity, the conflict revolving largely around what P had to ‘understand’ in order to make a capacitous decision about contraception. Defining contraception as a type of medical treatment (and arguably therefore medicalising it) the judgment endorsed a lower threshold for capacity. P needed only to understand the immediate medical issues associated with the procedures (such as the relative advantages, disadvantages, cost, effectiveness and side effects of each option), and not the broader social implications, such as the implications of parenthood. This ‘medicalising’ decision therefore affirmed rather than detracted from P’s decision making powers and incidentally supports Conrad’s thesis that the fact of medicalisation does not necessarily tell us anything about the direction of power distribution.

**E. *Medicalisation of Mental Capacity: Deferring to Medical Opinion?***

As highlighted above, a number of commentators have suggested that the law defers too readily to medical expertise on the issue of capacity.[[104]](#footnote-104) Before reflecting further on the law and judgments relating to mental capacity, this paper will briefly examine the diverse engagement of legal scholarship with the concept of medicalisation, and assess its utility in the context of exploring how mental capacity has been constructed in the court room.

 **The broad banner of medicalisation: jurisdiction, language and power**

Some of the findings in this paper can be regarded as a contribution to the sprawling literature on ‘medicalisation’. Medical lawyers will be familiar with the concept of medicalisation generally, although its mercurial nature makes it difficult to define. Medicalisation means literally ‘to make medical,’ and is used to refer to processes by which non-medical issues become colonised by the medical professions or medicine itself.[[105]](#footnote-105) This widely observed phenomenon shows no sign of losing its potency as an influential theme in the sociology of health and illness. In 2013 Peter Conrad, probably the most prolific contributor to medicalisation literature, reflected on the expansion of the medicalisation thesis beyond the realms of sociology, noting its infiltration into fields such as history, anthropology and economics.[[106]](#footnote-106) Conrad omitted to mention its impact in legal scholarship. Yet, as Veitch observed ‘…medicalisation has been instrumental in giving rise to the area of research that has come to be known as medical law.’[[107]](#footnote-107)

Early definitions of medicalisation tended to emphasise a ‘jurisdictional’ or ’control’ element; with life’s viscissitudes such as pain, childbirth, bereavement and mortality, increasingly being defined as properly falling within the medical domain, and therefore the ‘jurisdiction’ of the medical profession.[[108]](#footnote-108) Later applications of medicalisation abandoned this jurisdictional element, and focused more exclusively on the process of defining or conceptualising matters as medical, whether or not that resulted in an exertion of medical control.[[109]](#footnote-109) Conrad in the 1990s wrote that whilst traditionally it had been assumed that the process of medicalisation involved assigning jurisdiction to the medical profession over a particular matter, a transfer of jurisdiction was not a necessary feature of medicalisation. An issue could become the subject of a medical explanation without the involvement of the medical profession.[[110]](#footnote-110) For this reason, many prefer Conrad’s definition, according to which medicalisation ‘consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to treat it.’[[111]](#footnote-111) Some sociologists have lamented the loss of the jurisdictional focus, commenting that the concept ’…has become a ‘complete muddle’ because of the “decoupling” of medicalisation from the medical profession. It had become ‘so generalisable as to be meaningless’.[[112]](#footnote-112)

**Medicalisation and legal scholarship**

Although Conrad may have omitted to mention ‘law’ as a discipline touched by medicalisation, much medical law scholarship owes a debt to these ideas. Medical lawyers frequently refer to the phenomenon of ‘medicalisation’ in its more traditional jurisdictional sense, identifying a ‘gatekeeper’ role assigned to registered medical practitioners in various domains by statute and common law.[[113]](#footnote-113) Nearly 50 years on, the Abortion Act 1967 (as amended) still generally requires abortion to be certified by two registered medical practitioners as meeting legal prerequisites.[[114]](#footnote-114) Clearly modelled on the abortion statute, a similar ‘gatekeeping’ role would have been allocated to medical practitioners by Lord Falconer’s *Assisted Dying Bill* of 2014.[[115]](#footnote-115) Harrington, writing ten years prior to the MCA’s existence, hinted that judicial practice was to treat medical evidence as determinative of the issue of capacity, effectively installing medical witnesses (usually psychiatrists) as ‘gatekeepers at the threshold of ‘self-determination.’[[116]](#footnote-116) Whilst, the MCA test for incapacity gives prominence to clinical judgement in the form of the diagnostic threshold, this study suggests that the law falls just short of allocating a ‘gatekeeper’ role to medicine in CoP hearings on mental capacity. Medical evidence is not *necessary* for a judge to reach a decision where P’s mental capacity is in question,[[117]](#footnote-117) but ‘*in almost every case*, the court will need medical evidence to guide it.’[[118]](#footnote-118)

A muted form of medicalisation, but with a distinctly jurisdictional theme, is also in evidence in medical lawyers’ preoccupation with the judiciary demonstrating deference rather than healthy scepticism towards doctors. Much of this commentary revolves around the UK courts’ reliance on the ‘*Bolam* test’ to determine the standard of care in negligence litigation.[[119]](#footnote-119) According to this test a defendant doctor is not negligent if his conduct is supported by a ‘responsible body of medical opinion.’ *Bolam* led to accusations that the law had departed from the usual judicially determined normative standard in favour of a standard of care determined by other doctors.[[120]](#footnote-120) Its implications also generated the concept of ‘*Bolamisation’*, devised by Brazier and Miola to depict the courts’ abrogation of responsibility for supervising the medical profession on non-clinical issues. These concerns were rooted in the infiltration of the *Bolam* test into primarily ethical domains such as what was in an incapacitated patient’s ‘best interests’ and the risks that a doctor ought to disclose to a patient prior to treatment.[[121]](#footnote-121)

Although the intensity of that deference has waned,[[122]](#footnote-122) it is the deference focused strand of medicalisation which seems to have the most resonance when it comes to talking about the construction of capacity in the courtroom. Mixed evidence has emerged from this study regarding the level of scrutiny applied to medical evidence. On the one hand, judgments repeatedly assert jurisdiction over the functional criteria for incapacity, and a qualitative analysis of the judgments reveals a significant number of cases signalling an approach which might be termed ‘judicial diagnosis’. This term has been applied here to judgments which exhibit robust forensic scepticism by favouring lay evidence over expert assessments,[[123]](#footnote-123) challenging the expert evidence on normative grounds (e.g. for pitching the threshold of capacity too high (or too low)) or advancing non pathological/normalising constructions of P’s decision making style, thereby asserting authority over the ‘inferential gap.’ However, some of the findings of this research conform to a pattern which resonates with notions of medicalisation and deference. For example, it is clear that departures from a consensus of medical evidence on mental capacity *are* exceedingly rare, and there is undoubtedly a tension between, on the one hand, the routine request to psychiatrists and other medical expert witnesses to give their views on whether P meets the functional criteria of incapacity and the rarity with which medical evidence is rejected, and, on the other, assertions that the court is the ultimate arbiter of capacity.

It is recognised that the medicalisation of decision making capacity has a long history and it is not suggested that this is a new phenomenon forged by the CoP. Houston’s account of the professionalisation of ‘insanity authentication’ in the eighteenth century observes a collaborative endeavour at work.[[124]](#footnote-124) Whilst doctors were the beneficiaries of increased calls for medical witnesses to validate the ‘insanity’ of those considered for civil commitment, or regarded as lacking ‘cognition’ to manage their own affairs, doctors were not the instigators of medicalisation. The tendency to medicalise was attributed to the courts’ need for objectivity and certainty, ‘a way out of a legal dilemma’ as the profession’s own interest in fulfilling this potentially lucrative forensic function.[[125]](#footnote-125)

These findings raise a number of further questions – do some of these judgments amount to unacceptable (or illegitimate) juridification? If the direct participation of P can be so crucial in countering the medical evidence, how can the legal process ensure P is able to present his or her case effectively? These implications are explored by the author elsewhere, but for now the discussion examines further the implications of what appears to be heavy reliance on medical evidence regarding application of the social construct of capacity. Is heavy reliance on medical evidence compatible with P’s Article 8 ECHR and CRPD rights? Does the dominance of medical evidence endanger the presumption of capacity? Do we know enough about how independent expert witnesses are selected to be involved in CoP cases and the extent to which some of these are ‘repeat players’? And what are the implications of the recent drive towards using single joint experts[[126]](#footnote-126)?

