The Bioethical Self Under Review:
from Intrapsychic to Intersubjective Capacity

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ABSTRACT

The Mental Capacity Act 2005 and the practice carried out in its name, sit in a precarious place following a House of Lords Select Committee review. The concern with greater implementation of the Act, as signalled by the House of Lords, risks silencing more significant concerns with the Act. On one level, the House of Lords echoes the Law Commission in accepting mental incapacity as an issue which required and requires a legally sanctioned response. On a more nuanced level, the Act invites healthcare practitioners and others to adopt a particular lens for understanding the self or patient, a lens which bioethical discourse may challenge, endorse or ignore. This thesis seeks to critically engage with these two aspects of the Act from both an ethical and practical dimension.

A framing of contemporary practice in the context of prevailing historical mental health and bioethical discourses, facilitates the identification of mental capacity as receptive to a narrative bioethics approach. The papers in this thesis challenge the credibility of the MCA’s current understanding of capacity, itself predicated on an inconsistent understanding of the process of assessment. In doing so, this thesis suggests that an understanding of mental capacity grounded in the activity of narrative identity can inform a more nuanced understanding of the self, the assessor of capacity and the bioethicist, which is attentive to the tensions in practice by acknowledging values, relations of power and epistemic limitations. In opposition to any search for the ‘right’ way which offers certainty in dealing with incapacity, this thesis proposes a disposition of humility which resists closure and promotes ethical enquiry.
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David Gibson graduated in 2004 from National University of Ireland Maynooth with a first-class honours degree in Anthropology in Philosophy. He subsequently completed an MA in Continental Philosophy at University College Dublin in 2007, a higher diploma in Psychotherapy Studies at UC in 2010 and an MSc in Healthcare Ethics and Law from Royal of Surgeons Ireland in 2011. During his years as a student, David worked as a carer in a healthcare setting where his interest in medical ethics developed. He is currently a Lecturer in Philosophy and Human Development at St Patrick’s College, Dublin City University.

**PhD Publications:**


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This Thesis is in Memory of my Father
Eamonn Gibson
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Chapter 1
The Problem

“When we identify one thing as unlike the others, we are dividing the world; we use our language to exclude, to distinguish – to discriminate”¹

The belief that individuals can either have or lack the ability to make decisions is common, however the practice of classifying individuals according to such ability is neither objective or neutral.² The patient-doctor relationship and healthcare decisions therein, notwithstanding medical and technological advancements, have undergone considerable change in practice and understanding over the last century. Historically the privilege and power afforded to the medical profession permitted doctors to make determinations concerning the good of the patient.³ This approach experienced considerable resistance in the twentieth century as alternative conceptions of the patient’s good were acceded to. The idea that there should be a limit to what can be done to an individual by others is often understood to support the notion of negative liberty. The commitment to negative liberty finds expression in the legal requirement of consent,⁴ however this has been interpreted as granting a right of autonomy or self-determination.⁵ The protection offered by consent however is also tempered by a requirement that any decision is voluntary and made with capacity. A healthcare decision must be voluntary; made in the absence of coercion or undue influence.⁶ The notion of decision making ability or capacity, serves to restrain the right to refuse treatment as individuals must be considered to have positive liberty; the ability to either refuse or consent. As such, individuals afforded the status of capacity enjoy the liberty to sculpt their own involvement with the world, their liberty however is not exhaustive. A finding of incapacity removes the protection of negative liberty and requires a mechanism to be in place to

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³ The Hippocratic Oath demanded of physicians to use ‘power to help the sick to the best of my ability and judgement; I will abstain from harming or wrongdoing any man by it’, *Hippocratic Writings* J. Chadwick and W.N. Mann trs (London: Penguin Books, 1950) 67.
determine the appropriate form of substitute decision-making, of which best interests or a wills and preferences approach are established mechanisms. How decision making capacity is initially theorized and then formalised in law and subsequently practised contributes to a tradition of classifying what actions should count as autonomous and subsequently be afforded respect.

On coming into effect in August 2007, the Mental Capacity Act 2005 (MCA) placed on a statutory basis for England and Wales an understanding that decisions can be either capacitous or incapacitous, a two-stage process for identifying incapacitous decisions, and a best-interests mechanism for making decisions in situations of incapacity. In Section 1 of the MCA, five guiding principles are set out, emphasising the spirit or ethos of the Act as a dual commitment to vulnerable persons. The principles require both a respect for and promotion of autonomy as persons are assumed to have capacity, entitled to practicable supports, entitled to make unwise decisions and decisions made in accordance with the Act must be the least restrictive of a person’s freedom. Where an individual lacks capacity, actions in accordance with the MCA must protect and support the person in being guided by best interests but also the person’s future freedom. The process for identifying that a person lacks capacity in respect of a given decision requires first that they meet the diagnostic threshold; the person must have “an impairment of, or disturbance in the functioning of, the mind or brain”. Following this, the impairment must result in the inability to perform one or more of four functions pertaining to the decision: “to understand the information relevant to the decision, to retain that information, to use or weight that information as part of the process of making the decision, or to communicate his decision (whether by talking, using sign language or any other means)”. The capacity assessment process “serves as a gatekeeper for the right of autonomy” in establishing the conditions under which a person’s liberty to act without interference is safeguarded. As recognised by Lord Justice

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10 Department of Health. Mental Capacity Act (HMSO, 2005), (MCA hereafter) s1(5-6).
11 MCA, s2(1).
12 MCA, s3(1).
Donaldson, the presence of mental capacity calls for recognition of an individual as autonomous before the law and the associated respect of a person’s choices “whether the reasons for making that choice are rational, irrational, unknown or even non-existent”. In cases where a person is found to lack capacity in respect of a decision, a best-interests approach is the approved mechanism for others to decide on the appropriate decision to take. Although a determination of incapacity justifies interference under the MCA, the person’s legal capacity is distinguished from their ability. In accordance with the principles of the MCA, a best interests decision must include the person in the process where practicable and consider the past and present wishes and feelings of the person, beliefs and values as well as consult with others who are familiar with the person.

Although the MCA is well received for its rejection of historical practices, striking a balance between empowerment and protection, and adopting a functional definition of mental capacity, considerable difficulties remain. The adoption of a binary understanding of capacity, whereby a decision maker either has or lacks capacity can be seen to overlook the nuance of ability that exists on a continuum. Additionally, the decision to adopt a four-step functional approach that emphasises ‘use or weighing up’, incorporates greater complexity than an approach based on understanding alone. The possibility of performing a capacity assessment in accordance with the MCA is unclear as guidance on how ‘the use or weighing up of information’ is to be evaluated, whether decisions are to be considered at a discrete time or over time, how the wisdom of a decision is to be separated from the assessment, and finally what provides grounds to initiate an assessment, are unclear. Further challenges arise when the compatibility between the MCA and United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is considered both regarding the

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14 Re T (Adult: Refusal of Treatment) [1992] 3 WLR 782 at [3].
concept of mental capacity and the process of determining what decision is to be made in cases of incapacity. The relation between mental capacity and autonomy, both in theory and in practice, adds further complexity to the use and understanding of the MCA. Finally, questions can be raised about the overall coherence and legitimacy of mental capacity determinations when they can be disregarded at common law and where sixteen and seventeen years old enjoy some of the protections of the MCA.

The practice of assessing capacity is at its most basic a relational activity involving at least two people: an assessor and the assessed. As observed by Eldergill J, the MCA is a legal response to the ethical question posed by John Stuart Mill concerning when is it right to interfere in the actions of others. There is a risk however that capacity is understood through an overly individualistic lens in which capacity is seen as a factual and neutral description about an individual’s ability. Such an interpretation is supported when the MCA is viewed as evaluating the internal processes underpinning decisions not the content of decisions themselves, understood as a mechanism for responding to individuals with impairments and not a process for constituting impairments, associated with the language of testing for capacity and not conferring capacity and finally, framed solely in the language of being person centred at the expense of acknowledging the MCA’s role in conferring legitimacy on healthcare practitioners’ actions. Although the practice of conferring capacity or incapacity focuses on the performance of cognitive processes, it is reliant on an existing relationality being in place. In the case of the MCA, the relationality provides the framework on to which the ethical question of interference in the actions of another is situated.

The MCA and the practice carried out in its name can be read as engaging with broader philosophical issues concerning what view of the self or selfhood should guide bioethics and

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medical jurisprudence. Any critical examination of the MCA accordingly has a variety of options in what is the focus of their work. One can engage with the practical or immediate, examining the use of the MCA in particular cases, difficulties and opportunities in implementation, and identifying trends or approaches in its interpretation. A second approach can look at the MCA functionally, evaluating whether the definition of capacity should be less demanding, whether greater emphasis should be given to relationality, emotion or temporality, and examining the links between autonomy and capacity. A third approach can question the MCA as a practice in its own right, situating it as a historical practice, premised on an unequal relationship of power and reliant on a relational framework. In practice examinations of the MCA rarely stick to just one approach, often moving between the different practical, functional and ethical approaches. The aim of this thesis is to critically examine the MCA as a contemporary phenomenon in healthcare and relatedly its place within bioethical thought. The everyday healthcare issues or decisions for which the MCA provides a response to, are not of principle concern here. Instead the MCA is considered deserving of examination in its own right as it is a mechanism potentially applicable to all, justifies the interference in the actions and decisions of some and adopts a particular understanding of the self. The work is grounded by two questions. First, is the current understanding of mental capacity in the Act coherent and sufficient? The current model is labelled intrapsychic, wherein capacity is understood as a discrete feature of an individual’s engagement with an action. Second, should mental capacity be identified in bioethical thought as an issue relating to personal identity? The model in which mental capacity is read, as grounded in the condition of narrative identity, allows for a model of capacity labelled intersubjective.

The examination of the MCA here is concerned principally with the capacity assessment process, as it is in assessment that the intrapsychic model of mental capacity is endorsed. It is in practice that this understanding of mental capacity must be adhered to. Significantly the capacity assessment process and the process for determining what decisions are made for a person determined to lack capacity adopt distinctive approaches to understanding the self. Although the latter is only activated when a determination of incapacity occurs, the assessment process views the self at a discrete moment in time in respect of the cognitive capacities to make a decision. In contrast the best interests process views the self through time in respect of values and wishes. This primary focus on the understanding of capacity
and the assessment process in this thesis is due to the role it plays in classifying persons as different or other, and consequently in need of a best interests decision making process. To focus solely on the model of the self adopted in the best interest approach risks overlooking how persons are constituted as lacking in capacity and the understanding of the self that underpins this.

The thesis is structured as follows. In chapter 2 an overview of the contemporary practice of assessing capacity is situated at the intersection of historical trends in mental health law and the commitment to autonomy as self-determination in the healthcare relationship. These two discourses are identified as guiding the development of the MCA and its impact on healthcare. Framed accordingly, the MCA can be read as not strictly person centred or concerned with the support and recognition of autonomy but also as practitioner centred as it provides a legal mechanism for conferring legitimacy on healthcare decisions and offers the promise of an ethically appropriate response to the challenge of providing care to another. Although the UNCRPD holds considerable significance in contemporary considerations of the MCA and more broadly the treatment of persons more generally, the approach adopted in this thesis is concerned with the understanding of capacity and the self in the MCA. In chapter 3 the theoretical approach of the thesis is developed from a narrative bioethics perspective. A reading of feminist and critical jurisprudence allows for mental capacity practice to be situated as a practice of positing difference in persons. A philosophical engagement with narrative selfhood is identified as providing bioethics and medical jurisprudence with an alternative lens through which to understand personal identity debates. In chapter 4 the abstracts for the four research papers are situated as they relate to the aims of the thesis and each other. Methodologically this work draws on historical and philosophical approaches to describe and identify challenges in practicing in accordance with the MCA and understanding how mental capacity should be understood in bioethics.
Chapter 2
An Ethical and Legal Background

‘Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past. The tradition of all the dead generations weighs like a nightmare on the brain of the living’ 26

The practice of differentiating persons according to their decision-making ability, as legislated for in the Mental Capacity Act (MCA), is “not Altogether new”, 27 nor is its justification all too clear. In fact, the common sense understanding that some persons lack decision-making ability can all too easily justify a framework for classifying individuals accordingly. The idea that decision making ability is something persons may or may not have, can be viewed as the consequence of an earlier ethical questioning concerning the appropriate level of interference in person’s lives. A finding of incapacity then is not a neutral understanding of individuals or simply a fact about them, but rather is a product of a legally developed framework for understanding people. As such, contemporary ethical or practical problems that arise from a determination of incapacity are secondary to the ethical framework implicit in the MCA itself. This primary ethical position which guides mental capacity practice is often understood as emerging in the 1980s but can be traced back as far back as the 14th century. Accordingly, a coherent understanding of the theoretical and practical problems associated with mental capacity assessment must consider the historical developments and competing discourses that influenced the development of the MCA and contemporary practice.

The concept of mental capacity endorsed in the MCA poses a distinct challenge for any attempt to situate it historically. In addition to the common sense understanding of decision making ability, lies the question of ‘who’ is the object of the MCA. One approach may situate capacity in the context of mental health law, there in it sits alongside the Mental Health Act (MHA), as a mechanism through which the state in conjunction with the disciplines of law

and psychiatry police or respond to mental illness. Mental health law history may be viewed as a tension between legalism and medicalism, whereby each discipline seeks to achieve control or influence over the regulation of psychiatry. An alternative approach can view mental illness or disorder as understood from a liberal democratic perspective. Here psychiatry and the law are mutually supportive in legitimising processes which promote ways of understanding and treating those considered mentally disordered. A further approach may explore mental capacity in the context of the doctor patient relationship and the legality of treatment decisions. Here mental capacity may be considered alongside voluntariness and consent as that which underpins autonomous action and when lacking may legitimise appropriate action on behalf of patients. These respective approaches, each calling for an understanding of mental capacity alongside mental health law, as a product of liberal thought, and as a legal framework for conferring legitimacy on medical practice, reveal mental capacity as a contested concept.

This chapter proposes an understanding of mental capacity as a legal concept that allows for an understanding and sanctioning of particular ways of living. The approach to mental capacity adopted in the MCA is identified as emerging from the coming together of a legal-medical discourse perpetuated in mental health law and a philosophical-legal discourse which involves viewing patients as having a right to self-determination. This chapter traces the development of these two discourses as they contribute to a period beginning in the 1980s in which there is a concerted effort to reclaim mental capacity. This is followed by an overview of the principle understanding of mental capacity and the process for addressing cases of incapacity as set out in the first four sections of the MCA. Following this, current practice issues in adhering to the first four sections of the MCA are introduced. Finally, the MCA is considered in light of the commitments adopted in terms of defining mental capacity and how the MCA can be situated in ethical theory. The central question running throughout the following chapters concerns whether the philosophical-legal perspective underpinning mental capacity practice, namely a liberal intrapsychic understanding may be challenged by

a philosophical-legal approach that emphasises narrative identity and interpersonal understanding.