**F. Discussion: The Medicalisation of Capacity Assessment in the CoP – Does it Matter??**

***i) Reliance on medical evidence and human rights: a potential source of ‘arbitrariness’***

Previously expressed concerns about deference to medical judgement in the assessment of capacity[[127]](#footnote-127) have not spelled out the implications for ECHR and CRPD compliance. Deeply embedded in ECHR jurisprudence is the notion of medical evidence as a safeguard against (state) arbitrariness in deprivations of liberty. Under Article 5(1)(e) non-emergency deprivations of liberty may be lawful on the grounds that P suffers from ‘unsoundness of mind,’ but that ‘unsoundness’ must be verified by ‘objective medical expertise’.[[128]](#footnote-128) The objectivity attributed to the medical professional in ECHR case law seems to be assumed to be inherent to the profession itself, but is also reinforced by the regulatory framework underpinning it.[[129]](#footnote-129) Article 5 jurisprudence does not seemingly require that the decision on unsound mind must be taken *in accordance with* the medical expert view, rather that a finding of incapacity cannot be made without the support of medical evidence. The results of this study of CoP cases mirrors this position. It is clear from the judgments that the CoP can (and very occasionally does) make a decision that P has decision making capacity without any supporting medical evidence[[130]](#footnote-130), but it will not make a finding of incapacity in the absence of such evidence.

Increasingly human rights jurisprudence is recognising that the safeguard of medical evidence, if relied upon exclusively or excessively, can become a source of arbitrariness in itself. In the context of Article 8 of the ECHR, medical evidence is relevant to whether P has capacity, but case law has emphasised that it is for the judge to decide, therefore an overly deferential approach to the expert evidence may raise concerns about Article 8 compliance.[[131]](#footnote-131) The need to exercise rigorous scrutiny of the evidence on capacity is further amplified by the CRPD. If courts routinely treat the issue of capacity as a medical construct, or fail to exercise their own judgement on the issue, this would be to further endorse a medical model of capacity and could constitute a ‘custom or practice’ which discriminates against those with disabilities.[[132]](#footnote-132) Whilst it has not been the intention of the author to provide a sustained analysis of the challenges posed by CRPD commitments, it is clear that CRPD values underline the need for the court to ‘test’ the evidence, and to be alert to the risk of tensions and incompatibilities between the norms and values underpinning the expert evidence on P’s capacity and the principle of non-discrimination.

***ii) Do medical practitioners tend to take an ‘over-inclusive’ approach to incapacity?***

It is only to be expected that different disciplines should be oriented towards different perspectives on the same issue. The medical view generally on incapacity is often assumed to be ‘over-inclusive’ in its approach to incapacity, due to a nigh inevitable risk-averse approach to risk management and a divergence in values when compared with the autonomy promoting principles of the MCA. Medical opinion is frequently assumed to be more inclined to focus on consequences and ensuring a ‘good clinical outcome’, whereas legal perspectives tend to be more concerned with principles.[[133]](#footnote-133) This much is supported by research conducted elsewhere which repeatedly identifies the medical perspective as inherently defensive and risk averse, as pessimistic about patients’ capacity,[[134]](#footnote-134) adopting an approach which has the effect of minimising physical harm to health[[135]](#footnote-135) and as more likely to identify a means of using compulsion[[136]](#footnote-136); a state of affairs for which the law bears no small part of the blame. The dangers of over-reliance on psychiatry in judgements on capacity therefore include the possibility that the precepts of psychiatry and medicine may work against the statutory presumption of capacity. The House of Lords Select Committee on the Mental Capacity Act referred to a great deal of evidence suggesting that paternalism in the name of ‘protection’, ‘safeguarding’ and ‘risk aversion’ was prevalent in both health care (and social work) and concluded that this culture presented barriers to realising the empowering ethos of the MCA.[[137]](#footnote-137) A finding that the courts only *rarely* depart from professional opinion on capacity *could*, therefore, signal that the presumption of capacity is being neutralised. But, whilst it seems feasible that the medical perspective on capacity *could* incline to being ‘over-inclusive’, erring on the side of protection of P from physical risks and thereby minimising exposure to post hoc criticism, this position needs careful scrutiny. First it is surely an over-simplification to suggest that there is a monolithic ‘medical’ view. Secondly, there is little evidence to support a ‘medical perspective’ on capacity as compared with other disciplines. Most studies of inter-rater reliability look only for consistency between psychiatrists rather than testing for consistency across disciplines.[[138]](#footnote-138) Finally, accepting that doctors take an ‘over-inclusive approach’ to incapacity would be to ignore those studies which suggest entirely the opposite, for example, the study published in *The Lancet* shortly before the MCA became law, suggesting that hospital doctors were significantly underestimating the prevalence of incapacity amongst their elderly patients.[[139]](#footnote-139) To be certain that heavy reliance on psychiatrists in the CoP is problematic, we would need to know far more about inter-rater reliability between decision makers from different perspectives, for example, medical professionals and lawyers, or psychiatrists and psychologists. What is perhaps clear, however, is that capacity assessment is often only triggered where P refuses (rather than consents to) the course of action being recommended by the medical or social care professionals.[[140]](#footnote-140)

Whether the expert witness has a treatment relationship with P or is invited to give evidence as an independent expert with no prior relationship with P, an ‘over-inclusive’ approach to capacity *may* be present. It is noteworthy that whereas the risk of professional bias arising out of treating relationships is clearly identified in the judgments[[141]](#footnote-141), the potential for more generic professional biases was not explicitly acknowledged. However, it is perhaps the non-treating expert who should give more cause for concern here. These experts are more likely to give repeat performances in CoP proceedings and, therefore, any personal or professional perspective they have on capacity, or the appropriate balance between preserving P’s autonomy protecting P, will likely have a bigger impact on mental capacity hearings generally.

***iii) The professionalisation of expert capacity assessment and ’hidden law making’***

Further tensions are evident when we examine the level of expertise assumed to be necessary for giving evidence on capacity. Familiarity with the MCA and the test for incapacity is a requirement for many roles in health and social care. Yet increasingly, the business of giving evidence on mental capacity is becoming professionalised. Since changes to the rules on transparency in CoP proceedings effective from January 2014, the identity of expert witnesses is now usually made known in the court’s judgment.[[142]](#footnote-142) In the context of the dataset of judgments on mental capacity used in this research, it is clear that there is a relatively small ‘elite’ of professional capacity assessors who advertise their services as independent expert witnesses and who are ‘repeat players’[[143]](#footnote-143) in CoP cases. The court undoubtedly benefits from experts who have accumulated substantial expertise as specialists in their field, perhaps with specific medical conditions, and who are familiar with court processes and protocols. However, too little is known about the broader implications of relying on a relatively small group of experts.

Whilst it is recognised that the term ‘repeat players’ in the context of highly specialised experts is potentially stigmatising,[[144]](#footnote-144) the intention is not by any means to impugn the motivations or competence of those individuals, but to stress that the existence of repeat players cannot be denied and should not be ignored. For example, one such expert, a consultant psychiatrist with a particular specialism with autism, is described by Judge Cardinal as *‘*an eminent consultant psychiatrist… who spends a great deal of his time undertaking forensic work in the Court of Protection.’[[145]](#footnote-145) Others include a consultant psychiatrist who directs a company advertising his expert witness services who is mentioned in no less than 13 of the 155 health and welfare cases in the author’s dataset, and there are many who appear more than five times. It is important not to place too much reliance on these statistics but also to note that judgments will not necessarily capture all repeat involvements, as many capacity issues will be resolved without a court hearing or in unreported judgments. Organisations such as ‘Psychiatry direct’[[146]](#footnote-146) provide a network of professionals available to provide expert witness reports and it is clear that a number of witnesses derive a substantial secondary income from producing medico-legal reports. The difficulty of accessing expert witness reports in this area is widely acknowledged, but we need to be alert to the risk that relying on a concentrated resource of expertise[[147]](#footnote-147) could have a significant impact on the shape of mental capacity law. As expert witnesses give repeat performances in court, their opinions and preconceptions become known and can directly inform their selection in future cases.[[148]](#footnote-148) For example, a consultant psychiatrist with expertise in eating disorders generally appears in reported judgments concerning patients with anorexia nervosa[[149]](#footnote-149) and his evidence is generally preferred. With a wealth of accumulated clinical experience, he is clearly well placed to give evidence on the impact and progression of the disease. However, the judgments tend to endorse the expert’s expressed views on capacity, notwithstanding that this expert evidence tends to treat the capacity question as determined by the condition P was suffering from.[[150]](#footnote-150) This expert evidence therefore suggests a particular view of the relationship between anorexia and mental capacity which appears to be in conflict with MCA and possibly CRPD principles.[[151]](#footnote-151)

Far too little is known about how expert witnesses are selected, how frequently they appear in court, how their experience of litigation shapes their testimony and how their views on capacity generally have shaped CoP case law. Recent scholarship on ‘hidden law making’ has drawn attention to the potential for lawyers who are repeatedly involved in similar cases to have a significant impact on the shape of the law.[[152]](#footnote-152) The authors comment in particular on repeated use of the same counsel with a particular specialism for similar cases, and on the role of the Official Solicitor. The frequency with which some expert witnesses appear in the CoP could give rise to similar concerns that the players in court are having an obscured impact on law making in the relevant area.

If successful, the stated aim of more frequently resorting to a ‘Single Joint Expert’ (‘SJE’) in CoP cases[[153]](#footnote-153) could exacerbate these potential problems. Mirroring the Civil Procedure Rules, the CoP rules empower the court to direct that a single joint expert should be used.[[154]](#footnote-154) There will be increasing pressure to resort to this option given the increasing costs and burgeoning case load of the CoP.[[155]](#footnote-155) Yet it is arguable that the SJE option should only exceptionally be considered suitable for a determination of whether P has decision making capacity. Where there is doubt about P’s capacity it is simply not appropriate to instruct a SJE as this goes against the need for epistemic diversity on the issue of mental capacity and also creates tensions with the need for the court to rigorously scrutinise the evidence. Admittedly, there is a certain irony in questioning whether the courts are over-reliant on expert evidence, whilst simultaneously cautioning against reducing the breadth of expert evidence by resorting to SJEs. But it is argued that the poignancy of the decision itself, and its normative and multidimensional nature require that in all but exceptional cases, the court should be given a spread of evidence from which to form a view. Having more than one expert report broadens the evidence base and assists the court in its task of robust scrutiny of the evidence.[[156]](#footnote-156) Otherwise, there is a risk that the SJE’s view would go unchallenged, that value judgements would go unscrutinised and that alternative possibilities would be missed. Lord Neuberger speaking extra-judicially made public his general concerns about the impact of single joint experts on ‘who decides’.[[157]](#footnote-157) Given the findings in this research regarding deference to expert witness opinion, an increased use of single experts could effectively accord ‘gatekeeper’ status to psychiatrists in the assessment of P’s capacity in the courtroom, a situation which would be incompatible with the social nature of capacity.

**Conclusions**

Although many areas of law have been exposed to a medicalisation analysis, relatively little attention has been paid thus far to the potential for medicalisation in the construction of P’s capacity in the Court of Protection.[[158]](#footnote-158) It is tempting to view medicalisation as a ‘mirror of Erised,’[[159]](#footnote-159) a concept so malleable and indefinite that it has become a lens through which academics see what they want to see. For, on the one hand, despite judgments explicitly asserting the upper hand in mental capacity assessment, this study suggests that both statute and judgments from the CoP have to some extent endorsed mental capacity as largely the domain of medical expertise (specifically that of psychiatry). The import of the diagnostic threshold looms large here – once P is regarded as suffering from an impairment (whether mental disorder or brain dysfunction) the inclination to pathologise aspects of P’s behaviour is strong, and the courts must show resilience if the CRPD’s non-discriminatory vision is to be delivered.

Taken collectively, the sheer number of ‘medical’ experts called to give evidence on the issue of capacity, the fact that they are routinely asked for their views on whether P’s incapacity is demonstrated according to the (non-medical) functional criteria and the rarity with which the CoP appears to depart from unanimous medical opinion on capacity, tend to shore up suggestions that the law is characterised by a ‘deferential’ or even ‘medicalised’ approach to medical evidence on this issue. But direct evidence of deference from the judgments is elusive. Drawing from a sample of 66 CoP judgments where the issue of mental capacity was examined in detail, a mixed picture of bothdeference *and* robust scrutiny emerged. Whilst it is certainly possible to agree that post-MCA, the courts are very unlikely to depart from medical evidence even on the issue of the whether P is ‘unable to make a decision,’ the relationship between adoption or rejection of the expert view and judicial scrutiny is complex. A decision departing from medical opinion does not necessarily demonstrate a non-deferential approach. Equally, evidence of non-deference approximating ‘judicial diagnosis’ is evident in a number of cases where the CoP chose between competing medical views on capacity. Within the negotiable territory of the functional criteria, the CoP claims jurisdiction, and has repeatedly manifested a determination to oppose medicalised constructions of P’s behaviour. These judgments do not sit well with a medicalised account of capacity and demonstrate an approach which is, in many ways, antithetical to supposed deference to clinical judgement.

The court’s willingness to take on board lay evidence (from P and P’s family) to make a finding against the weight of professional expert evidence has also provided a fundamental safeguard against excessive deference to medical opinion. This is underscored by the fact that in cases such as *CC, SB,* *IA* and *X*, it was the evidence of P which was clearly crucial in tipping the scales against a finding of incapacity.[[160]](#footnote-160) But lay voices will often be absent from these proceedings, and the level of judicial scrutiny of the capacity question should not be contingent on whether P can participate in proceedings, and whether P has family or a close friend who can proffer evidence on P’s capacity to make a decision. Rather, it might be worth considering whether the nature of mental capacity as a social construct necessitates a broader range of expertise being heard than is currently the case. The need for a multidimensional approach to capacity assessment which is not hostage to any particular discipline is crucial if the Court of Protection Rules’ ‘overriding objective’ of ‘deciding cases justly’[[161]](#footnote-161) is to be achieved. The *JB* judgment cited above which manifested clear evidence of forensic scepticism is also explicit in recognising the need for something close to epistemic diversity: ‘Bearing in mind JB's longstanding mental illness it is entirely appropriate that the core assessment of her capacity comes from psychiatrists, *but other disciplines also have an important contribution to make.’*[[162]](#footnote-162) Further research is merited on how other disciplines, such as psychology, social work or even philosophy might contribute to capacity assessment.