2.1 The Sanctioned Self: Developments in Mental Health Law
Together, the MCA and MHA constitute one of the ways in which the state has addressed the issue of how to “deal” or respond to mental illness. This response is not isolated however but part of a long history tracing back to the 14th century. It is only in understanding the developments in mental health law over the last 600 years that the contemporary understanding of capacity and the challenges of practice can be appreciated and evaluated. Mental health law, as both representative of the state’s response to mental illness and also the legislative context through which persons become understood and responded to, is instrumental in sanctioning ways of living. This sanctioning is two-fold. Firstly, in identifying the conditions under which one’s existence may come to be classified as disordered, idiotic, lunatic, etc., mental health law sanctions how existence is to be understood. Secondly, in permitting specific forms of treatment or action to be performed on or against those considered other, mental health law both sanctions the behavior of those performing the action but also imposes sanctions on those classified as other. In this section, an overview of developments in mental health law is constructed through a reading of how classification and intervention in the lives of others has been justified and how that justification has changed

Although the 18th century is heralded as the period in which medicine and the law engaged with mental illness or disorder, as far back as Ancient Greece the question of how to treat those considered insane is an issue. The roots of the modern treatment of people considered to have mental illness can be traced back to the Statute De Praerogativa Regis of 1324. Under the statute the entitlement of the crown extended to the land or lands and property of idiots and lunatics. The different labels of idiot and lunatic served to distinguish between

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those with innate or natural mental illness and those who had been of sound mind and may once again retain such ability. In the case of idiots the Crown became entitled to the profits of their estate and for lunatics the profit of the estates was held in trust for the individual. Significantly the Crown’s interest in mental illness here exhibited both a mechanism for classifying persons which justified a particular action and a concern with those with mental illness and estates. These two features became defining features of mental health law over the coming centuries. The second half of the 14th century sees the opening of the first psychiatric hospital in Bethlem, London, which allowed for the admittance of ‘lunatics’ from 1377.

As of the 18th century the prerogative jurisdiction of the crown was assigned to the Lord Chancellor. In place at this time was a growing concern with vagrants and the state’s attempt through legislation to instruct each county to provide facilities to address “rogues, vagabonds, sturdy beggars and other idol and disorderly persons”. The predominant provision of care or response to those considered mentally disordered was carried out informally by families and religious institutions. Care of individuals in madhouses or asylums was predominantly the preserve of the rich, however there was no medical or legal regulation of this care. The end of the 18th century sees a shift in the state’s interest from simply the property of the mentally ill to the mentally ill person more generally.

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34 ibid.
35 Michael MacDonald, Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth Century England, (USA: Cambridge University Press, 1981) 6, understood the chief concern of the crown in dealing with landowners with lunacy “was to preserve the integrity of their estates so that their lineages would not be obliterated by the economic consequences of their madness”.
emergence of a state supported asylum system for incarcerating the mentally ill at this time beckons in the “carceral era”, where an equating of the mentally ill with detained patient takes root.\textsuperscript{42} Although sometimes read as a sign of the state’s greater interest or care for those who are ill, the requirement to differentiate those who can serve and maintain the economy and society from those who are unable, is offered as a more accurate explanation of the change of interest.\textsuperscript{43}

To facilitate the new phase in the state’s response to mental illness, a raft of legislation developed at the end of the 18\textsuperscript{th} and beginning of the 19\textsuperscript{th} century. The Madhouses Act 1774 introduces an inspection regime and a requirement for the licensing of private madhouses. The Act also created a Lunacy Commissions which were tasked with the duty of inspecting and licensing premises.\textsuperscript{44} The Vagrancy Act 1774, in contrast addressed the institutional responses to the poor mentally ill. In response to the practice of institutional workhouses which held those either socially undesired or disordered, the Vagrancy Act establishes a process for justifying their detention. Two justices of the peace could order a disordered person in public to be held in a secure institution.\textsuperscript{45}

The passing of the County Asylums Act 1808 permitted magistrates of each county to establish an asylum. Alongside this support for an institutional response to mental illness, concerns were noted about the treatment of individuals in asylums and also the inability of medicine to provide treatment or a cure for mental illness. The failure of the 1774 Act to address how individuals were treated resulted in the appointment of a Parliamentary Select Committee in April 1815. Godfrey Higgins, a Yorkshire Magistrate carried out an enquiry into the York Asylum. Higgins observed “maltreatment of the patients extending to rape and murder; forging of records to hide deaths among the inmates; an extraordinarily widespread use of chains and other forms of mechanical restraint”.\textsuperscript{46} In 1828 The Board of the

\begin{itemize}
\item \textsuperscript{42} \textit{Ibid}, 259.
\item \textsuperscript{43} Andrew Scull, \textit{The Most Solitary of Afflictions: Madness and Society in Britain 1700 – 1900} (New Haven: Yale University Press, 1993) 3.
\item \textsuperscript{44} Clive Unsworth, ‘Mental Disorder and the Tutelary Relationship: From Pre- to Post- Carceral Legal Order’ (1991) 19(2) \textit{Journal of Law and Society} 259.
\item \textsuperscript{45} Nicola Glover-Thomas, \textit{Reconstructing Mental Health Law and Policy} (UK: Butterworths, 2002) 4.
\item \textsuperscript{46} Andrew Scull, \textit{The Most Solitary of Afflictions: Madness and Society in Britain 1700 – 1900} (New Haven: Yale University Press, 1993) 111. For a detailed account see Kathleen Jones, \textit{A History of the Mental Health Services} (London: Routledge and Kegan Paul 1974) 66 – 75.
\end{itemize}
Metropolitan Commissioners in Lunacy was established, who were tasked with both inspecting and licensing madhouses. The remit of the Board was extended under the Lunatics Act 1842 and then renamed the Commissioners in Lunacy under the Lunatics Act 1845. The issue in the treatment of lunatics concerned how they should be cared for but with an implicit understanding that lunatics could be “treated without consent”.47

The Lunatics Act 1845 represents the basis of modern mental health law, facilitating the development of asylums throughout England and Wales.48 At this time the asylum became more than an option but rather the appropriate response for the mentally disordered.49 Each county was mandated to construct an asylum for pauper lunatics.50 The Act, reflecting the aspirations of medicine to find the biological basis of all illness, adopted a naturalistic understanding of health. The Lunacy Commission and local magistrates were tasked with the registration and inspection of county asylums, workhouses and private institutions.51 The Act required that before an individual could be placed in an institution a request by an individual be backed by two medical professionals. The Act established clinical judgment as privileged, allowing for individuals to be treated without consent. Two grounds are observed by Cavadino which justify the detention of the disordered, either a risk to others or in the individual’s own interests.52 Unsworth observes that the Lunacy Commission allowed for granting that “any person of unsound mind, whether he be pronounced dangerous or not” could be placed in detention within an asylum.53 The state’s interest in mental illness however still maintained a distinction between poor and wealthy lunatics.54 The commission established a process of inspection requiring at least two inspections a year by a barrister and

a doctor.\textsuperscript{55} The Act required that all institutions providing care of the mentally ill have appropriate documentation concerning both patient care and where relevant, detention.

The mid-nineteenth century witnessed the development of the medical profession alongside the establishment of an institutional response to mental illness. In 1841 the Association of Medical Officers of Asylums and Hospitals had been founded, which in 1865 was renamed the Medico-Psychological Association, then in 1926 the Royal Medico-Psychological Association and finally in 1971 became the Royal College of Psychiatrists.\textsuperscript{56} The Medical Registration Act 1858 brought together the previously distinct categories of physician, surgeon, and apothecary.\textsuperscript{57} The 1845 Lunacy Act served to reinforce this emergent medical profession, as legislation sought to ensure the appropriate medical and institutional response to mental illness. The support for the medical profession soon came under scrutiny as the Lunacy Commission increasingly became concerned with the ethics of psychiatric treatment, seeking to identify what appropriate forms of treatment means.\textsuperscript{58} Towards the latter half of the nineteenth century there were growing concerns about treatment within institutions and the possible abuse of power by the medical profession. These concerns resulted in the establishment of a Parliamentary Select Committee to examine lunacy laws in 1877.\textsuperscript{59} The Select Committee highlighted the importance of protecting individual liberty, the implementation of reviews of detention processes, and the idea that care “should be carried out at home or in the less restrictive environment”.\textsuperscript{60}

The 1890 Lunacy Act, which consolidated the 1889 Lunacy Acts (Amendment) Act, established a clear understanding of the procedures required for the detention process and is considered a highpoint for legalism. The Act established the only procedures under which lunatics could be detained in any institution. The detention of a patient required judicial oversight wherein a “reception order” made up of the initial petition and two medical

\textsuperscript{56}ibid, 4.
\textsuperscript{59} ibid, 51.
certificates provided the basis for admission. The Act introduced the requirement that those admitted without judicial authority, had within twenty-four hours, a right of hearing concerning their admission. The Act further required a monthly report to be submitted following patient admission. Where individuals were detained over a certain period, a report would have to be provided to the Commission. The initial stage for review was set at one year stretching to five years for patients in long term detention. Although referred to commonly as the highpoint of legalism by some, the Act’s protective focus was aimed at private patients who under the Act could not be incarcerated without judicial authority. The Act however also served to legitimise the medical approach to mental illness, merely adding legislative protections to ensure the appropriate persons were in institutions.

The Mental Deficiency Act 1913 rebranded the Lunacy Commission as the Board of Control and radically altered its remit. The Board in 1919 came under the Ministry of Health but from 1913 was the primary governmental department directing the state’s response to mental illness. This renewed focus on addressing mental illness emerged at a time when a growing fear of the effect mentally ill people may have on others was emerging. The Act expanded on those who were to come under its remit to include those with mild learning disabilities. From the turn of the century the issue of consent in treatment began to have greater influence and by the 1920s the issue is recognised by the Board of Control. As the Act came into force in 1920, arguments for eugenic policies emerged. The Brock Committee set up in 1929 in England was tasked with considering the possible utilization of eugenic practices to prevent mental disorder. The report of the Committee held that sterilization was justified where in the patient’s interests, but held that sterilization on eugenic grounds should remain illegal.

In 1924 the government announced a Royal Commission led by Hugh Pattinson MacMillan to examine the law in England and Wales as it relates to those who are mentally ill or of

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62 ibid, 54.
63 ibid, 77.
64 ibid.
unsound mind. The Commission was prompted by an alleged case of wrongful detention and the related concern that the 1890 Act had failed to protect patient’s liberty as intended. The report evidenced a shift away from legalism as a call for a greater acknowledgement of medical opinion was required. The report called for greater medical discretion and as such justices of the peace should act in accordance with medical recommendations. The Commission however rejected the idea that infringement of liberty was common. The reason for this turn back to medicalism is questionable, as psychiatry’s ability to address mental illness showed no clear success. Significantly the Commission did call for greater protection for the medical professional, arguing that the appropriate defence should be the use of reasonable care.

The Mental Treatment Act 1930 carried forward the shift back to medical authority. The Act introduced a procedure for voluntary admission whereby notice was to be provided in writing, established a seventy-two-hour notice before voluntary patients could discharge themselves, and crucially introduced a temporary treatment order for patients’ incapable of consenting for treatment. Applications for admission to institutions, then called mental hospitals, were to be made directly to the hospital. The Act required that after six months the patients were either released or to be detained under the Lunacy Act. The Act demonstrated a shift in therapeutic control, whereby greater scope for voluntary engagement with mental health services emerged but procedures were maintained that allowed for medical discretion to hold sway.

The period between the 1930s and 1950s bears witness to the continued expansion of psychiatry and ‘developments’ in treatment options including electro shock treatment, psychosurgery and pharmacology. The foundation of the NHS under the National Health Service Act 1946 contributed to moves for an attempt to develop comprehensive mental

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71 *ibid*, 115.
health services. In 1954 a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency was established and published its final recommendation in May 1957.\textsuperscript{72} The Commission, echoing moves as far back as the 1890s, called for greater informal or voluntary admission procedures. The Commission recommended removing the requirement for written application in the case of voluntary admission, that the basis for formal admission be based on strictly medical grounds requiring two medical recommendations and the removal of the role of the magistrate in the process. The Commission proposed in its place the introduction of Mental Health Review Tribunal, which would examine and review the use of compulsory powers.

The Mental Health Act 1959 enacted many of the Commission’s recommendations and in doing so is considered the highpoint of medicalism.\textsuperscript{73} The Act brought together mental illness and learning disability under one statute and removed the practice of determining someone as mentally disordered by reason of immoral conduct. The Act required that detention would only be permitted where an individual has a mental disorder and the justification was either the protection or well-being of the individual or the protection of others. At the core of the Act’s agenda was a move away from institutional care and the development of guardianship as an appropriate mechanism for responding to those who are mentally ill or disordered. The Act established for patients the ability to seek review of their detention by appeal to a Mental Health Review Tribunal (MHRT). The MHRT’s however required of patients to demonstrate that they are not suffering from a mental disorder, rather than placing the onus on doctors to establish the presence of a condition. As the Act permitted decisions to be made on behalf of people considered mentally disordered, the application of the royal prerogative in relation to mental health can be considered to have been put in to abeyance. In bringing guardianship directly under statute, the prerogative power was removed from common law and placed on a statutory footing.\textsuperscript{74}

In the years following the 1959 Act, confidence and support for the deferential approach to medicine came under sustained scrutiny. The anti-psychiatry movement cast doubt on the

\textsuperscript{73} \textit{ibid}, 27.
\textsuperscript{74} Peter Bartlett and Ralph Sandland, \textit{Mental Health Law: Policy and Practice} (4\textsuperscript{th} Edition, Oxford: Oxford University Press, 2014) 27.
legitimacy of mental illness as comparable to physical illness, suggesting rather that mental illness diagnosis was a means of social control. The Act’s ability to keep those considered unsafe and a threat to others was called into doubt. Arguably the most important development at this stage was the growing concern with patients. The National Association for Mental Health (MIND) under the direction of Larry Gostin, its legal officer, campaigned for greater legal protection to be afforded to patients in mental health services. In 1975 an interdepartmental committee renewed the 1959 Act and a white paper for reform of mental health law was published in 1979. This movement for greater legal protection is often referred to as ‘new legalism’, as distinct from the legalism associated with the 1890 Act.75

The Mental Health Act 1983 adopted the more legalistic approaches called for in the years following the 1959 Act. The Act provided clarity in respect of the responsibilities of various professionals in the mental health service. The Act reduced the periods patients could be involuntarily detained for, holding that compulsory treatment could only be for six month periods which could be followed by another six month period. Patients were afforded double the right to seek Mental Health Review Tribunals as before. Importantly, the powers of personal guardians were considerably reduced. The guardian could no longer consent on a patient’s behalf and so the guardian’s power over or for the individual in question was considerably curtailed.