The themes of medicalisation have usefully illuminated certain tensions in the business of capacity assessment, in particular the import of the dominance of medical voices versus the multidisciplinary nature of capacity. The picture which has emerged includes components of both medicalisation and of the court robustly asserting jurisdiction on capacity. These dynamics in the judgments are, in this context, often mutually reinforcing. Just as the law is increasingly reverted to in order to legitimise decisions made in the clinical domain[[163]](#footnote-163), expert medical evidence plays a role in legitimising the law’s judgements. The twin authorities of medicine and law mutually reinforce the legitimacy of the other in resolving contentious cases. This intertwining of jurisdictions, a phenomenon which might be termed medico-legalisation, provides much needed certainty for the parties on the issue at hand. Reliance on expert evidence in a framework of judicial authority, reinforced by the rhetoric of the law’s supremacy, aids this illusion of certainty, objectivity and value free judgement and can provide much needed ‘closure’ for the family whilst also facilitating public confidence in case outcomes. The functional benefits of this partnership need, however, to be balanced with justifiable concerns. Relying too heavily on medical judgement risks glossing over the normative, social nature of capacity assessment and excluding other voices, a position which is unsustainable. Heavy reliance on psychiatry in the assessment of capacity without clear justification risks introducing arbitrariness into the determination of fundamental human rights (right to a private life, Article 8 ECHR) and legal capacity (Article 12 CRPD). A procedure which better embraces epistemic diversity would be preferable, but there is much research to be done to identify how and, according to what model of decision making, that might be achieved.

*Acknowledgements*

The author is very grateful for the helpful comments of the anonymous *Medical Law International* Reviewers on an earlier draft of this paper.

1. *London Borough of Islington v QR* [2014] EWCOP 26 at [84]. [↑](#footnote-ref-1)
2. See e.g. B. Secker, ‘Labeling Patient (In)Competence: A Feminist Analysis of Medico-Legal Discourse.’ (1999) 30(2) *J Soc Phil* 295; R. Pepper-Smith, W. Harvey and M. Silberfeld, ‘Competency and Practical Judgment’ (1996) 17(2) *Theoretical Medicine* 135 and, more recently, J.Craigie, ‘Against a singular understanding of legal capacity.’ (2015) 40 *Int J Law and Psychiatry* 6, stressing the value-infused nature of the capacity threshold in her argument that the same threshold of capacity should not necessarily be applied to personal decision making and criminal responsibility because of the distinct philosophical and political concerns at stake and N.Banner, ‘Unreasonable reasons: normative judgements in the assessment of mental capacity.’ (2012) *J of Eval in Clinical Practice* 1038 stressing the normative aspects of capacity assessment. [↑](#footnote-ref-2)
3. M. Donnelly, *Health Care Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) at 152. See also J. Harrington, ‘Privileging the medical norm: liberalism, self-determination and refusal of treatment.’ (1996) 16 *Legal Studies* 348; D. Gibson, ‘Conceptual and Ethical Problems in the MCA 2005’ (2015) 4(2) *Laws* 229; S. Michalowski, ‘Is the MCA diagnostic test to assess mental capacity compliant with the UNCRPD?’ *Essex Autonomy Project: Briefing Paper* available at <http://autonomy.essex.ac.uk/wp-content/uploads/2014/06/1.-Briefing-Paper-One-FINAL.pdf>; in 1993 David Carson expressed concerns that any statutory test which placed too much emphasis on the evidence of psychiatrists risked inappropriately medicalising the issue of mental capacity - D. Carson, ‘Disabling progress: the Law Commission’s proposals on mentally incapacitated adults’ decision making.’ (1993) 15(5) JSWFL 304, 312. It can also give rise to adverse commentary in relation to specific cases – see e.g. K.Moreton, ‘Gillick Reinstated: Judging Mid-Childhood Competence in Health Care Law.’ (2015) 23(2) Med L Rev 303 arguing that a recent decision concerning whether a 13yr old could consent to an abortion took a ‘medicalised approach’ to the determination of P’s capacity and demonstrated judicial deference to medical opinion. [↑](#footnote-ref-3)
4. It is of course true that the majority of capacity assessments do not involve court applications – this article is only concerned with those exceptional cases that result in a court ruling. [↑](#footnote-ref-4)
5. The CoP also deals with P’s capacity in the context of property and financial matters, but the approach to these cases is quite different and they are outside the scope of this article. [↑](#footnote-ref-5)
6. E.g. *Re MB (Caesarean Section)* [1997] 2 FLR 426 - a patient with capacity ‘may, for religious reasons,...for rational or irrational reasons or for no reason at all, choose not to have medical intervention’ at 497. [↑](#footnote-ref-6)
7. S.1(5) and s.4 MCA. [↑](#footnote-ref-7)
8. Although frequently used in the context of models of democracy. [↑](#footnote-ref-8)
9. *Per* Hedley J in *PC v City of York Council* (cited in [2013] EWCA Civ 478 at [13]). [↑](#footnote-ref-9)
10. For a rare example of the full extent of these powers see e.g. *Re DD* [2015] EWCOP 4 where Cobb J acknowledges the wide powers of the court (reflected in s.16(5) of the MCA) and reluctantly authorises forcible entry into P’s home, conveyance to the hospital and surgical sterilisation of P including restraint and detention if necessary and proportionate (at [135] to [140]). [↑](#footnote-ref-10)
11. A. Ruck Keene, ‘Capacity is not an off switch – case commentary’ *Mental Capacity Law and Policy Newsletter. http://www.mentalcapacitylawandpolicy.org.uk/capacity-is-not-an-off-switch.* [↑](#footnote-ref-11)
12. Medicalisation can mean that ‘medical opinion is increasingly attributed with ‘apparent facticity,’ whereby value judgements are transformed into indisputable ‘facts.’ S. Nettleton, *Sociology of Health & Illness.* 3rd Edn.(Polity Press, Cambridge, 2013) p.7. [↑](#footnote-ref-12)
13. C. Foster and J. Miola, ‘Who’s in charge? The relationship between medical law, medical ethics and medical morality? ‘(2015) 23(4) Med L R 505 at 529. [↑](#footnote-ref-13)
14. B. Secker, ‘Labeling Patient (In)Competence: A Feminist Analysis of Medico-Legal Discourse.’ (1999) 30(2) *J Soc Phil* 295. [↑](#footnote-ref-14)
15. For a rare example, see *Re AB* [2016] EWCOP 37 confirming that covert medication, as an example of treatment without consent, interfered with the right to respect for private life and should be in accordance with a law which included safeguards against arbitrariness. [↑](#footnote-ref-15)
16. *Storck v Germany* (2005) 43 EHRR 96. [↑](#footnote-ref-16)
17. *Ivinovic v Croatia* [2014] ECHR 964. [↑](#footnote-ref-17)
18. *AH v West London MHT* [[2011] UKUT 74 (AAC)](http://www.bailii.org/uk/cases/UKUT/AAC/2011/74.html), [15]-[16]. [↑](#footnote-ref-18)
19. *Burnip v Birmingham CC* [2012] EWCA Civ 629 at [21] and *P v Cheshire West* [2014] UKSC 19 at [36]: *‘*Although not directly incorporated into our domestic law, the CRPD is recognised by the Strasbourg court as part of the international law context within which the guarantees of the European Convention are to be interpreted.’ [↑](#footnote-ref-19)
20. *General Comment No.1* (Committee on the Rights of Persons with Disabilities, 2014), para 14. [↑](#footnote-ref-20)
21. *General Comment No.1* (Committee on the Rights of Persons with Disabilities, 2014), para 14. [↑](#footnote-ref-21)
22. See Lucy Series’ thoughtful discussion on whether it is ever possible to get away from a discriminatory characteristics of ‘mental’ incapacity: ‘Is Article 12 keeping you awake at night?’ Small Places blog – accessible at <http://thesmallplaces.blogspot.co.uk/2011/09/is-article-12-keeping-you-awake-at.html>. [↑](#footnote-ref-22)
23. *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, particularly Baroness Hale at [45]. [↑](#footnote-ref-23)
24. *Wye Valley NHS Trust v B* [2015] EWCOP 60 at [11]. [↑](#footnote-ref-24)
25. Probably the most well known and widely cited of these is A. Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the past or Lodestar for the Future?’ (2006-7) 34 *Syracuse J Int’l L & Comm* 429. Cf G. Richardson, ‘Mental Capacity in the shadow of suicide: what can the law do?’ (2013) 9(1) *International Journal of Law in Context*  87 for a persuasive argument that application of the CRPD would not be much different in effect and the binary divide would likely be ‘rediscovered’ via attempts to identify who needed support with decision making. [↑](#footnote-ref-25)
26. The House of Lords Select Committee reviewing the operation of the Mental Capacity Act in 2013 found itself unable to take a view on whether the MCA was CRPD compliant but acknowledged that ‘better alignment in practice should be regarded as a reasonable aim.’ *House of Lords Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: Post-Legislative Scrutiny,* HL Paper 139At 53. [↑](#footnote-ref-26)
27. P. Bartlett, A. Ruck Keene and N. Allen, ‘Litigation Friends or Foes? Representation of ‘P’ before the Court of Protection.’ (2016) Med L Rev special issue – awaiting publication at p.? [↑](#footnote-ref-27)
28. M. Kapp and D. Mossman, ‘Measuring decisional capacity: cautions on the construction of a capacimeter.’ (1996) 2 *Psych, Pub Pol and Law* 73. [↑](#footnote-ref-28)
29. S.1(2). [↑](#footnote-ref-29)
30. *MCA Code of Practice* (2007). Many of the CoP judgments adopt the ‘stage 1’ and ‘stage 2’ approach despite the warnings from *PC v City of York Council* [2013] EWCA Civ 478 at [58] that the MCA’s ordering of the issues requires an ‘inability to decide’ to be identified first. [↑](#footnote-ref-30)
31. The Code of Practice at para 4.11 recognises that an impairment or disturbance may be identified *without* any disorder, examples including concussion and the symptoms of drug or alcohol use. These examples are however extremely rare in reported judgments. [↑](#footnote-ref-31)