The developments in mental health law from the 18th century up until 1983 serve as a clarion call to any attempt to understand and engage with contemporary mental health legislation. The shifts in the state’s response to mental illness have their origins not simply in medical and legal disciplines, seeking to achieve primacy, but also public concerns about safety, degeneration, liberty, and the provision of care. Although numerous Acts have been passed and changes in practices have occurred over the last few hundred years, what is "striking is less how much things have changed, as how much they have remained the same".76 The focus on developments in periods of legalism, medicalism and new-legalism are significant, however it must also be acknowledged that mental health law is largely the result of

psychiatry and the law working alongside each other. Unsworth invites the developments in mental health law to be understood as a “Relation de tutelle” or a tutelary relation. Although developments in law and society have sought to change the ‘who’ that comes under the remit of this relation and for what reason, how persons in positions of power are to act in this relation, and the space in which this relation is to be performed, the relation of tutelary has remained. The developments under the Mental Health Acts of 1959 and 1983 represent a further transition period in how this tutelary relation is to be performed and justified, involving a shift from an institutional focus on the entire person towards a non-institutional approach that focuses on specific aspects of a person’s life.

The understanding of mental capacity law as principally a form of relation is taken up in chapters three, six and eight and identified as the frame through which bioethics should begin to understand mental capacity practice. The ethical or legal principles under which the tutelary relation is performed may alter, however the relation itself remains and is a fundamental vehicle through which the state engages in sanctioning particular subjectivities and lives. Soon after the 1983 Act, a perceived difficulty in the tutelary relation is observed and constitutes the beginning of a process that leads to the Mental Capacity Act. This development is discussed in section 2.3. To understand the developments of the tutelary relation it is important to appreciate the broader developments in theorizing the healthcare relationship in bioethics and medical law throughout the 20th century.

2.2 A Movement Away from Paternalism

Over the last century the practice of medicine and healthcare more generally has experienced a considerable movement away from its traditional authority. The patient who previously was understood as a “passive recipient of medical care” is now considered vital to the decision-making process and their perspective is critical. The rejection of traditional paternalistic practices, wherein doctors were entrusted with acting appropriately, has seen ideals of

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autonomy, self-determination, liberty, and freedom, posited as guiding principles for the healthcare relationship. Contemporary health care practice can be considered as the site of competing commitments; “to enhance the patients’ well-being and to respect the person as a self-determining individual”. The question about when a patient’s wishes should not be respected or taken as action guiding, or how to act when a person lacks the ability to be self-determining, are but two difficulties emerging from this more recent trend in healthcare. The provision of healthcare is thus challenged by the question of what good it should pursue, where is the patient to have a role and how is this to be practised. The engagement with these debates in both law and bioethics can be seen in the development of informed consent procedures to regulate the healthcare relationship. The rise in informed consent procedures here is discussed in the context of a move away from paternalism, as it is through the respect for autonomy and self-determination that paternalist medicine is seen to be challenged. The identification of where practice is coming from, namely paternalism, is grounded in what practice we seek to eclipse rather than how we want to guide practice. The developments in law and ethics’ engagement with the healthcare relationship up until the 1980s and 1990s, contribute to the context in which difficulties in the tutelary relation were first acknowledged and then responded to in the 1980s and onwards.

A feature of modern healthcare law is the requirement of consent for medical treatment. A healthcare decision is considered valid where the decision is made voluntarily and where the decision maker has capacity to make the decision on foot of being provided with the appropriate information. The coherency of consent thus requires a duty or practice on the part of healthcare professionals to disclose information to patients. The adoption of informed consent procedures, comprised of disclosure of information and capacitous and voluntary

81 Edmund Pellegrino, ‘Moral Choice, the Good of the Patient, and the Patient’s Good’ in Hugo Tristram Engelhardt Jr and Francois Jotterand (eds) The Philosophy of Medicine Reborn: a Pellegrino reader (United States: University of Notre Dame Press, 2008) 164 – 178, Pellegrino identifies four senses of the good: “the patient’s ultimate standard for his life’s choices”; the biomedical good (paternalism); the “patient’s perception of his own good at a particular time” and; the “operation of the capacity to use reason to make choices and to communicate these through speech.
82 John Coggon and Jose Miola, ‘Autonomy, Liberty and Decision-Making’ (2011) 70 Cambridge Law Journal 523. Coggon and Miola observe that in the movement away from paternalism there has been a failure of the courts to “distinguish political concepts of liberty and moral concepts of autonomy”.
decision making, is a recent phenomenon having only developed after the 1950s.\textsuperscript{83} The idea of consent being relevant in medical care however can be traced back to the mid eighteenth century.\textsuperscript{84} The relevance of the disclosure of information however is until the mid-twentieth century for the doctor’s benefit, as it provides a defence against charges of battery or negligence. The legal requirement for the modern approach to consent, developed in the United States through a series of decisions in the court of battery.

In \textit{Mohr v. Williams} (1905)\textsuperscript{85} the court found that violation of the body is forbidden without express permission.\textsuperscript{86} For consent to be valid the patient here must understand information related to risks and have the ability to weigh these up and finally authorise the treatment. The \textit{Mohr v Williams} case further reinforced the view that for certain healthcare treatments a patient’s express authorisation is required. The 1914 case of \textit{Schloendorff v. Society of New York Hospitals} involved the removal of a tumor when the patient had expressly only permitted examination under anaesthesia.\textsuperscript{87} Although the case centred on liability and the issue of information provided irrelevant, Justice Cardozo articulated a patient’s right to self-determination.\textsuperscript{88} Significantly however the right to self-determination is only for those of ‘adult years and a sound mind’, thus placing a caveat on the right. The basis of modern informed consent procedures thus emerged in the context of self-determination grounding the right to be free of bodily violation.\textsuperscript{89}

The development of the duty to inform or disclose information to allow for consent begins to emerge in the late 1950s. In the case of \textit{Salgo v. Lelgand Stanford Jr. University Board of Trustees} (1957),\textsuperscript{90} the court found that physicians have a duty to disclose relevant facts which

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\textsuperscript{85} 95 Minn. 261, 104 N. W. 12 (1905)
\textsuperscript{87} \textit{Schloendorff v. Society of New York Hospital} (1914) 211 NY
\textsuperscript{88} \textit{Ibid}, at [125] “every human being of adult years and sound mind has a right to determine what shall be done with his own body: and a surgeon who performs an operation without his patient’s consent commits an assault”.
\textsuperscript{90} 317 P.2d
\end{flushleft}
are necessary for a patient to authorise the treatment. This commitment to disclosure was tempered however with the ruling that the level of information provided should be left to medical discretion. The case enhanced the understanding of consent towards one which is based on appropriate levels of information (informed consent) but which is also based on respect for self-determination. In the years that followed cases of malpractice adopted the importance of disclosure of information but two options of redress remained, claims in negligence or battery. This resulted in two streams or approaches to informed consent and malpractice, one grounded in battery and the other in negligence. The question of what level or standard of information should be disclosed to patients was opened up in cases in the early 1970s, notably *Canterbury v. Spence*.\(^91\) This case concerned the disclose of a 1% risk of paralysis as part of a laminectomy for severe back pain. The court ruled that the standard for information disclosure should not rest simply with doctors, but rather be based on the what the reasonable person would wish to know.

The development of medical law in the UK addressed similar issues as those in the United States in addressing malpractice and identifying the appropriate requirements of consent. Where a patient is touched or has their body violated without consent, the actor is considered guilty of trespass and the tort of battery committed. Accordingly, where consent is secured, doctors may not be sued under battery. In *Chatterton v Gerson*,\(^92\) this protection of consent for both patient and doctor is such that any contact without authorisation is forbidden, whether any harm accrues from the action or not. Crucially however the standard for disclosure is understood in broad terms. The UK courts reflect a preference to read medical malpractice failings through the lens of negligence.\(^93\)

An action in negligence requires that the defendant, here a healthcare professional, owe the patient a duty of care, breach that duty, and the breach result in damage.\(^94\) For the focus of this work however, the first two are relevant as they pertain to the developing understanding of the therapeutic relationship. The origin or source of the duty healthcare professionals have

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\(^91\) 464 F.2d (D.C. Cir. 1972)
\(^92\) [1981] 1 QB 432
\(^93\) *Sidaway v. Bethlem Royal Hospital Governors* [1985] AC 871.
towards their patients is largely presumed, with greater focus being directed to identifying breaches of duty. In the case of Bolam, the question concerned what degree of information concerning risks associated with electro-convulsive therapy should be disclosed. Although the court found that the doctor had failed to disclose information that Mr Bolam would have considered important, the standard level of information to be disclosed was set by professional standard. In the case of Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital, the House of Lords considered whether the failure to disclose a two per cent risk of nerve damaged and a less than one per cent risk of damage to spinal cord by the doctor and hospital constituted negligence. The ruling itself, made ten years after the operation, principally adopted the Bolam approach to the professional standard of disclosure of information. There was no breach of the duty of care owed to Mrs Sidaway. The decision in 1985 is a rejection by four of the five law lords of the ‘reasonable person’ standard which emerged in US cases concerning informed consent. Notably, Lord Justice Scarman rejected the judgement and attested the right of patients to self-determination. The adoption of a Bolam approach however was tempered with the requirement that reasonable medical practice alone is not sufficient to provide a defence against negligence.

The Sidaway approach to medical negligence and consequently the doctor-patient relationship is radically departed from in Montgomery v Lanarkshire Health Board. The case considered whether the failure to inform Nadine Montgomery, pregnant with her first baby, of the risk of shoulder dystocia, a recognized complication of insulin dependent diabetes, was negligent. The decision of Dr McClelland against advising Mrs Montgomery of the risks associated with a natural birth also included a failure to discuss the possibility of an elective caesarean section. The undisclosed risk materialized at birth, resulting in a failed natural delivery and a period of partial or complete occlusion of the umbilical cord resulting in oxygen deprivation. Mrs Montgomery’s son was diagnosed with cerebral palsy as a result of deprivation of oxygen. An elective caesarean section would have resulted in her son being born uninjured. The case was initially heard in the Court of Sessions and subsequently the Inner House and both counts found against Mrs Montgomery on the grounds of Dr McClelland acting in accordance with a standard accepted by the medical profession. The

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95 Bolam v Freirn Hospital Management Committee [1957] WLR 582.
case was successfully appealed to the Supreme Court who were invited to reconsider the duty of care towards a patient.

In the majority ruling Lords Kerr and Reed observe a changing understanding of the doctor-patient relationship which is evident in the General Medical Council’s guidance and the influence of human rights approaches towards one in which patients are considered legitimate participants in healthcare decisions and not simply subject to medical paternalism.97 Doctors have a duty to “take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatment”.98 The test of materiality is comprised of two aspects, a reasonable patient and a particular patient test.99 To facilitate the meeting of this duty there is an expectation that doctors engage in dialogue, with a requirement that doctors be sensitive to the way information is disclosed to a patient.100 Two exceptions to the duty of disclosure hold in cases of therapeutic privilege, where the disclosure would be detrimental to the patient’s health, and by necessity, where the patient requires emergency treatment and is unconscious or unable to make a decision.101 In the concurring minority ruling of Lady Hale, the starting point is the autonomy of patient choice.102 Accordingly the disclosure of information relevant to a procedure must also include its alternatives, as to fail to do so is to reduce all decision to simply yes/no types.103 The ruling in Montgomery can be seen on a narrow level to reflect a move towards a subjective patient standard for disclosure. However, on a broader level it seeks to consider the nature and necessity of dialogue in the doctor-patient relationship and so address both negligence and consent.104

97 ibid, at [77-81].
98 ibid, at [87].
101 Montgomery v Lanarkshire Health Board [2015] UKSC 11 at [88].
102 ibid, at [107-108].
103 ibid, at [109].
Accompanying developments in how the law theorised and ruled on the healthcare relationship, the emerging field of bioethics and medical ethics, alongside societal developments contributed to a changing discourse around patient’s rights and the healthcare relationship. In response to the practice of medicine in the aftermath of the Second World War, concern with the ethical aspects of medicine emerged in the 1950s and 1960s. The moral principles of ‘respect for autonomy, beneficence, and justice’, can be seen to support or justify the adoption of informed consent procedures in the US and to a lesser extent in the UK.\textsuperscript{105} These three principles, alongside non-maleficence were proposed as four basic principles to both guide and facilitate critical debate on medical and biomedical issues.\textsuperscript{106} During the 1960s and 1970s the rise in resistance movements such as the civil rights and women’s rights movements, contributed to a greater call for accountability and critically a shift to the rights of individuals.

2.3 Reclaiming Mental Capacity
The Mental Health Act 1983 set out the statutorily approved definition of the tutelary relation. The tightening up of guardianship regulations and clarification about processes involving consent from the 1959 to 1983 Acts, itself a product of a call for greater legal protection for patients, led to the identification of perceived difficulties in the law.\textsuperscript{107} The powers of the guardian under the Act were limited and prevented medical decisions being made on behalf of a patient by a guardian. Under Part IV of the 1983 Act, any form of medical treatment required the consent of the patient save where an urgent treatment is required to save the patient’s life, where treatment is not irreversible and necessary to prevent serious deterioration, and where treatment is neither irreversible or hazardous to alleviate serious suffering or where it is the minimum interference necessary to prevent harm to the patient or others. The 1983 Act accordingly only sanctioned treatment without consent in specific cases. Where individuals lacked the ability or capacity to make decisions but failed to come under the Act’s remit, although unable to make a decision, there was no approved procedure

\textsuperscript{107} Brenda Hale, ‘Mentally Incapacitated Adults and Decision-Making: An English Perspective’ (1997) 20(1) \textit{International Journal of Law and Psychiatry} 59, identified the problem as one of “glaring deficiencies”.