32. [2012] EWCOP 4378, no paragraph reference available. See also W. Martin and S. Michalowski, ‘Is the MCA’s diagnostic test to assess mental capacity compatible with the UNCRPD?’ *Briefing Document* (April 2014) available at <http://autonomy.essex.ac.uk/is-the-mca-compliant-with-the-uncrpd-briefing-papers>, suggesting that the finding of incapacity sometimes flows from the diagnosis. [↑](#footnote-ref-32)
33. [2010] EWCOP 1910 at [39]. [↑](#footnote-ref-33)
34. *Unfitness to Plead* (Law Commission, 2016) at 3.128. [↑](#footnote-ref-34)
35. See Martin and Michalowski above at n.31 suggesting its incompatibility with the UNCRPD in the context of the MCA, and also Kirsty Keywood, giving oral evidence to the *House of Lords Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: Post-Legislative Scrutiny*, HL Paper 139, vol.2 at 923. It was also deliberately not incorporated into Ireland’s Assisted Decision Making Act 2015. This point is beyond the scope of this article but, for an introduction to the issues, see P. Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law.’ (2012) 75(5) MLR 752. [↑](#footnote-ref-35)
36. See N. Banner, ‘Unreasonable reasons: normative judgements in the assessment of mental capacity.’ (2012) *J of Eval in Clinical Practice* 1038. [↑](#footnote-ref-36)
37. C. Foster, ‘Autonomy in the Medico-legal Courtroom.’ (2014) 22 Med L Rev 48 at 59. [↑](#footnote-ref-37)
38. [2010] EWCOP 1549. [↑](#footnote-ref-38)
39. [2012] EWCOP 2136. [↑](#footnote-ref-39)
40. n.1 at [84]. [↑](#footnote-ref-40)
41. And often also on the issue of best interests- see eg the evidence of Dr Glover on the issue of whether it was in P’s best interests to have a below the knee amputation: *Wye Valley NHS Trust v B*  [2015] EWCOP 60. [↑](#footnote-ref-41)
42. *PC v City of York Council* [2013] EWCA Civ 478. [↑](#footnote-ref-42)
43. M. Silberfeld and D. Checkland, ‘Faulty Judgment, Expert Opinion and Decision Making Capacity.’ (1999) 20 *Theoretical Medicine and Bioethics* 377. [↑](#footnote-ref-43)
44. See also D. Dwyer, *The Judicial Assessment of Expert Evidence* (CUP, 2007)at 146 – making the point that the question of causation is rarely relevant or only of secondary interest to the expert’s practice. [↑](#footnote-ref-44)
45. *Re M (Best Interests: Deprivation of Liberty)* [2013] EWCOP 3456. [↑](#footnote-ref-45)
46. [2013] EWCOP 3456 at [7]. [↑](#footnote-ref-46)
47. See *PC v City of York Council* [2013] EWCA Civ 478 for importance of ‘causal nexus’ at [58] to [60]. [↑](#footnote-ref-47)
48. Preserved by s.1(4) of the Act. [↑](#footnote-ref-48)
49. [2013] EWCOP 3456 at [22]. [↑](#footnote-ref-49)
50. P. Daly, *A Theory of Deference in Administrative Law: Theory, Application and Scope.* (CUP, 2012) at 7. [↑](#footnote-ref-50)
51. Ibid at 8. [↑](#footnote-ref-51)
52. ‘[i]n the case law prior to the MCA (Mental Capacity Act), when uncontradicted expert evidence was presented to the court, the court’s ultimate decision almost invariably accorded with that of the medical expert.*’* M. Donnelly, *Health Care Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) at 152. [↑](#footnote-ref-52)
53. For examples of studies in medical law which do adopt a quantitative approach as a starting point, see e.g. A. MacLean, ‘Beyond *Bolam* and *Bolitho*’ (2002) 5 *Medical Law International* 205 and M. A. Jones, ‘Informed Consent and Other Fairy Stories’ (1999) 7 Med L Rev 103. [↑](#footnote-ref-53)
54. M. Donnelly, *Health Care Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) at 152. [↑](#footnote-ref-54)
55. Namely Sir James Munby’s Practice Note of January 2014 - *Practice Guidance (Transparency in the Court Of Protection)* [2014] EWCOP B2, particularly para 16: ‘Permission to publish a judgment should always be given **whenever the judge concludes that publication would be in the public interest and whether or not a request has been made by a party or the media’** (author’s emphasis). [↑](#footnote-ref-55)
56. What degree of confidence we can have that these judgments are a representative sample and that it can generate reliable inferences about what happens in the CoP generally? It could certainly be said that as it comprises only the ‘public facing’ judgments of the CoP selected by the judges for publication, but there is no reason to think that these judgments are not representative of the health and welfare caseload of the CoP. The relatively small number of cases identified in a trawl of bailii spanning eight years is itself worthy of comment and provides evidence of this selectivity of publication. By way of illustration, the CoP’s annual report in 2010 reported that the Court had made 218 orders on welfare issues (*Court of Protection Report 2010,* p.25) whereas only 18 of these appeared as published judgments on bailii. This history of gross under-publication followed by modest liberalisation seriously hampers understanding and analysis of the CoP’s work. [↑](#footnote-ref-56)
57. This examination does not probe the ‘consensus’ cases identified in this study on the assumption that anything said in those judgments which might signal scepticism is of minimal significance given that it clearly did not impact on the outcome as the court’s decision still followed the unanimous expert evidence. [↑](#footnote-ref-57)
58. [2012] EWCOP 2136. [↑](#footnote-ref-58)
59. [2013] EWCOP 1417. [↑](#footnote-ref-59)
60. [2016] EWCOP 4. [↑](#footnote-ref-60)
61. *CC v STCC* [2012] EWCOP 2136; *Re SB (A Patient; Capacity to Consent to Termination)* [2013] EWCOP 1417 and *Re Z* [2016] EWCOP 4. In the remaining twelve judgments, the judge preferred the evidence of one expert over evidence of other expert(s). [↑](#footnote-ref-61)
62. This is based on 55 judgments out of the 66 where the professional status of the experts giving evidence on capacity is identified in the judgment. [↑](#footnote-ref-62)
63. The extent to which the voices of others in the capacity assessment process act as effective checks on the influence of the medical view is currently being explored by the author for the purposes of a separate research paper . [↑](#footnote-ref-63)
64. E.g. A. MacLean, ‘Beyond *Bolam* and *Bolitho*’ (2002) 5 *Medical Law International* 205 at 213. [↑](#footnote-ref-64)
65. Of the 155 health/welfare judgments, 66 cases dealt with capacity issues in detail, 41 were categorised as cases where P’s mental capacity was addressed, but only cursorily and in the remaining cases, P’s capacity was not addressed in the judgment at all. The judgments where P’s capacity was addressed cursorily included Ps diagnosed as being in a minimally conscious state, permanent vegetative state or with severe learning disabilities, but also a number of other fact combinations where it was far less clear on the face of the judgment that P obviously lacked capacity. These 41 judgments contain no explicit scrutiny of the evidence on P’s capacity – typically these judgments include the comment that ‘it was ‘common ground’ (E.g. *YA(F) and A Local Authority & Ors* [2010] EWCOP 2770; *A Local Authority v PB & Anor* [2011] EWCOP 2675; *JO v GO & Ors* [2013] EWCOP 3932; *Liverpool City Council v SG & Ors* [2014] EWCOP 10) that P lacked capacity, that the evidence of the consulting psychiatrist was ‘compelling’ (e.g. *DH NHS Foundation Trust v PS* [2010] EWCOP 1217) or that the parties were in agreement that P lacked capacity (e.g. *HT v CK & Anor* [2012] EWCOP 4160; *PB v RB & Ors* [2012] EWCOP 4159; *A Local Authority v WMA & Ors* [2013] EWCOP 2580). This should not necessarily be viewed as supporting evidence of judicial deference to expert evidence; just because the court’s scrutiny of P’s capacity is not visible on the face of the judgment does not mean that such scrutiny is non-existent. [↑](#footnote-ref-65)
66. At [50]. [↑](#footnote-ref-66)
67. At [29]. [↑](#footnote-ref-67)
68. [2016] EWCOP 4 at [53]. [↑](#footnote-ref-68)
69. *STCC* at [62]: ‘it is the court alone that is in the position to weigh up all the evidence as to the functional test and thus it is the court that must make the ultimate decision’ (echoed in *Re SB* at [36] to [38] and underlined in *Re Z* [2016] EWCOP 4 at [69]by the words: ‘the expert advises and the court decides’). [↑](#footnote-ref-69)