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to make decisions on their behalf. The 1983 Act however maintains under Section 63 that consent is not required for treatment of a mental disorder a person is suffering from. The Act can be read as distinguishing between mental capacity and legal capacity, a distinction the Law Commission later makes, and identifies the only grounds whereby the presence of incapacity can permit treating an individual as lacking legal capacity.

To appreciate why the developments in guardianship and consent are identified as problematic, it is necessary to situate the issue of capacity historically. That the MHA only permitted a finding of legal incapacity in limited situations and failed to address incapacity more generally is not inherently problematic. The Mental Capacity Act 2005 is itself only concerned with some forms of incapacity, namely those with their origins in mental disorder. The justification for identifying the law as deficient often references that such difficulties only arose after 1959 with the ending of the Royal Prerogative. Accordingly, what makes the MHA 1983 deficient is its failure to provide a legal mechanism that echoes a previous mechanism for responding to mental disorder. The difficulties are historical in a second sense as the issue of incapacity brings together considerations of patients right to self-determination as codified in consent procedures, the courts attempt to establish protections for medical professionals from claims through the tort of battery, the continued practice of medicine and research, and the developments in the tutelary relation over hundreds of years.

The coming together of these discourses resulted in identification of deficiencies concerning individuals who lack decision making ability but are not detained in accordance with the Mental Health Act. Notably the question of whether medical practice on those lacking mental capacity would be considered through the tort of battery or negligence, and whether research on persons lacking mental capacity is defensible, emerged. A distinctive feature of discussions about capacity and consent at this time is the acceptance that there are people


109 A possible objection to this understanding could claim that any inability to make decisions that falls outside of the definition in the MCA is not an example of mental incapacity. If adopted however, the 1983 MHA could not be framed as deficient in relation to mental capacity, as the Act simply determines an equivalence between mental incapacity and legal incapacity.

who lack mental capacity, the principle concern being the question of how the medical and legal professions address this phenomenon. This approach perhaps draws both on the common sense understanding and historical precedent which holds that certain people are incapable of making decisions. This engagement with the question of what to do in cases of incapacity, rather than in the first instance define and explain what incapacity is, established both the tone for future discussions of incapacity but also validated the historical and common-sense perspective on ability. This response to the limitations of guardianship and consent provisions in the MHA 1983 Act can be seen in examining both legislative and common law developments. This thesis seeks to bring the focus back to the issue of a definition and understanding of capacity.

In 1989 the Law Commission, as part of its fourth programme of Law Reform undertook to address the law as it relates to decision making on behalf of mentally incapacitated people. The consultation process began in 1991 with the publication of an overview paper outlining the notion of capacity, existing law, perceived deficiencies, and possible values which might guide future legal reform. The overview set out to begin the process through consultation papers and submissions that would result in a coherent response to existing law. Following on from the initial consultation, three further consultation documents were published in the areas of private law, medical treatment and research and vulnerable adults. Finally, in 1995 the Law Commission delivered its final report on mental capacity including recommendations and a Draft Mental Incapacity Bill.

The Commission proceeded from the understanding highlighted in *Re F*, that there is a deficit in law as it relates to incapacitated adults. Underlying the ruling in *Re F* and the

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Law Commission’s consultation however is the support for the notion of mental incapacity itself. Although the consultation is extensive, the concept of mental capacity in itself is not subjected to criticism but rather the definition is debated. That there are people who lack mental capacity is not the issue here, rather the fundamental question driving the consultation is that in the event of incapacity “who decides” what decisions to take.\textsuperscript{117} The Commission adopts an understanding of a distinction between legal capacity and incapacity and mental capacity and incapacity. Mental capacity refers to the individual’s ability to make decisions. Legal incapacity refers to the status that arises “whenever the law provides that a particular person is incapable of a particular decision, undertaking a particular juristic act, or engaging in a particular activity”.\textsuperscript{118} Accordingly the criticism of the law, a result of the MHA Acts of 1959 and 1983 is that those who lack mental capacity, for example $F$, may not have that status acknowledged sufficiently through law and still be considered to have legal capacity by virtue of not being considered legally incapacitous.

The Commission’s examination of the concept of capacity and possible definitions of capacity to guide reform identified multiple existing legal standards of capacity. The Commission also considered approaches to capacity from medicine and psychology, wherein multiple approaches to competence, as distinct from capacity are considered. The Commission itself drawing on both approaches to capacity but also risk, proposed three main approaches to defining capacity. A “status” approach allowed for the determination of an individual’s capacity based on ‘diagnosis’, ‘age, residence, etc.\textsuperscript{119} Such an approach has historical precedent as capacity at times has been denied on multiple grounds. The legal deficit to which the Law Commission’s project responds can be seen to arise from a movement, which began with the 1959 MHA and was amended in the 1983 MHA Act, away from a simple status approach to incapacity. An “outcome” approach calls for an individual’s capacity to be judged by the decision made.\textsuperscript{120} This approach requires a standard, often that of the assessor, against which a decision can be evaluated. A ‘function’ approach is

\textsuperscript{119} The Law Commission, Mentally Incapacitated Adults and Decision-Making: An Overview (Law Com No. 119, London: HMSO 1991) para. 2.43.
\textsuperscript{120} ibid.
considered to focus on the “personal ability of the individual concerned to make a particular decision and the subjective process followed by him in arriving at it”. The common law approach is considered to adopt a functional approach, albeit a fragmented one.

Following widespread engagement with its initial document, the Law Commission was convinced of the need for reform. The first of its follow up documents however focused on the legal machinery required where there is a finding of incapacity made, and as such only initially engaged with the conception of capacity itself. The foundations for what would underpin the Mental Capacity Act 2005 however are discussed briefly at the outset. The Commission questioned whether a finding of incapacity should require the presence of a “mental disorder”. In support of a diagnostic threshold, the Commission identified that a reliance on a functional test alone may be too burdensome and that it coheres with the European Convention on Human Rights which allows for the treatment of persons of unsound mind differently to others. The Commissions found that the existing definition of mental disorder from the Mental Health Act 1983 should be the diagnostic threshold. The functional component of the assessment is held to draw on the approaches of Ontario, Alberta and Newfoundland in Canada, where the emphasis is on understanding of information and ability to appreciate consequences. Accordingly, the Law Commission proposed that incapacity can be conferred where an individual is unable to understand information, adequately foresee the consequences of the decision or retain the information to make a decision. A final additional basis on which incapacity can be conferred is on the basis of an inability to communicate a decision. The subsequent consultation paper published in 1993 built on and clarified the position from the previous paper. The functional assessment of capacity proposed is not an assessment of the rationality of the decision or a rationality

121 ibid, para. 2.44.
123 ibid, paras 3.11-3.12.
124 ibid, para. 3.18.
125 ibid, para. 3.22.
126 ibid, para. 3.24.
127 ibid, para. 3.41.
test. A finding of incapacity must not simply rely on a diagnosis and a failing but in fact that the inability is because of or due to the mental disorder.

The Commission’s final report entitled Mental Incapacity was published in March 1995 and proposed a “single piece of legislation to make new provision for those who lack capacity”. The report which included a draft mental incapacity bill, reiterated the positions taken on capacity by the Commission over its previous papers. A diagnostic threshold was recommended so as to ensure that the “test is stringent enough not to catch large numbers of people who make unusual or unwise decision(s)”. The diagnostic threshold is clarified as “any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning”. The functional element of capacity requires that to be found to be unable to make a decision there must be either a failing in “understanding or retaining information” and “using information”. Alongside this proposed definition were stated principles which should guide practice. Finally, the report recommended that certain decisions be considered only possible to enter into by a person with capacity. Where an individual is considered to lack capacity a best interests decision may not permit decisions to be made on an individual’s behalf in regard to marriage, sexual relations, divorce, amongst others.

The Law Commission’s proposals although largely the basis on which subsequent capacity legislation are based, were not without criticism. The suggestion that the Law Commission’s proposal constituted a functional approach is questioned by Wilson. In establishing a requirement to meet a diagnostic threshold, the Law Commission is specifying that it is only concerned with incapacity in a certain set of people. Carson argues that the inclusion of a diagnostic threshold reveals that the Law Commission is not simply concerned with mental

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129 *ibid*, para. 2.20.
131 *ibid*, para. 3.8.
132 *ibid*, para. 3.12.
133 *ibid*, paras 3.15-3.17.
134 *ibid*, para. 4.29.
Rather, there are “implicit values” at work in seeking to single out the presumed other for which incapacity can be applied, leaving those who simply lack capacity, but lack a diagnosis, no protection through interference. These values can be traced back to the impetus to address incapacity in the 1980s, a period in which Gunn observed the presence of incapacity in relation to many cases was “not debated”.

As the Law Commission’s project developed, the courts began to rule on mental capacity as cases arose. The commitment to self-determination took on a distinctive turn at common law with the courts increasingly invited to declare the legality of medical actions and also address the question of the right to refuse treatment. The case of Re B in 1987 concerned the request for the court to authorize the sterilization of a minor approaching her eighteenth birthday. B who was defined as having a ‘moderate degree of mental handicap’ was considered incapable of consenting to sterilization. The decision to authorize sterilization, on the grounds that it was in B’s best interests, led to concerns being raised about procedures for sterilizing mentally incapacitated adult patients.

In the 1988 case of Re F, the court declared the legality of sterilizing a thirty-five-year-old mentally handicapped patient who was considered incapable of providing consent. The case fell outside the remit of Part IV of the Mental Health Act 1983 and also the Court of Protection’s power over the property and affairs of incapacitated adults. Following involvement by the Lord Chancellor who permitted the official solicitor to represent F, the case was appealed to the Court of Appeal and House of Lords. The House of Lords ruled that doctors have a duty to treat incapacitated patients where it is necessary in their best-interests. Treatment is considered necessary where it is carried out to save life or to prevent deterioration or ensure improvement in a patient’s health. The question of whether treatment is necessary was to be determined by asking whether the doctor acted in accordance with professional opinion. The court also advised that only in certain treatments of incapacitated

137 ibid, 313.
141 Ibid, 238.
adults would it be advisable to come before the court. The method to decide how to treat an incapacitated adult is to draw on the mechanism to identify liability in negligence. In *Re G.F. (medical treatment)*\(^{142}\), the court ruled that sterilization for incapacitated adults could be carried out without court consultation provided two doctors agreed on the intervention and that it was a therapeutic procedure, in the best interests of the patient and the least intrusive option to achieve the desired outcome.

In two cases in 1992 the approach adopted in *Re F* was applied to the question of the right to refuse treatment. In *Re T (adult: refusal of Treatment)*\(^{143}\), the court considered the refusal of a blood transfusion for a woman who had been raised as a Jehovah Witness. In his ruling, Lord Justice Donaldson MR described the “absolute right to choose whether to consent to medical treatment, to refuse it” for patients who do no lack mental capacity.\(^{144}\) Lord Justice Donaldson’s ruling can also be read as providing clarity on the court’s understanding of what mental capacity refers to, an issue the Law Commission were examining at the same time. In stating that for a decision to be respected, it neither has to be considered sensible, rational, irrational, or the reasons even clear. The case of *Re S (adult) (refusal of medical treatment)*\(^{145}\), involved the authorizing of a caesarean section on a refusing woman, as her life and her foetus were in danger.

The right to refuse treatment as set out in *Re T* was reaffirmed in *Airedale NHS Trust v. Bland*, where Lord Justice Goff ruled that a competent refusal of treatment is to be respected under the principle of self-determination.\(^{146}\) The right to refuse treatment subsequently has been respected in *Re B (Adult: Refusal of Medical Treatment)*\(^{147}\), where the decision to remove artificial ventilation that will result in death was respected, and in *Re W*\(^{148}\) in which a prisoner diagnosed with psychopathic disorder had his right to refuse treatment respected.

\(^{142}\) [1992] 1 FLOR 293.

\(^{143}\) *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782.

\(^{144}\) *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, [102], “This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent”, citing Lord Justice Templeman, *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 All ER 643 at [29].

\(^{145}\) [1993] Fam 123.

\(^{146}\) *Airedale NHS Trust v Bland* [1993] AC 789.

\(^{147}\) *Re B (Adult: Refusal of Treatment)* [2002] EWHC 429 (Fam).

In the case of *Re C (mental patient: medical treatment)*, the issue arose of what approach or definition of mental capacity the courts should use. The case concerned whether an individual diagnosed with paranoid schizophrenia had capacity to refuse amputation and for his decision to be considered a valid advance directive. In *Re C*, Thorpe J is considered to set out what would become the first statutory test at common law. At the request of Thorpe J, Dr. Eastman, a psychiatrist set out the criteria for capacity based on his reading of the Law Commission’s proposals. Thorpe J endorsed a three stage approach requiring ‘first, comprehending and retaining treatment information, secondly, believing it and, thirdly, weighing it in the balance to arrive at choice’. Significantly Dr Eastman and Thorpe J acknowledge that this definition is drawn from the Law Commission’s consultation paper.

This reliance on the Law Commission casts doubt on whether the notion of capacity at common law and now statute is anything but a legal concept. In the years following Thorpe J’s ruling the definition and application of capacity came under further scrutiny. In *Re MB (An Adult: Medical Treatment)*, Lord Justice Butler-Sloss omitted the second requirement of believing information in the definition of capacity, adopting instead a two stage test of comprehension and retention, and use of information in weighing it up to arrive at a decision. Lord Justice Munby in *Local Authority X v MM* would later claim that the *Re C* ruling is compatible with both *Re MB* and the MCA, holding that believing information is equivalent to understanding information.

Following the Law Commission’s extensive consultation process the Government announced it did not intend to bring a draft bill forward based on the Commission’s final report. In 1997, under the new Labour Government a new consultation paper was issued called *Who Decides*. The paper drew on the recommendations of the Law Commission’s

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recommendations. This was followed in 1999 by a white paper, *Making Decisions*.$^{156}$ On June 27th 2003 a draft Mental Incapacity Bill was published which was scrutinised by parliament. A revised Mental Capacity Bill was introduced in 2004 and was subject to considerable debate. In the intervening years between the Law Commission’s final document and the Mental Capacity Act coming into effect, the common law largely adopted the recommendations of the Law Commission. The Mental Capacity Act was signed into law on 2005 was passed in April 2005 and came in to force from the 1st October 2007.