70. At [44]. It has long been understood to be for the court to determine the level of ‘understanding’ required for P to be able to make a decision. P needs only understand the ‘salient’ factors relevant to the decision and it is for the court to determine which factors have that relevancy: Macur J in *LBL v RYJ* [2010] EWHC 2664. [↑](#footnote-ref-70)
71. *Re SB* [2013] EWCOP 1417 at [38]. This approach is also followed in *Re Z* [2016] EWCOP 4 at [60]. [↑](#footnote-ref-71)
72. [2016] EWCOP 4 at [53]. [↑](#footnote-ref-72)
73. [2016] EWCOP 4 at [41]. [↑](#footnote-ref-73)
74. [2013] EWCOP 1417 at [40]. [↑](#footnote-ref-74)
75. See T. Jingree, ‘Duty of care, safety, normalisation and the Mental Capacity Act 2005’ (2014) 25(2) *Journal of Community & Applied Social Psychology* 138where comparative evaluation is observed in discourse analysis to opposite effect, the position of adults with learning disabilities being compared to the situation of everyone else as a means of justifying restrictions of choice. [↑](#footnote-ref-75)
76. <http://www.parliamentlive.tv/Event/Index/0fe8cea8-89db-453c-afb2-7a97d8b20db1> accessed 15/1/16. [↑](#footnote-ref-76)
77. Most involving direct meetings, but in a few cases involving communication by letter: e.g. *Re W (Anorexia)* [2016] EWCOP 13 and *Wandsworth CCG v IA* [2014] EWCOP 990 discussed below. [↑](#footnote-ref-77)
78. *MCA Code of Practice*, para 1.2. [↑](#footnote-ref-78)
79. See e.g. the recent study by I. Sleeman and K. Saunders, *‘*An audit of mental capacity assessment on general medical wards.’ (2013) 8 *Clinical Ethics* 47 – in this study only seven patients had notes of a capacity assessment on their file and in all seven cases the patient had disagreed with the medical team about treatment, suggesting that refusal had triggered capacity assessment. [↑](#footnote-ref-79)
80. [2012] EWCOP 2136. [↑](#footnote-ref-80)
81. Ibid at [63]. [↑](#footnote-ref-81)
82. See particularly [2012] EWCOP 2136 at [38] to [43]. [↑](#footnote-ref-82)
83. *A Local Authority v TZ*  [2013] EWCOP 2322; *X v A Local Authority* [2014] EWCOP 29; *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342; *Wandsworth Clinical Commissioning Group v IA* [2014] EWCOP 990; *King’s College Hospital NHS Foundation Trust v C & Anor* [2015] EWCOP 80. [↑](#footnote-ref-83)
84. [2014] EWCOP 29 at [12]-[13]. [↑](#footnote-ref-84)
85. At [16]. [↑](#footnote-ref-85)
86. [2014] EWCOP 990. [↑](#footnote-ref-86)
87. [2014] EWCOP 990 at [23]. [↑](#footnote-ref-87)
88. [2013] EWCOP 2322. This case is at the margin of the conflict cases there being no disagreement between experts in court, but an expert opinion from a court appointed expert being in conflict with the view of the Official Solicitor, the Local Authority and a written report from Professor R. [↑](#footnote-ref-88)
89. Described as ‘mild learning disabilities, atypical autism and hyperactivity disorder’. [↑](#footnote-ref-89)
90. Ibid at [53]. See, similarly the case of *D Borough Council v AB* [2011] EWCOP 101 where the court regarded the expert’s formulation of what Alan needed to ‘understand’ as wrong in requiring regard to the personality and characteristics of the other person with whom sexual relations were anticipated and also disagreed that further education of *AB* was a ‘bad idea’ as it would create unnecessary anxiety. The judge however ultimately agreed with the expert evidence that *AB* lacked capacity. [↑](#footnote-ref-90)
91. [2015] EWCOP 80. [↑](#footnote-ref-91)
92. At [59]. [↑](#footnote-ref-92)
93. The role of the family is also vital in the case of *Wandsworth v IA* discussed above. [↑](#footnote-ref-93)
94. [2015] EWCOP 80 at [93]. [↑](#footnote-ref-94)
95. [2014] EWCOP 342. [↑](#footnote-ref-95)
96. Ibid at [27]-[28] – emphasis added. [↑](#footnote-ref-96)
97. Ibid at [28]. [↑](#footnote-ref-97)
98. Ibid at [28]. [↑](#footnote-ref-98)
99. Ibid at [39]-[40]. [↑](#footnote-ref-99)
100. E.g. *A Local Authority v AK* [2012] EWCOP B29 agreeing with the evidence of Dr R, Dr Q, Dr T and Dr S’s report that there was a 30 per cent chance that AK had capacity to marry (as compared with Dr S’s earlier report that he thought AK did have capacity on this matter: ‘on the totality of the medical evidence….I am completely satisfied that…AK did not have capacity freely to decide’ at [51]; *London Borough of Islington v QR* [2014] EWCOP 26 (preferring the evidence of Dr Killaspy and Dr Kingett over that of Dr Akuenza. ‘Lack of insight’ plays a crucial part in the expert evidence in this case but the evidence does not clarify where ‘insight’ maps onto the statutory criteria. See \*\*\*\* self identifying reference\*\*\*\*). [↑](#footnote-ref-100)
101. The court is rarely openly critical of the expert – for a very rare example in these cases see *Re PB* [2014] EWCOP 14: ‘The judge remarked that the expert’s evidence was ‘speculative, approached more as a philosophical or academic debate than an opinion. …he was reluctant himself to factor a consistent body of information from reliable sources as to PB's thought processes. His emphasis on PB's sophisticated, dextrous use of language, which was not in dispute, caused him to lose focus on the issue of using and weighing the information and…. took the individual elements but did not put them together’ at [79]. [↑](#footnote-ref-101)
102. [2011] EWCOP 1704 at [56]. [↑](#footnote-ref-102)
103. [2010] EWCOP 1549. [↑](#footnote-ref-103)
104. See above at n.2. [↑](#footnote-ref-104)
105. K. Veitch, ‘Juridification, Medicalisation and the Impact of EU Law: Patient Mobility and the Allocation of Scarce NHS Resources.’ (2012) 20 Med L R 362 at 365. [↑](#footnote-ref-105)
106. P. Conrad, ‘Medicalization: Changing Contours, Characteristics and Contexts’ in W. Cockerham (Eds), *Medical Sociology on the Move* (Springer, 2013) 195 to 214 at 195. [↑](#footnote-ref-106)
107. K. Veitch, above n.105 at 370. [↑](#footnote-ref-107)
108. Most famously I. Illich, *Limits to Medicine.* (Penguin, 1977) and I. Zola, Medicine as an instrument of social control.’ (1972) 20 *Sociological Review* 487 (1983) at 295. [↑](#footnote-ref-108)
109. P. Conrad, ‘Medicalisation and Social Control.’ (1992) 18 *Annual Review of Sociology* 209*.* This perhaps explains a recently expressed view that Illich and Zola’s work has been ‘neglected’ in modern texts – see J. Davis, ‘Ivan Illich and Irving Kenneth Zola: Disabling Medicalisation’ in F. Collyer (ed) *Palgrave Handbook of Social Theory in Health, Illness and Medicine* (Palgrave, 2015) at 306. [↑](#footnote-ref-109)
110. Others maintained its relevance to power structures, but disputed that it *necessarily* channelled power towards medical establishments, viewing medicalisation as a process with the potential to either reinforce or disrupt existing power relations, e.g. A. Reiheld, ‘Patient Complains of...How medicalisation mediates power and justice’ *International* 3(1) (2010) *Journal of Feminist Approaches to Bioethics.* 72. [↑](#footnote-ref-110)
111. Ibid n.105 at 211. [↑](#footnote-ref-111)
112. J. Davis, ‘How medicalization lost its way.’ (2006) 43(6) *Society* 51. [↑](#footnote-ref-112)
113. #  Notably prominent in the fields of abortion law and end of life decision making. See e.g. Sheldon’s still astounding work, S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (Pluto Press, 1997), A. Grubb, ‘Abortion Law in England: Medicalisation of a Crime.’ (1990) 18 JLME 146, E. Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (2001); E. Lee, *Abortion, Motherhood and Mental Health: Medicalising Reproduction in the US and Britain* (Aldine Transaction, 2003) and on end of life, J. Miola, Medical Ethics and Medical Law: A Symbiotic Relationship. (Hart Publishing, 2007) (particularly chapter 7; G. Sayers, ‘Non-voluntary passive euthanasia: the social consequences of euphemisms.’ (2007) 14(3) European Journal of Health Law 221; S. Ost, ‘The De-medicalisation of assisted dying: is a less medicalised model the way forward?’ (2010) 18 Med L Rev 497.