2.4 The Mental Capacity Act 2005
The Mental Capacity Act (MCA) began to come in to force in England and Wales in October 2007. The MCA established principles governing the use of the Act, a two stage definition of mental capacity, and a ‘best interests’ procedure for decision-making in events of incapacity. The MCA received considerable praise as a response to historical practices of over riding individual’s liberty,$^{157}$ as putting on a statutory footing existing common law,$^{158}$ promoting autonomy,$^{159}$ and as empowering.$^{160}$ The Act sets out five statutory principles which underpin the use of the Act, although they are not legally binding. A person must be presumed to have capacity until it is established that they lack capacity, a person is not to be treated as unable to make a decision unless all practicable steps to help him have been taken without success, a person is entitled to make unwise decisions without being treated as unable, any act or decision made on behalf of a person who lacks capacity must be done in their best interests, and any act done or decision made must be considered such that the effect achieved is that which is least restrictive of the person’s rights and freedoms.$^{161}$ The origins of these principles can be traced back to the initial Law Commission reports, where the principles were placed alongside the definition of capacity.

$^{157}$ Toby Williamson, ‘Capacity to Protect – the mental capacity act explained’ (2007) 9 (1) *The Journal of Adult Protection*.
$^{161}$ MCA, s1.
In Sections Two and Three a two-stage diagnostic and functional definition of mental capacity is endorsed. The Act defines a lack of capacity as arising when in relation to a decision at a material time that the person is unable to make a decision “because of an impairment of, or a disturbance in the functioning of, the mind or brain”.\textsuperscript{162} For a finding of incapacity and where the diagnostic threshold is met, the impairment or disturbance must result in the inability of one of the following:

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

The Act requires not simply the presence of an impairment and an inability in one of the four areas, but for a “clear causative nexus” between the impairment and the functional inability.\textsuperscript{163} The structure of the MCA, in placing the definition of impairment before functional ability, whilst placing functional ability before impairment in the opening line of section two leaves open the question of whether the diagnostic or functional dimension should be assessed first.\textsuperscript{164} The MCA requires that a person’s status in respect of age, appearance, condition, or behaviour may not be the basis on which a lack of capacity is conferred. In addition, a person is not to be regarded as unable to understand information related to a decision where a simplification or alternative means of communication could be used which would facilitate such understanding.\textsuperscript{165}

Where a person is found to lack capacity, Section 1(5) of the MCA requires that decisions made on their behalf “must be done, or made, in his best interests”. Significantly, the MCA fails to define what best interests are or what the intention of a best interest decision should be. Rather, the MCA sets out a series of issues which the decision maker must consider. Section 4 requires that the substitute decision maker in such situations identify whether the person is likely to regain capacity, but also that no decision should be taken before it is

\textsuperscript{162} MCA, s2(1).
\textsuperscript{163} \textit{PC v City of York} [2013] EWCA Civ 478 at [52].
\textsuperscript{164} MCA, s2(3 a, b).
\textsuperscript{165} MCA, s3(2).
required to do so. When seeking to ascertain the decision that is in the person’s best interests, the substitute decision maker is required to consider the “person’s past and present wishes and feelings”, “the beliefs and values which would be likely to influence his decision if he had capacity”, and “other factors he would be likely consider if he were able to do so”.166 Furthermore, where possible the decision maker is expected to consult those named by the person who should be consulted on such matters, anyone involved in the person’s care, any donee of a lasting power of attorney and any other deputy appointed by the court.167 Whilst cognisant of this information and aware of the relevant circumstances at hand, the decision maker can determine a best interests decision. However, there can be no desire to bring about death. The various requirements or checklist through which a person’s best interests can be measured, must be considered. The call for decision makers to give consideration to a set of issues resulted in the identification of the need for a sorting mechanism or ‘balance sheet’, to identify what action should be taken. The problem posed by identifying what is within a person’s best interests is discussed in chapter six in the context of mental capacity and Anorexia Nervosa.

The decision to adopt an intrapsychic understanding of mental capacity need not have been taken. The Law Commission’s consultation process in the early 90s is evidence that how decision-making capacity is to be defined reflects a choice, which entails consequences for practice. Significantly, this process for identifying what capacity should mean followed from a set of cases in which the presence or state of incapacity was presumed. The consultation process served to delegitimize any essentialist notion of mental incapacity by opening up the concept’s meaning to being negotiated and chosen. The likening of a search for a single definition of mental capacity to the “search for the holy grail” speaks to the complexity of the concept of capacity but significantly to how a definition of mental capacity fails to encompass the practice carried out in its name.168 Worryingly, the Law Commission adopted this approach in seeking to identify a definition of mental incapacity.

166 MCA, s4(6).
167 MCA, s4(7).
The Law Commission could have adopted other definitions or theories of mental capacity. Although the Law Commission conceptualised the choice as one between status, outcome or function and then focused on identifying the appropriate approach to functional capacity, other approaches were available. The influential work of Roth, Miesel and Lidz identified five common approaches to defining competence: “1) evidencing a choice, 2) “reasonable” outcome of choice, 3) choices based on “rational” reasons, 4) ability to understand, and 5) actual understanding”.169 Grisso, Appelbaum and Hill-Foutouhi propose that capacity relates to the ability to understand, appreciate, reason and communicate a choice.170 In the Hopkins Competency Assessment Test, capacity and the ability to give informed consent is tied to understanding.171

An alternative approach seeks to understand mental capacity in context, thus challenging the attempt to define mental capacity in the absence of broader issues. Buchanan and Brock propose requirements that any coherent theory of incapacity must include: 1) Ethical principles – identifying the ethical values that are to be served through the process, 2) Guidance principles – identifying the principles to guide any decision where an individual is found to lack capacity, 3) Authority principles – identifying who the appropriate surrogate decision makers are, and 4) Intervention principles, identifying the specific conditions under which the court may intervene.172 The MCA meets the first two requirements set by Brock and Buchanan of ethical principles (Part 1, Section 1) and guidance principles (Part 1, Section 4). The failure to adequately address the third and fourth principles in the MCA can lead to questions concerning who is to instigate a questioning of incapacity and when is such a questioning to be instigated, to be raised. These questions are taken up in chapter six and eight.

169 Ibid, 280.
2.5 Contemporary Issues

The conceptual and practical commitments underpinning the MCA have resulted in difficulties or tensions emerging in practice. Of significance here are issues related to the understanding and application of the MCA’s approach to capacity assessment and the determination of best interests. These implementation issues arise in part due to mental capacity practice operating at the intersection of legal, medical and political discourse. The approach to mental capacity adopted in the MCA however, as noted above, is a legal construction.

The MCA requires of assessors of capacity to adhere to an understanding of mental capacity as time specific and distinct from both the wisdom of the decision and the best interests of the person involved. In *CC v KK and STCC*, Baker J held that KK, an 82 year old woman with Parkinson’s Disease, vascular dementia and paralysis down her left side, had capacity to make decisions about her residence. Addressing the issue of capacity assessment, Baker J warned against imposing an unrealistic standard of ability in weighing up information, such that any errors or limitations on a person’s part are considered indicative of inability.

Furthermore, the danger of conflating capacity assessment with best interests analysis is identified as misunderstanding the scope of the MCA and risks allowing for the wisdom of a decision to impact on the determination of capacity. This ruling highlights the opportunity within MCA practice for the values and perspectives of practitioners to influence the provision of information, framing of a decision and provision of support, which leads to a deviation from the fundamental principles of the Act.

Although the MCA attests the right of persons to make unwise decisions, the risk of conflating an unwise decision with incapacity remains considerable. As the MCA is premised on a presumption of capacity, there is a responsibility on the assessor of capacity to prove that incapacity is in accordance with the two stage diagnostic and functional approach. The

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174 [2012] EWHC 2136 (COP)
175 ibid, at [64-65].
176 ibid, at [65].
177 ibid, at [74].
case of *Heart of England NHS Foundation Trust v JB* addressed this requirement. JB, a 62 year old lady, suffered from hypertension, poorly controlled insulin-dependent type II diabetes, diabetic retinopathy and anemia. In addition, JB was diagnosed as suffering from paranoid schizophrenia and at the time of the hearing had a gangrenous foot. The case considered whether JB had capacity to make a decision about amputation of her foot. Jackson J, in ruling, highlighted the requirement that determination of capacity adhere to sections 2 and 3 of the MCA. Although JB was found to meet the diagnostic threshold of section 2, Jackson J ruled that JB maintained the ability to understand, retain and weigh the information relevant to proposed surgery. Echoing the ruling in *CC v KK and STCC*, Jackson J identified the risk of psychiatrists demanding a level of decision making ability above that recognised in the MCA. As noted by Jackson J and by Case, the use of psychiatric terminology of insight when assessing capacity risks confusing two distinct approaches to categorising human understanding.

The case of *Wye Valley NHS Trust v Mr B* considered whether a best interests decision could be made to amputate a 73 year old man’s foot despite Mr B’s express wishes against such an operation. Jackson J, drawing on the judgment of Baroness Hale in *Aintree University Hospitals NHS Trust v James*, held that the purpose of the best interests tests is to consider matters from the patient’s perspective. Accordingly Jackson J warned of any understanding that a lack of mental capacity should result in the individual’s rights or freedoms being denied. The ruling that the amputation would not be in Mr B’s best interests was a result of a balancing of the considerations in favour and against the procedure. The case is significant as that decision can be framed in the context of ‘life-sustaining treatment’ and the section 4 (5) requirement that a best interests decision may not be motivated by a desire to bring about death. In affording such importance to the perspective of Mr B, as evidenced in the decision by Jackson J to visit and listen to Mr B, the ruling supports

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179 *ibid*, at [43].
181 [2015] EWCOP 60
182 [2014] AC591 at [44-45]
183 *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60 at [9]
affording the patient’s wishes and feelings central importance in the best interests process.184

The claim of Jackson J that the MCA is sufficiently developed to afford protection to the rights of an individual found to lack capacity however is contestable.185

Of significance in these rulings about the assessment of capacity and best interests determinations is an awareness by the courts that the individual, at the heart of the capacity assessment, might be denied their rights through the privileging of the subjectivity and values of assessors of capacity. The concern with practitioners’ values impacting assessment are taken up in chapter six, wherein the challenge of acting in accordance with the Act is scrutinized. Whereas the central issue in CC v KK and STCC and Heart of England NHS Foundation Trust v JB concerned the adherence to the MCA, chapter six explores whether the MCA’s approach is coherent and achievable on its own terms. The issue of the subjectivity of individuals being relegated in importance within both assessment and best interests determinations is taken up in Chapter eight. In proposing a narrative approach to mental capacity assessment which identifies processes by which the values and perspectives of assessors and others can override subjectivity, the understanding of the self underpinning the MCA is itself challenged.

2.6 Mental Capacity and Autonomy

The concept of autonomy is the most dominant philosophical idea in contemporary bioethics.186 Significantly, the MCA is widely regarded to be central to ensuring respect for the right to autonomy.187 The popularity of different approaches to autonomy however have resulted in a varied discipline where an appeal to autonomy can relate to perspectives in developmental and individual psychology, free will debates, and discussions concerning subjectivity, to name only a few.188 In this context Gerald Dworkin notes that perhaps the

only common feature across perspectives is “that autonomy is a feature of persons and that it is a desirable quality to have”. In bioethics more generally, autonomy is often associated with self-determination or self-government, and is characteristically understood as “relational”, “selective”, and “graduated”. Autonomy is relational in that freedom is always from something, selective as is always context specific and not a universal claim, and graduated as there are different levels of autonomy. The popularity of appeals to autonomy must be considered in the context that the concept functions as a “moral, political, and social ideal” that allows for particular practices to be challenged and rejected. The rise in consideration of personal autonomy in bioethics, reveals an attempt to shape the understanding of how the therapeutic relationship and more generally how bioscience should be guided ethically.

The prevalence of the concept of autonomy in bioethics today is often attributed to the four-principled approach introduced by Beauchamp and Childress in the late 1970s and the report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research also in the 1970s. The philosophical origins of the turn to autonomy can be traced to the radical distinct version of autonomy in John Stuart Mill and Immanuel Kant. The approach more influential in bioethics is derived from Mill. Although Mill’s influence on debates is unquestionable, it is significant that he rarely mentioned the term autonomy. Addressing the issue of the relation between man and society and the concern with the well-being and flourishing of people, Mill sought to define the appropriate levels of interference by society or the majority over the individual. The importance of liberty lies in its ability to protect and allow for the cultivation of one’s own character. This commitment underscores Mill’s famous line that the only grounds on which power can be imposed on another “is to prevent harm to others”. The individual’s protected character and contention

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194 ibid, 13.
that it must be developed with limited interference informs the statement of liberty.\textsuperscript{195} A reading of autonomy from Mill’s account of liberty then associates autonomy with non-interference. The question of how an individual’s character develops in the context of non-interference however remains unclear.\textsuperscript{196} A further question of the adequacy of developing an account of negative liberty, the right to non-interference, argues that a notion of positive liberty is implied as that which is deserving of protection. The view that individual character and liberty should be protected requires a coherent understanding of the individual’s development and existence in the world.\textsuperscript{197}

The other understanding of autonomy influential in bioethics is set out by Kant. In contrast to a Millian approach, Kant’s understanding is not principally an account of individual autonomy.\textsuperscript{198} Instead autonomy relates to the achievement of meeting one’s duties which are to others. To be or achieve autonomy is to act in accordance with one’s obligation. Obligations may not be simply reduced to subjective choice, or the preserve of self-determination. Autonomy requires the acknowledgement and willing of that which is fit to be a universal law. As such Kant’s principled autonomy is inconsistent with the understanding of autonomy as self-determination per se. The identification of obligations for Kant can be arrived at by the identification of those principles which cannot be principles for all and as such must be rejected. The Kantian conception of autonomy goes beyond the simple freedom or liberty rights associated with a Millian account, as in addition to freedom from, Kant’s conception “justifies requirements to support and assist others”.\textsuperscript{199}

A more recent approach to deciphering approaches to autonomy and one which is influential in considerations of capacity is developed by Mackenzie and Stoljar.\textsuperscript{200} They propose a division between procedural and substantive autonomy approaches. Procedural approaches, of which there are structural and historical models, identify critical reflection as relevant for

\begin{flushleft}
\textsuperscript{195} ibid.
\textsuperscript{199} ibid, 88.
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autonomy. The approach in structural or internalist approaches, is to understanding motivation and critical endorsement of motivations as underpinning autonomy. The hierarchical approaches of Harry Frankfurt\textsuperscript{201} and Gerald Dworkin\textsuperscript{202} adopt such a perspective, understanding autonomy to require an endorsement of his/her first order desires at the level of his/her second order volitions. Where there is noncongruence between first order desires such as wanting to eat large amounts of processed foods and a second order volition that values healthy eating, then there would be a contradiction in action and subsequently no autonomy.\textsuperscript{203} The criticisms associated with this approach are that it is content neutral, opens up a regress objection, and rests on an assumption that autonomy involves consistency with the true self of second order volitions.\textsuperscript{204}

The rejection of neutral approaches to autonomy underpins substantive approaches to autonomy. Mackenzie and Stoljar identify “\textit{strong substantive Theories}”, as those which place a requirement to identify right from wrong to be considered autonomous.\textsuperscript{205} The inability of an individual to appreciate or reason what is right, whether due to oppression or otherwise, precludes an individual from being considered autonomous. Where the context one is in, labelled “oppressive socialization” is such as to undermine competence to engage with norms and reason, then autonomy is compromised.\textsuperscript{206} An alternative weaker substantive theory associated with Paul Benson requires individuals to have a sense of “self worth” or a sense of self as a condition of autonomy.\textsuperscript{207}

The adoption of different approaches to autonomy thus admit of a different emphasis or significance in understanding the self and whether its relation to others is relevant. Theorists who advocate for internalist approaches associate cognitive functioning or authentic endorsement with autonomy. Approaches concerned with factors like power, coercion and control, focus on the impediments to autonomy as self-determination. Procedural approaches

\textsuperscript{201} Harry Frankfurt, ‘Freedom of the Will and the Concept of a Person, (1971) 68(1) \textit{Journal of Philosophy}.


\textsuperscript{204} \textit{ibid}, 59-66.


\textsuperscript{206} \textit{ibid}.


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are internalist, arguing that autonomy involves a particular process either endorsement or critical reflection. A substantive approach establishes normative constraints on autonomy, relying on an interpretation of the good.

A relational account of autonomy challenges the metaphysical presuppositions underpinning an individualist account. Identity is understood as a product of social relationships and cultural contexts. Relational personhood in contrast to ‘cognitive capacity’ is the precondition on which identity is established. Second person accounts argue that it is through others that persons develop, arguing against the idea of being “causa sui”.

Feminist, critical and gender theories challenge the principles of an internalist understanding of autonomy, suggesting that nothing can escape discourses of power. Following a metaphysical reconsideration, autonomy can be detached from individualist ideals and understood through relatedness and socialization. A care perspective which proposes nurturing and interdependence as cornerstones of practice offers a substantive relational approach. Where viewed relationally, autonomy is a form of cultural competence.

Having introduced varying approaches to understanding autonomy, it is now necessary to situate the MCA as it relates to autonomy. The MCA is commonly read as adopting a Millian liberal approach to autonomy, wherein autonomy corresponds to the right of non-interference or self-determination. This adoption can be read as it relates to the understanding of freedom, the adoption of content neutrality, and the distinction between individuals on the basis of internal deficiencies. The Act upholds an understanding of capacity as corresponding to

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209 Galen Strawson in arguing against free will views articulates a relational conception of identity. In order for free will to be attributed to an individual, that individual would have to be responsible for their own values. In practice an individual’s values, beliefs and ideals have their origin outside of the self and consequently fail to be “causa sui”. ‘The Impossibility of Moral Responsibility’ (1994) 75(½) *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition*, 5.


internalist ability to perform a decision making task and in doing so dismisses the relevance of external factors. The concern with external factors in medical decision making is taken up by the requirement that decisions are voluntary. The Act rejects the idea that capacity relates to the wisdom or outcome of the decisions. This commitment however is tempered by the requirement that for certain decisions a greater level of capacity is required. Finally, the Act endorses the basic Millian principle of liberty, that it is upon the basis of an unsound mind that interference in the lives of others is permitted. This distinction allows for the MCA to reaffirm a distinction between weak and strong legal paternalism. The former refers to interference in the life of another on the grounds that the person is not engaging in self-determining action. The latter in contrast, involves the interference in individual’s lives that are engaging in self-determining behaviour. Feinberg has labelled these two approaches as “benevolent” and “nonbenevolent paternalism”. Drawing on Beauchamp, Feinberg queries whether weak paternalism, as the interference in other people’s actions, is actually paternalistic, as the interference occurs “only when that conduct is substantially nonvoluntary”.

The MCA can however be also seen to engage with a more robust or developed sense of autonomy. The test for incapacity in the Act is identified by Coggon and Miola as adopting “negative affirmation of autonomy”, as it requires the case to be made that an individual lacks capacity. This requirement of healthcare professionals to assess not just understanding but the ability to weigh up and communicate information is identified as going beyond a simple liberal approach. The application of autonomy approaches can also be seen in the analysis of specific judgements. Coggon identifies that judges have open to them the opportunity to

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216 “It is not a question of protecting a man against himself or of interfering with his liberty of action. He is not acting at all in regard to this danger” Thomas Beauchamp ‘Paternalism and Bio-Behavioural Control’, (1976) 60 (1) The Monist 67.
employ radically different conceptions of autonomy.219 The application of a Kantian “ideal desire”, procedural hierarchical “best desire”, and first order “current desire” in different cases, suggests that there may be considerable inconsistencies in the law.220

The relation between mental capacity and autonomy is further complicated by the continued application of the High Court’s inherent jurisdiction.221 Whereas the MCA is concerned with internal deficiencies which compromise decision making ability, the inherent jurisdiction is concerned principally with external factors, notably undue influence, which render individuals vulnerable. Before the MCA came into effect, the High Court had exercised a jurisdiction over those considered incompetent or vulnerable, a wider group than those covered under the MCA.222 Those considered to lack capacity but do not come under the remit of the MCA sections 2 and 3, can be considered through the lens of the inherent jurisdiction. The case of DL v A Local Authority concerned an elderly couple who were thought to be subject to the undue influence of their son.223 Theis J ruled that the High Court’s inherent jurisdiction has survived the MCA.224 The Court of Appeal upheld this decision and reaffirmed the High Court’s protective powers over vulnerable persons. The ruling established a test for engaging the inherent jurisdiction as well as establishing its scope as beyond simply countering establishing safety for the person involved.225 The ruling is critiqued as overstepping the High Court’s own remit and in doing so challenging the integrity of the MCA’s supposed exhaustive remit to set out the conditions under which decision making can be evaluated.226 The issue of distinguishing between those who fall under the MCA or the inherent jurisdiction is raised by Keywood in respect of the distinction between undue influence and the inability to weigh up information.227 Furthermore, the understanding of vulnerability conceived by the courts is ostensibly status based, wherein

222 Re SA [2005] EWHC 2942 (Fam) at [76].
223 [2012] EWCA Civ 253, 255.
224 A Local Authority v DL [2011] EWHC 1022 (Fam) at [53].
225 [2012] EWCA Civ 253 at [33] and [53].
vulnerability as meaning at risk of harm is due to an internal characteristic. By virtue of the inherent jurisdiction being concerned with external factors, although not exclusively, a basis for identifying when to apply the jurisdiction is somewhat clearer than the internal approach adopted in the MCA.

2.7 Conclusion
The discussion developed in this chapter is intended to provide a historical and discursive overview of the MCA and in particular its definition of mental capacity. As argued above, the emergence of the MCA in 2005 is the product of a period of judicial creativity beginning in the 1980s in which a prevailing discourse committed to self-determination influences the reimagining of the tutelary relation embedded in mental health law. There are two aims to drawing out the argument in this chapter, and that are availed of in developing this thesis in the following chapters. Firstly, to highlight the complexity of theoretical approaches available to bioethicists and others in any analysis of the MCA. The MCA can be read as protecting and supporting the right to self-determination or autonomy, continuing a historical tradition of allowing power over others’ decisions to be maintained, part of a shift away from paternalistic medicine, or as a mechanism for responding to those who are vulnerable, etc. Secondly, to highlight the importance of choice as it relates to the phenomenon that the MCA seeks to address, the role of choice in defining mental capacity and the choices in how the MCA more generally is interpreted in practice.

The development of procedures for responding to persons lacking in capacity can be read through the language of empowerment and protection and at a theoretical level in relation to autonomy. The decision to understand that there are persons who lack capacity can serve to reify the belief that the state should legislate in respect of capacity. Such an approach allows for the issue of mental incapacity to be framed as an ethical issue which must be responded to appropriately. The current difficulties with implementation of the Act however have their origins in what is omitted from the Act and associated guides for practice. A historical understanding undermines the contention that the Act can be aligned simply with its espoused

principals, somehow neglecting the long established tutelary relation of which the MCA is simply a continuance. In practice, the assessment of capacity and the best interests mechanism reveal limitations and tensions in the MCA’s principles. These contemporary challenges in adhering strictly to the MCA are acknowledged in *CC v KK and STCC* and *Wye Valley NHS Trust v Mr B*. Although the Act is admirably committed to self-determination and protection, the failure to adequately address the historical and the substantively evaluative dimension of practice makes the failure at implementation hardly surprising and perhaps a relief. That practice is carried out in the Act’s name and there is a concerted effort to improve implementation accordingly raises concerns. If the historical and conceptual difficulties confronting the Act remain unaddressed and yet practice continues, the legitimacy and coherence of such practice can be questioned.

It is to a theoretical response to these problems that this work next turns, with particular focus on how the MCA should be understood.
Chapter 3
Theoretical Approach

“The search for a single test of competency is a search for a Holy Grail. Unless it is recognized that there is no magical definition of competency to make decisions about treatment, the search for an acceptable test will never end. “Getting the words just right’ is only part of the problem. In practice, judgment of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine”\textsuperscript{229}

It is evident from the previous chapter that mental capacity as a concept and the application of the MCA in practice are both dependent on and reify various philosophical and ethical perspectives. The purpose of this chapter is to situate mental capacity as a subject of concern for critical jurisprudence and to introduce the narrative identity approach to personal identity debates in bioethics. This thesis draws together these two approaches in developing a narrative bioethics approach to mental capacity. Therein, it seeks to develop an account of mental capacity and bioethical selfhood as intersubjective, a move away from the intrapsychic model endorsed in the MCA. This broader theme is guided by two questions. Firstly, is the current understanding of the MCA coherent and sufficient? Secondly, should mental capacity be identified in bioethical thought as an issue relating to personal identity?

In recent years a variety of relational approaches have informed legal and ethical commentaries on mental capacity practice and have identified limitations of a liberal reading of the self. These criticisms when considered alongside the conceptual difficulties concerning the definition of mental capacity, the application of diverging ethical principles, and the widespread application of the Act, contribute to a set of problems which ethical consideration of the MCA might explore. This thesis however is meta-ethical in principle, seeking to contribute to a more nuanced and detailed understanding of mental capacity and the practices associated with it. This approach seeks to challenge the reading of mental capacity through liberal theory but also seeks to be distinguished from contemporary relational approaches. The thesis develops a reading of mental capacity practice as an activity of narrative identity.

negotiation and that accordingly an intersubjective model of capacity should be adopted. The shift to understand the self in capacity discourse as embodied, relational and in context, it is argued, must be accompanied by a move to acknowledge that capacity assessment involves the identities of two people at a minimum. The rejection of liberal approaches should not be limited to developing a more nuanced understanding of the object of capacity assessments but rather see capacity assessment itself as a relational practice between or amongst people.

The concept of mental capacity is a distinctly challenging one for bioethical consideration. Mental capacity as it is defined in the MCA, is not per se a traditional topic for bioethical consideration. Rather, it is a legal response, perhaps even a bioethical legal response, to the perceived problems and deficits in the law identified in the 1980s. Although the development of both the common law and statutory response to mental capacity draw on issues from medicine and philosophy, the MCA is principally a legal instrument. The Act which was once considered an ethical and legal response to a problem can now, as it guides healthcare practices in England and Wales, be itself considered an ethical issue. Conceiving of mental capacity assessment as a narrative practice and accordingly mental capacity as intersubjective, provides bioethics but also healthcare practitioners and those receptive in the legal sphere with a way to challenge what Coggon identifies as conceptual difficulties in contemporary practice. Read as a narrative practice, mental capacity is considered as a historical practice which is characterized by changing justifications over time. However, these justifications as noted by Unsworth, only alter the understanding and format of the tutelary relation not the existence of the relation itself. The justifications whether they are self-determination, autonomy, best interests, mental disorder, etc, are but secondary values which shape the operation of a tutelary relation itself.

To aid the analysis developed throughout the rest of this thesis, this chapter has two aims. First, it seeks to frame the MCA within the lens of critical jurisprudence and as such requiring further examination. Second, it seeks to outline how a narrative approach to personal identity provides the ground for a theoretical approach for bioethical discourse. A narrative bioethics

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approach is introduced as providing a method which can allow for mental capacity theory and practice to be examined by the two-guiding question of this thesis. In doing so, the following chapters in this thesis demonstrate how mental capacity as an object of critical jurisprudence and narrative identity activity may be read together in narrative bioethics.

3.1 Conceptualizing Mental Capacity in Critical Jurisprudence

Critical Jurisprudence refers to a type of legal endeavour that has developed from but also acts in opposition to legal realism. Where realism identifies that the law reflects a moral perspective and judicial interpretation is subjective, critical jurisprudence thematises the law’s understanding and interpretation, positing judicial thinking as a contingent discourse characterized by ideals. Although a field of legal enquiry, it is heavily influenced by philosophical discourses, in particular post-structuralism of the 20th Century. Philosophical considerations of being and epistemology developed an understanding that knowledge can only be perspectival, that people are caught in a dialectic with objects in the world, that people are inescapably intertwined with others and existence is embodied. Sociological considerations of deviance argue that deviance eludes being interred in the individual but rather is a label conferred by the audience or community one is in. Labels, like knowledge claims are never neutral, but the product of a particular time. They are socially constructed.

Literary theory holding that nothing exists outside of language, views all actions as interpretive and discursive. The notion that there can be the unmediated thing is dismissed. Each notion of a thing is identified by what it is not, which is infinite.

The law as read through a poststructuralist lens is not simply an internal system where principles, interpretations and ideals can be observed and challenged, rather it is involved in and complicit in shaping “social being”. The law engages in “social reproduction” in defining and perpetuating acceptable forms of individuality in relation to others and oneself. The process of categorising individuals along certain axes is integral to the legal process, allowing for legal measures and relevant precedents to be identified and applied to particular cases. Dichotomies of ‘woman or man’, ‘competent and incompetent’, ‘child or adult’ and ‘white or other’ among others can be drawn on by the law to differentiate and categorise individuals. The need to provide a coherent schema for understanding human existence is observed in naturalism, positivism and realism.