 [↑](#footnote-ref-113)
114. S.1(1) – a Bill introduced in 2014-15 proposed to reduce the requirement to signing off by one registered medical practitioner, but the Bill did not make it past its first reading in the House of Lords. A similar gatekeeping role is assigned to registered medical practitioners (usually being psychiatrists) for determining unfitness to plead in criminal proceedings – see s.4(6) of the Criminal Proceedings (Insanity) Act 1964. [↑](#footnote-ref-114)
115. Clause 3 - P’s declaration that he/she was terminally ill and had reached an informed, voluntary and capacitous decision to end their own life would have required the counter-signature of two registered medical practitioners; the attending doctor (tasked with providing the ‘assistance’) and an ‘independent doctor.’ [↑](#footnote-ref-115)
116. J. Harrington, ‘Privileging the medical norm: liberalism, self-determination and refusal of treatment.’ (1996) 16 *Legal Studies* 348 at 359. [↑](#footnote-ref-116)
117. *Baker v Tilly* [2013] EWHC 759 - overturning a decision of the Master (costs judge) that P lacked capacity to litigate, made in the absence of medical evidence (as D would not co-operate with a capacity assessment).

 [↑](#footnote-ref-117)
118. In *Masterman-Lister v Brutton* [2002] EWCA Civ 1889 at [29] - on litigation capacity. See also *Camarthenshire CC v Lewis* [2010] EWCA Civ 1567 at [8]: *per* Rimer LJ ‘the problem raised by this case is as to how, once the court is possessed of information raising a question as to the capacity of a litigant to conduct the litigation, it should satisfy itself as to whether the litigant does in fact have sufficient capacity. I cannot think that the court can ordinarily, by its own impression of the litigant, safely form its own view on that.’ [↑](#footnote-ref-118)
119. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 581. [↑](#footnote-ref-119)
120. See e.g. E. Jackson, *Medical Law: Text, Cases and Materials* (OUP, 2013), at 113 and J. Montrose, ‘Is negligence an ethical or sociological concept?’ (1958) 21(3) MLR 259: ‘A motorist is not excused because he shows that he acted in accordance with the common practice of motorists. The question of negligence is one of what *ought to be done* in the circumstances, *not what is done* in similar circumstances by most people or even by all people’ (at 259). [↑](#footnote-ref-120)
121. M. Brazier & J. Miola, ‘Bye-bye Bolam: a medical litigation revolution? (2000) *Medical Law Review* 8(1) 85 at 90 and developed further in J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship.*  (Hart Publishing, 2007). [↑](#footnote-ref-121)
122. Exemplified by the ‘Bolitho gloss’ which means that the body of opinion supporting D’s conduct may fail to protect D from liability in negligence if that evidence ‘does not withstand logical analysis’: *Bolitho v City & Hackney Health Authority* [1996] 4 All ER 771. See e.g. R. Mulheron, ‘Trumping Bolam: A critical legal analysis of Bolitho’s gloss.’ (2010) 69(3) CLJ 609. [↑](#footnote-ref-122)
123. *Wandsworth CCG v IA* [2014] EWCOP 990; *Re SB* [2013] EWCOP 1417*,* and *CC v STCC* [2012] EWCOP 2136*.* [↑](#footnote-ref-123)
124. R. A. Houston, ‘Professions and the Identification of Mental Incapacity in Eighteenth Century Scotland.’ (2001) 14(4) *Journal of Historical Sociology* 441. See also J. Eigen, *Witnessing Insanity: Madness and Mad Doctors in the English Court.*  (Yale University Press, 1995) exploring the growing role of medical witnesses in the 18th and 19th centuries. [↑](#footnote-ref-124)
125. Ibid., Houston at 457. [↑](#footnote-ref-125)
126. Practice Note 15 for the Court of Protection issued May 2014 states: ‘In addition, where possible, matters requiring expert evidence should be dealt with by a single expert’ (para 1). [↑](#footnote-ref-126)
127. Above at n.2. [↑](#footnote-ref-127)
128. The first of three requirements set out in *Winterwerp v Netherlands* (1997) 2 EHRR 387. Such expertise is not required in an emergency but must be obtained as soon as possible thereafter. [↑](#footnote-ref-128)
129. *Law Commission Consultation on Mental Capacity and Deprivation of Liberty* (2015) at 7.174 citing *Nagach v Netherlands* App No 5379/02 (Admissibility). [↑](#footnote-ref-129)
130. The ‘deviation’ cases discussed above. [↑](#footnote-ref-130)
131. *Ibid.* at para [40]. [↑](#footnote-ref-131)
132. Article 4. [↑](#footnote-ref-132)
133. S. Sarker and G. Adshead, ‘Black robes and white coats: who will win the new mental health tribunals?’ (2005) 186 *Brit J of Psychiatry* 96. [↑](#footnote-ref-133)
134. B. Angell and G. Bolden, ‘Justifying medication decisions in mental health care: Psychiatrists' accounts for treatment recommendations.’ (2015) 138 *Social Science and Medicine* 44*.* [↑](#footnote-ref-134)
135. J. Peay, *Tribunals on Trial: A study of decision making under the Mental Health Act 1983.* (Clarendon, 1989). [↑](#footnote-ref-135)
136. J. Peay, *Decisions and Dilemmas: Working with Mental Health Law.* (Hart Publishing, 2003) pp.14-16. [↑](#footnote-ref-136)
137. See Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: Post-Legislative Scrutiny, HL Paper 139, particularly 84 to 89. [↑](#footnote-ref-137)
138. R. Cairns et al, ‘Prevalence and predictors of mental incapacity in psychiatric in-patients’ (2005) 187 *British Journal of Psychiatry* 379; S. Whyte et al, ‘Testing Doctors’ Ability to Assess Patients’ Competence’ ( 2004 ) 27 *International Journal of Law and Psychiatry* 291; Mukherjee S, Shah AK, ‘The prevalence and correlates of capacity to consent to a geriatric psychiatry admission’. (2001) 5 *Ageing & Mental Health* 335. [↑](#footnote-ref-138)
139. V. Raymont et al., ‘Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study.’ (2004) 364 *Lancet* 1421. See also the House of Lords which suggested that whilst there were problems of over-identification of incapacity, equally there were problems of the presumption of capacity being used as a device to avoid responsibility for decision making (at 105). [↑](#footnote-ref-139)
140. For a recent exception, see the case of *Re CD* [2015] 74 – assessment of capacity to consent to surgical removal of ovarian masses. [↑](#footnote-ref-140)
141. E.g. *Oldham MBC v GW and PW* [[2007] EWHC136 (Fam)](http://www.bailii.org/ew/cases/EWHC/Fam/2007/136.html), cited with approval in e.g. *CC v STCC* [2012] EWCOP 2136; *PH v A Local Authority* [2011] EWCOP 1704; *GW v A Local Authority* [2014] EWCOP 20; *A Local Authority v M* [2014] EWCOP 33; *Kings College NHS Trust v C* [2015] EWCOP 80;and *Re CS* [2016] EWCOP 10. [↑](#footnote-ref-141)
142. This general rule of identifying expert witnesses is set out in para 20 of *Practice Guidance (Transparency in the Court Of Protection)* [2014] EWCOP B2. [↑](#footnote-ref-142)
143. M. Galanter, ‘Why the “haves” come out ahead: speculation on the limits of legal change.’ (1974) 9(1) *Law and Society Review* 165 – a seminal paper which explores the organisational and tactical advantages enjoyed by those repeatedly engaging in litigation as compared with ‘one-shotters’. [↑](#footnote-ref-143)
144. G. Grant and D. Studdert, ‘The injury brokers: an empirical profile of medical expert witnesses in personal injury litigation.’ (2013) *Melbourne University Law Review* 831. [↑](#footnote-ref-144)
145. *A Local Authority v WMA & Ors* [2013] EWCOP 2580 at [19]. [↑](#footnote-ref-145)
146. <http://www.psychiatrydirect.co.uk/expert-witness/>. [↑](#footnote-ref-146)
147. E.g. in *PH v A Local Authority* [2011] EWCOP 1704 at para [16]*,* the judge refers to earlier authority where the expert’s construction of s.3 is adopted by the court, noting that ‘coincidentally’ it is the same expert as appointed in the present case! [↑](#footnote-ref-147)
148. S. Gross, ‘Expert Evidence.’ (1991) Wis L Rev 1113 at 1132. [↑](#footnote-ref-148)
149. Appearing in [*Re E (Medical treatment: Anorexia)* [2012] EWCOP 1639](http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCOP/2012/1639.html&query=%22Dr+Tyrone+Glover%22&method=boolean); [*A NHS Foundation Trust v Ms X (By Her Litigation Friend, the Official Solicitor)* [2014] EWCOP 35](http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCOP/2014/35.html&query=%22Dr+Tyrone+Glover%22&method=boolean), [*Wye Valley NHS Trust v B* [2015] EWCOP 60](http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCOP/2015/60.html&query=%22Dr+Tyrone+Glover%22&method=boolean)and *Re W (Anorexia)* [2016] 13. [↑](#footnote-ref-149)
150. *Re E (Medical treatment: Anorexia)* [2012] EWCOP 1639 – the case provides an interesting contrast with *Ms B v A NHS Trust* [2002] EWHC 429 where the protective bias of the treating clinicians is considered to be a reason for discounting their view that P lacked capacity. See further n.150 below where *Re E* is referenced further. [↑](#footnote-ref-150)
151. *Re E (Medical treatment: Anorexia)* [2012] EWCOP 1639 at [52] – that anyone with severe anorexia would lack capacity in relation to issues surrounding eating – a position which appears to be in conflict with s.2(3)(b) which states that a lack of capacity cannot be established merely be reference to a particular condition suffered by P. [↑](#footnote-ref-151)
152. J. Montgomery, C. Jones and H. Biggs, ‘Hidden law making in the province of medical jurisprudence.’ (2014) 77(3) MLR 343 at 366-367. [↑](#footnote-ref-152)
153. Above at n.126. [↑](#footnote-ref-153)
154. Rule 130. [↑](#footnote-ref-154)
155. These pressures have culminated in a pilot case management scheme to commence mid-2016. [↑](#footnote-ref-155)
156. For similar reasons the Law Commission has advised that two expert medical reports should be the minimum in fitness to plead cases (*Unfitness to Plead* (Law Commission, 2016) at 4.43). [↑](#footnote-ref-156)
157. ‘One thing that worries me is if you have a single joint expert, that’s who decides the case. Is the judge there only as a figurehead?’: ‘Expert witness critic says no need for regulation- yet.’ *Law Society Gazette*, 7th November 2014. [↑](#footnote-ref-157)
158. E.g. J. Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship.* (Hart Publishing, 2007) and, although not specifically using the term medicalisation, but clearly concerned with jurisdictional matters in the application of the best interests test: M. Quigley, ‘Best interests, the power of the medical profession and the power of the judiciary.’ (2008) 16(3) *Health Care Analysis* 233 and J. Montgomery, ‘Law and the Demoralisation of Medicine.’ (2006) 26(2) *Legal Studies* 185. [↑](#footnote-ref-158)
159. J. K. Rowling, *Harry Potter and the Philosophers Stone*. (Bloomsbury Publishing, 1997). [↑](#footnote-ref-159)
160. This contrasts well with the case of *Re C* [1994] 1 WLR 290 where Thorpe J thought that the evidence of C himself ‘added little’ to the expert evidence (at p.293, para C). [↑](#footnote-ref-160)
161. Rule 3(1). And see Peter Jackson J in *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342 at [38]: ‘Bearing in mind JB's longstanding mental illness it is entirely appropriate that the core assessment of her capacity comes from psychiatrists, *but other disciplines also have an important contribution to make*.’ [↑](#footnote-ref-161)
162. Ibid at [38]. [↑](#footnote-ref-162)
163. E.g. S. Halliday et al, ‘An Assessment of the Court’s Role in Withdrawing Clinically Assisted Nutrition and Hydration from Patients in a Permanent Vegetative State.’ (2015) 23(4) Med L Rev 556 referencing applications to the court to legitimise diagnostic decisions. [↑](#footnote-ref-163)