Critical jurisprudence, although reflecting a conceptual schema from where positions, criticisms and notions are articulated, takes as its object “institutional and doctrinal politics of law and the politics of law’s self-understanding in the form of jurisprudence and legal theory”. The methods of critical jurisprudence thus vary and can be ascribed to any political movements or theoretical approaches which thematise the pillars or principles of jurisprudence and the law. Douzinas and Geary posit four general themes which critical jurisprudence may take as its object: the relation between force, power and law, where the act of critique pulls the theorist into a “process of social eristics”; the relationship between reason and force, exploring the place of values and ideals underpinning the law; the sense of injustice, exploring how injustice is acknowledged, responded to and theorised and; foundations and their deconstruction, which dismisses the notion that there can be a coherent grounding on which law or other disciplines can build from.

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240 ibid, 13.
241 Edward H. Levi, An Introduction to legal Reasoning (Chicago: University of Chicago Press, 1949) 2. Legal reasoning affirms to a threefold process. “Similarity is seen between cases; next the rule of law inherent in the first case is announced; then the rule of law is made applicable to the second case . . . The finding of similarity or difference is the key step in the legal process” cited in Martha Minow, Making All the Difference: Inclusion, Exclusion and American Law (New York: Cornell University Press, 1990) 2.
243 ibid, 40.
244 ibid, 21.
245 ibid, chapter 1.
Feminist legal theory represents one expression of a critical jurisprudential approach. The work of Minow, Fineman and Scales take as their issue assumptions and articulations of difference in the law. Categories of difference and theoretical cornerstones privileged at law however are neither neutral nor objective, but emerge in and maintained by “relationships of differential power”. Current classifications of difference operant in law have their origins in the development of liberal political thinking. The renaissance evidences a shift in how individualism is conceptualised. This change, which Maine explains as the movement from “status to contract”, allowed some people to be considered individuals while others remained determined by status. Courtesy of their status, people were considered different from others and not afforded the privilege of individuality.

Martha Fineman observes how in family jurisprudence the law has posited the “individual as the relevant unit of analysis”. In doing so the law suggests that independence can be achieved but at the same time fails to afford primacy to interdependence. As a consequence the importance of caring, support and familial relationships are degraded. In contrast to the law’s ideals of “independence and self-sufficiency”, the law could acknowledge dependency as a “universal and inevitable part of the human development”. The law’s failure to reify interdependence in place of autonomy, facilitates viewing the experience and condition of another as a product of their autonomous choice, which in turn allows for a political or societal indifference to responsibility for that condition.

Minow, in considering categories of difference, accepts that such reductionist thinking is a requirement of a legal system. However, she questions the justification by which differences are articulated and understood. The identification of others as different can allow for different
responses, from integration to separation, or between neutrality and accommodation. It can also serve as a tool for exclusion or inclusion. Although the response to difference can prove beneficial, Minow is concerned with the negative aspects of labels of difference. Drawing inferences from legal consideration of mental retardation and the issue of mental competence, Minow identifies three approaches to difference. In the first, identified as traditional, mental incompetence is considered “natural and immutable”. A second approach responds to the classification of difference in the first and invokes rights of individuals to address any mistreatment performed on the basis of the difference. A third approach identifies classifications of difference as revelatory of “relationships of power between those who label and those who are labelled”. The three approaches are labelled as the “abnormal-persons approach”, “rights analysis approach” and the “social relations approach”. The ‘abnormal-persons approach’ locates the difference within or discrete to the individual, the ‘social relations approach’ however locates the ascription of difference to a relationship.

Scales writing from a poststructuralist perspective provides a feminist methodological approach to the labelling of difference, itself a process of othering. Methodologically individuals can: a) “eschew neutrality”, as to do otherwise is to commit oneself to saying and doing nothing, b) “challenge false necessities”, submitting legal ‘truths’ or dichotomies to scrutiny, c) “Deconstruct the status quo from the Level of Knowledge”, questioning the law’s attempt to posit any claim as truthful or objective, d) “Look to the Bottom”, directing analysis at those “whose subjectivity has been relatively unfettered and whose has been systematically constrained”. If the law were to take on the poststructuralist critique, it would have to view its dichotomies, jurisprudence and rulings as provisional and resist any effort to endorse one view as objective or real.

254 ibid.
255 ibid.
257 ibid., 109.
The work of Fineman, Minow and Scales respectively identify the consequences of an agenda of difference, a theoretical understanding of conceptualising difference and propose a feminist method for critical legal thought. The concept of mental capacity as defined in the MCA is identified here as worthy of a critical jurisprudential perspective. Minow observes ‘dilemmas of difference’ as a distinctive feature of liberal democratic countries where inequalities are condemned and value plurality is espoused and yet distinguishing practices are maintained which establish inequalities. Minow identifies five features of liberal notions of difference which contribute to the ‘abnormal-persons approach’. These are that differences are “intrinsic”, that there is an “unstated point of reference”, that the person judging the difference is without perspective, that the perspective of the person judged is taken into account, and finally that “existing social and economic arrangements are natural and neutral”.

The consultation process beginning with the Law Commission’s 4th program of Law reform comprised of consultation papers, which sixteen years later resulted in the MCA, can be seen to meet four of the five conditions of ‘dilemmas of difference’. The Act identifies incapacity intrinsically, permitting the finding of incapacity to individuals with an ‘impairment of, or a disturbance in the functioning of, the mind or brain’. The MCA’s stated point of reference or observation is provided within the Act and the Code, where there is a commitment to assuming all adults have capacity until established otherwise. Capacity is not explicitly theorised, rather the lack of capacity is defined, leaving a trace of what capacity may be. The impetus to assess and the assessment of capacity requires that professionals adopt a value neutral perspective, as capacity may not be doubted ‘merely by reference to – (a) a person’s age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity’.

The values and perspective of the individual being assessed are considered secondary to the assessment of capacity in accordance with common law rulings. Individuals maintain the right to make unwise decisions. This indifference to values however, qualified as behaviour over time, may be

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260 MCA, s2 (1)
261 MCA, s1(2).
262 MCA, s2(3).
indicative of a lack of capacity. The relation between capacity and values seems contradictory. The values or beliefs informing an individual action are distinct from the capacity of the decision, however the values informing behaviour over time may be reflective of a lack of capacity. Either capacity is distinct from values in individual action and action through time or capacity is related to underpinning values. Otherwise clarification is needed to distinguish between an unwise decision and an unwise decision repeated. Finally, the consultation process of the Law Commission reflects an acceptance that the legal and social distinction of individuals as either having or lacking capacity is a given. The first and subsequent reports of the Law Commission fail to demonstrate a critical consideration of the distinction itself but rather a concern with how capacity and its lack should be distinguished.

The identification of a political and legal understanding of difference in the MCA as a ‘dilemma of difference’ questions the legitimacy and pragmatism of an ‘abnormal-persons approach’. The failure to identify that the assumptions of one’s particular perspective constitute models of difference may allow for oppressive and totalising practices to emerge. The MCA reifies, as Fineman identifies in family law, that the individual is the currency of analysis. Mental capacity is framed as an intrinsic feature of individuals which at the same time serves to negate or overlook the role of others in the process of identifying others. Minow suggests however the lens of ‘dilemmas of difference’ provides an opportunity for a critical engagement with instantiations of difference. “Stating the assumptions that have gone unstated, I believe, opens room for debate and for new kinds of solutions. Discovering that difference arises in relationships and contexts that are themselves mutable introduces new angles of vision, new possibilities for change”.

The appreciation that the MCA relies on an act of differentiation that adopts an ‘abnormal person’s approach’ informs the contention developed throughout this thesis that the MCA

264 Stephen J. Gould cites such blindness as the source of injustice “(f)ew tragedies can be more extensive than the stunting of life, few injustices deeper than the denial of opportunity to strive or even to hope, by a limit imposed from without, but falsely identified as lying within . . . . We inhabit a world of human differences and predilections, but the extrapolation of these facts to theories of rigid limits is ideology”, The Mismeasure of Man (New York: W.W. Norton & Company, 1981) 28-29.
can be reconceptualised through a social relations approach. This approach is distinct from a
‘rights-based approach’ to those considered to lack mental capacity. The risk in focusing on
the appropriate rights based approach to particular people is that it accepts that such people
are different and the issue is to identify the appropriate response. The adoption of a social
relations approach to mental capacity or competence, as proposed by both Stefan\textsuperscript{266} and
Holstein\textsuperscript{267}, calls for an appreciation of the “interactional processes” and authority
conventions through which determinations of competence and capacity are made.

This thesis draws on feminist legal approaches to explore the question of the appropriate
understanding of mental capacity practice and the question of how the MCA should be
understood in bioethical discourse. The development in chapter 2 of a historical and
discursive account of the MCA demonstrates the methodological approach of Scales. The
framing of mental capacity at the intersection of discourses and values challenges the notion
of neutrality or objectivity in the development of the Law Commission’s publications and
the MCA, identifying the MCA as continuing the tutelary relation as a mechanism for
sanctioning the subjectivities of persons through mental health law, and presenting the
decision to legislate for mental incapacity which reifies the dichotomy of incapacity and
capacity as neither objective or neutral but instead contestable. This jurisprudential approach
is guided by two key themes, a focus on the foundational assumptions and values
underpinning capacity assessment and a conceptualisation of mental capacity assessment as
a form of provisional othering.

The first theme is examined in chapter 6 by drawing on the theoretical consideration of
differentiation and othering offered by feminist theory in examining the rulings of the Court
of Protection in two cases involving women diagnosed with severe Anorexia Nervosa. The
MCA posits that individuals can at a time be found to have or lack capacity, but in doing so
reflects political, social, and legal ideals. The examination of the cases before the Court of
Protection seeks to identify the ideals guiding and reified in judicial rulings. In support of the

\textsuperscript{266} Susan Stefan, ‘Silencing the Different Voice: Competence, Feminist Theory and Law’, (1993) 47
University of Miami Law Review.
\textsuperscript{267} James A. Holstein, ‘Court Ordered Incompetence: Conversational Organization in Involuntary
calls by Lord Munby \(^{268}\) for greater transparency in the Court of Protection and the family court, the research suggested the guiding values and assumptions of the MCA as worthy of acknowledgement and identification.

The second theme is examined in chapter 8 in which a practice of ‘social eristics’ is engaged in and an understanding of capacity is proposed that allows for individuals to be differentiatied based on a model of inter-subjective experience. In proposing a schema by which individuals can be treated differently, capacity will be understood as a relational label conferred on individuals within a political and value-laden context. In awareness that capacity labels emerge in and are dependent on value system, each conferring is provisional. The conferral of a lack of capacity in relation to a decision reveals not that an individual has a deficit but that the assessors and conferrers of incapacity are permitted to sanction the identities of others.

The contention that the MCA and associated mental capacity practice can be considered through the lens of critical jurisprudence sets the context for the remainder of this chapter. The language and rhetoric which suggests that mental capacity is intrinsic and as such intrapsychic (a feature of the mind or brain) and that the MCA protects the right to self-determination or autonomy is challenged by feminist scholars which identify that the Act and practice is a relational practice predicated on values which permit the evaluation of other’s subjectivity. Although the call for an understanding of mental capacity practice as relational and value laden is not new, the question of how the MCA should be understood in bioethical discourse in light of such an understanding is less clear. The following section outlines how bioethical discourse may begin to understand the MCA.

3.2 A Narrative Identity Approach to Personal Identity

The issue of personal identity for bioethical thinking draws considerable influence and guidance from the consideration of personal identity in philosophy and ethics more

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generally. At a basic level, personal identity debates focus on whether personal identity does influence or have a bearing on practical or ethical issues. These practical issues are traditionally divided up into “self-regarding practical concerns” and “other-regarding practical concerns”. There are some approaches which hold that personal identity must be addressed and understood first. That understanding can then be used to address practical issues. A second begins with practical problems and then turns to personal identity theory to consider its relevance in the debate. The traditional approach in philosophy and bioethics is the former approach, beginning with the question of personal identity. A more recent development in personal identity debates is the emergence of a narrative identity approach which calls for a more nuanced understanding of the person. Although mental capacity might seem distinct from questions relating to narrative identity now, this thesis develops an argument for conceptualising capacity assessment as an activity of narrative identity. A narrative identity approach to personal identity can be developed by reading Marya Schechtman alongside Paul Ricoeur.

In developing approaches to narrative identity both Schechtman and Ricoeur challenge the notion that personal identity is reducible to a question of sameness or that it is simply first personal. The development of Schechtman’s narrative approach to personal identity is grounded in the adoption of a characterization approach to personal identity. The characterization approach is concerned with the question of attributing “actions, experiences, beliefs, values, desires, character traits” to a person. Engaging in characterization questions thus involves questioning what should be attributed to a particular person’s identity. This questioning however is not limited to a first personal perspective, in which I alone ask question about myself but necessarily is a third personal activity as well. Personal identity in this sense is made up of characteristics which are attributed in different strengths or degrees to people and the significance of these attributions is the role they play in a person’s “life” and “story”.

272 *ibid*, 77
The development of Ricoeur’s account of personal identity is grounded by a distinction between two major uses of the concept of identity: “identity as sameness (idem)” and “identity as selfhood (ipse).” The understanding of the problem of personal identity as focused on permanence in time, leads to a renewed attempt to identify the “relational invariant” or criterion of identity that allows for sameness in identity to be identified through time. The focus on what remains the same through time can be at the expense of appreciating the self or who of identity. Crucially for Ricoeur, an appreciation of selfhood calls for attention to “character and keeping one’s word.” In calling attention to identity as selfhood, Ricoeur seeks to bring personal identity debate away from a strictly first personal perspective. A person’s character corresponds to “the set of lasting dispositions by which a person is recognized” by both themselves and others. Character is an expression of selfhood, as it relates to the who of personhood and the actions or characteristics attributed to him. However, it also conforms to identity as sameness, as character provides a means by which a person can be recognized by himself and others over time. In contrast the activity of keeping one’s word expresses a person’s “self-constancy” a form of resoluteness in the face of time and change. These two aspects of the self, the perseverance of character, and the self-constancy in keeping one’s word, provide two alternative every day aspects which ground permanence in time. Ricoeur proposes that narrative identity occupies a space between these two aspects of the self.

The second dimension of narrative identity of significance here concerns the activity and achievement of identity. Central to grasping the arguments of Schechtman and Ricoeur is the requirement to understand that narrative selfhood is something engaged in by persons and yet it is the very process which allows for the achievement of personhood. Ricoeur understands the activity of narrative identity to operate between the functions of history and fiction, however at a more fundamental and everyday level. In this everyday activity, the narratives a person narrates speaks to three relations: “between man and the world is what we call referentiality; the mediation between men, communicability, the mediation between

274 ibid, 118.
275 ibid.
276 ibid, 121.
277 ibid, 123.
man and himself, *self-understanding*. The need to engage in narrative identity however speaks to a human need to live through and in the “imaginary”, to respond to experience which calls for narration. The poetic response of narrative however seeks to achieve a threefold mediation. It brings together events and occurrences in to one coherent story, it mediates between heterogeneous elements bringing them in to one account, and finally it mediates between chronological and non-chronological accounts. The activity of narrative seeks to bring a sense of unity or coherence to life, however it remains provisional.

To appreciate the subtlety and depth of Schechtman’s perspective, it is important to appreciate her tempering of and ultimate rejection of an understanding that person’s self-constitution is strictly first personal. The achievement of personal identity, whereby a person has come to constitute themselves through narratives, requires the person to consciously engage in attributing characteristics to herself and to understand herself as a person with a particular identity through time. The narrative activity that itself constitutes personhood although labelled self-constitution, in reality, “is an intrinsically social concept”. The development of personhood, achieved through the continued act of self-constitution, is culturally specific. There is a requirement to appreciate and abide by the conventions of one’s community or culture, so that one’s self-understanding in narrative is synchronised with that which others hold. “An individual’s self-narrative must conform in certain crucial respects to the narrative others tell of his life”.

The form of narrative personhood for Schechtman, like the conception of self-constitution, is not as rigid or demanding as first appears. Although to be a person one must consciously attribute characteristics to themselves and view themselves as persisting through time, there is no requirement to knowingly hold or endorse a particular narrative. The emphasis of Schechtman is on the activity of consciousness, an approach she identifies in Locke’s

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279 ibid
283 ibid.
284 ibid., 105.
foundational work on personal identity. Locke’s definition of a person establishes a demand that a person is an intelligent being, capable of appreciating that they are a self through time. This grounds Schechtman’s alternative interpretation of ‘sameness of consciousness’ in Locke as not associated with memory but rather the activity of consciousness, which can take an explicit narrative format. Consciousness can extend back in to the past, where actions, feelings, beliefs, are afforded importance through attribution. However, this may not be exhaustive of the effect the past may have on the present, as persons may uncritically carry on certain behaviors, attitudes or anxieties from the past in to their daily life. That which we carry over from the past either consciously or not, thus provides a script or lens through which we make sense of who and what we are, but also structures how we constitute ourselves going forward.

The third dimension of narrative identity proposed here relates to the mechanics of narrative identity. The achievement of narrative identity as that which obtains for human beings comes about through narrative activity. Ricoeur contends that while narrative identity mediates between selfhood and sameness, and seeks to achieve mediation while addressing three relations, it does so through a mimetic process involving three stages. The first stage as mimesis\textsubscript{1} refers to the prior side of narrative composition. This is a competency or familiarity with the expectations of and requirements of any attempt to narrate experience. The second stage as mimesis\textsubscript{2} refers to the activity of emplotment whereby a threefold mediation is proposed. This activity however is ruled governed, operating as it does in a particular cultural situation with its own “schematization”\textsuperscript{291}. The telling of a story operates between the possibility of innovation and the constraint of sedimentation.\textsuperscript{292} The final stage of mimesis\textsubscript{3} corresponds to the stage of application, whereby a narrative creation encounters the world and its readership.\textsuperscript{293} The narrative’s projected understanding or horizon however

\textsuperscript{286} \textit{ibid}, 449.
\textsuperscript{287} \textit{ibid}, 433-434.
\textsuperscript{290} \textit{ibid}, 64.
\textsuperscript{291} \textit{ibid}, 68.
\textsuperscript{292} \textit{ibid}, 70.
\textsuperscript{293} \textit{ibid}, 77.
can be accepted or rejected. As narratives are produced from and under the influence of culture, so too are they evaluated and read from those within culture(s).

In Schechtman’s account the understanding of narrative self-constitution as a social concept is emphasized in the discussion of constraints placed on persons. While persons may not explicitly endorse or hold a narrative account of themselves, albeit one or many may be operative or influential at a given time, there is a requirement at certain times for any person to share or articulate their narrative activity. Schechtman situates the “Articulation Constraint”, as a demand occasionally experienced by persons in which they are required to give an account of their subjectivity, to share with others why they do, believe, think, and act the way they do.\(^{294}\) The inclusion of an articulation constraint suggests that personal identity speaks to more than simply one’s own understanding of themselves but rather has a practical significance. The request for persons to articulate what the perspective is which guides their actions and understanding of themselves, which may be in an explicit narrative form, reveals that others can place demands on persons to account for themselves. Crucially for Schechtman she holds that personhood is impacted upon considerably when that person has an “inability to articulate one’s narrative sufficiently”.\(^{295}\)

The account of narrative identity developed by Ricoeur and Schechtman provides to the discipline of bioethics an alternative account through which to interrogate human experience in the examination of healthcare. Although not yet applied to the activity of capacity assessment, the appeal of an account of identity which emphasizes the attribution of characteristics and action, the role of others and the contingency of personhood is self-evident. The activity of evaluating decision making and conferring capacity or incapacity, the role of assessors in evaluating capacity and the significance of capacity as a characteristic of legal personhood, are all potentially readable as activities of narrative identity. The justification for such a reading is turned to next.

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\(^{295}\) *ibid*, 117.
3.3 Narrative Bioethics

To claim that there is a distinctive approach in bioethics centered on narrative can be seen to prompt an immediate need for clarification. How is narrative bioethics set up to resolve ethical dilemmas or issues? How does narrative bioethics relate to or compare with traditional moral theories in ethics? Is the approach simply a call for the narrative or storied aspects of bioethics to be acknowledged? To try and answer these questions definitively is not possible and this is due to a distinctive feature of narrative bioethics. To do so would be to violate a commitment to humility borne out of the project of narrative bioethics always remaining incomplete. Narrative approaches to bioethics have multiple strands each with a distinctive emphasis. At a general level, narrative bioethics can be viewed as a set of approaches in bioethical discourse which seek to acknowledge and emphasize the significance of the narrative and the storied dimension of ethical understanding as it relates to ethical approaches, everyday life, ethical education, legal judgments, illness etc. The origins of the narrative turn in bioethics may be traced back to a broader shift to narrative approaches in the 1980s. This period witnessed a growing interest from philosophers, narratologists and literary theorists in narrative. Developing at the same time was a concerted effort to give moral theory a personal dimension, seeking to move away from impersonal approaches in ethical discourse. Furthermore there was a concern with the role healthcare professionals play in their own narrative acts of reading, writing and listening. The emerging interest in narrative approaches to personhood and concerns with impersonal approaches to ethical theory contributed to an emergence of a narrative approach to bioethics. The development of narrative approaches in medicine, bioethics and also in medical anthropology reveal a shift

in how the person in healthcare and medicine can be understood as well as how medicine and bioethics are understood.

The approach of narrative bioethics emerged in the nineties as increasingly more attention was given to the role of narrative. A set of seminal texts provided an overview of what are some of the styles of narrative bioethical approaches. In these texts an approach began which continues until today about how to understand, situate and practice narrative bioethics. In this section, this process is continued as a framework for narrative bioethics which addresses four issues. The first addresses the place of narrative in bioethics, the second outlines ways of doing narrative bioethics, the third identifies the call of narrative bioethics and the fourth the limitations of narrative approaches. Such an understanding is prefaced with a caveat that narrative bioethics erodes such distinctions in theory and practice but also exceeds such an understanding. Before offering an overview of narrative bioethics, it is necessary to mention that the name ‘narrative bioethics’ is itself contended in the literature. To some, the approach of narrative bioethics is still unclear, failing to achieve any refinement in method or purpose over the last twenty years and also myopic to the wider engagement with narrative in academia. To refrain from using the name narrative bioethics, as it fails to adhere to the demands of traditional conventional theories, while intended to avoid confusion, risks privileging non-narrative based methods in bioethical discourse.

The adoption of narrative approaches to bioethics is often held to involve rejecting top down approaches to ethics. Rather in contrast it begins with particularities and the lives and context of situations. At a broad level, narrative approaches make two claims about the place of narrative in bioethics. First, a descriptive claim holds that narratives or stories are central to all stages of bioethical practice. The four domains of bioethics as moral education, moral methodology, moral discourse and moral justification can be viewed as reliant on

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stories and the everyday meaning making activities people perform with narrative. This understanding can be held to elaborate on the more general recognition of the role of narrative in everyday existence. It is through stories that we come to learn as children but when we are older, literature and other texts become a way through which particular ethical questions and principles are identified and explored. The narrative, story or case of a particular patient or an ethical issue is considered essential to bioethical discourse. Cases provide the reader with the space or context in which to enter the world(s) of others and to articulate ethical questions. Students and ethicists alike are invited in to offer possible interpretations and proposed narratives in the midst of action. Bioethicists as those involved in emplotting narratives are not separate from but rather are involved in interpreting and framing events. Cases and stories also however become the appropriate means through which moral theories are tested out. How cases are responded to can take principilist or narrative approaches. In the former cases are considered to identify the appropriate ethical or legal principle to apply. In the later context is relevant to the extent that it allows for recognition of the identities of those involved. Bioethics however not only avails of narratives but in seeking to establish principles to be generalized, attempts to step outside of the particularities of narratives. The task of the bioethicist can also be read as having to identify what is the actual story or the appropriate plot in a particular case is.

Second, narrative bioethics make a normative claim about what should be acknowledged and recognized as significant in bioethics. It is through the reading and listening to stories that

310 Laurie Zoloth and Rita Charon, Rita Charon and Martha Montello (eds) Stories Matter: The Role of Narrative in Medical Ethics (New York: Routledge, 2002) 30.
313 See Tod Chambers and Kathryn Montgomery, ‘Plot: Framing Contingency and Choice in Bioethics’, in Rita Charon and Martha Montello (eds) Stories Matter: The Role of Narrative in Medical Ethics (New York: Routledge, 2002) 77-78, where an appeal to Russian formalists allows for a distinction between story as the set of events and plot is a particular arrangement of those events.
ethical reasoning is refined. As moral deliberation takes place through narrative, bioethical consideration should turn to the effect of narrative reasoning on medical practice. Here narrative bioethics calls for attention to be on the patients, their lives, interpretations, experiences and journeys through illness. The development and application of ethical wisdom and knowledge is to some degree dependent on narrative. The failure of bioethics to sufficiently engage with narrative can be identified as problematic both professionally and personally. There is a risk that bioethical discourse will proceed without sufficient awareness of its operation in a dialogic space of authors and readers. Furthermore, there is a concern that bioethical discourse may be limited in its own engagement if it omits narrative dimensions.

The place which narrative occupies in bioethics can be seen to inform two layers or stages at which narrative bioethics can be practised. At an initial stage narrative bioethics requires an attending to the patient or individual at the centre of the issue at hand, acknowledging that narrative is central to lived experience. The experience of illness or the encounter with biomedicine constitutes one such space in which a narrative response may be required. The awareness of or sensitivity to the telling of stories and invoking of narrative schemas may ground an understanding or “narrative knowledge” which can ground or underpin further practice. This knowledge, as the second stage, can be considered a “narrative competence” where it allows for healthcare practitioners and ethicists to acknowledge and

318 Laurie Zoloth and Rita Charon, Rita Charon and Martha Montello (eds) Stories Matter: The Role of Narrative in Medical Ethics (New York: Routledge, 2002) 22.
319 Ibid, 27.
engage as a reader of another’s experience, to attempt to move out of the privilege of their own perspective and seek a greater appreciation of narrative negotiation and reconstruction.\(^{323}\) The risk in practicing narrative bioethics is the belief that this process is every complete, or that there is ever sufficient understanding.

The approach of narrative bioethics can be interpreted as issuing a paradoxical call on practitioners, to both attempt to attend to the subjectivities of those possibly disempowered, silenced or not acknowledged,\(^{324}\) while refuting any suggestion that such understanding can be achieved. As such, narrative bioethics demands the humility that goes with rejecting any attempt at closure in understanding.\(^{325}\) Narrative bioethics requires the commencement of a project that will never be complete for it is in completion that damage may accrue. It lies in this place of moving toward without arriving, the domain of the personal and interpersonal in which the ethical dimension can be seen to lie. It is always possible to add to existing interpretations or perspectives, to attend to context in a distinct or novel way, to add more. Such a perspective however issues a challenge to bioethicists and practitioners in healthcare as the right solution or expertise on an issue, will always remain elusive. The narrative bioethical approach can be viewed as complementary to what is missed or denied by analytical or traditional bioethical approaches, acting to compliment or “fill in the gaps”.\(^{326}\)

Although narrative bioethics emerged in response to limitations of traditional approaches, to suggest it is there to compliment these approaches is problematic. A narrative bioethics approach understands the issue at the heart of bioethical enquiry in a different way. As opposed to thinking of “what to do”, Montello argues attention needs to shift to “how we got here”.\(^{327}\) The call on doctors, ethicists and others to attend to the other’s subjectivity,


\(^{326}\) Tom Tomlinson, ‘Perplexed about Narrative Ethics’ in Hilde Lindemann Nelson (ed) *Stories and their Limits: Narrative Approaches to Bioethics* (New York: Routledge, 1997) 124; See also Joan McCarthy, ‘Principilism or narrative ethics; must we choose between them?’ (2003) 29(2) *Medical Humanities* 65.

language and difficulties is not so that ethical reasoning might be better informed but because it is that which is significant for ethical reasoning and healthcare. 328

The place, practice and call of narrative bioethics necessarily point to the limitations of the approach. A bioethical approach interested in challenging the single perspective or meta-narratives through the acknowledgment of and sensitivity to varying perspectives is liable to criticisms of succumbing to relativism, failing to provide a basis for morality or justification and unsuited to healthcare practice where ethics cases require closure. 329 Narrative bioethics alone, it is suggested, is incapable of underpinning an ethical approach in and of itself. Although narrative and or narrative identity are now widely acknowledge as relevant and significant in illness and bioethics, two questions remain. What role should narrative bioethics play? How can narrative approach sit alongside other traditional approaches?

Narrative bioethics as a disciplinary approach leads to greater multivocality than clarity. At the core of the approach is an unwillingness to privilege the dominant or established perspectives in healthcare and bioethics. When applied methodologically, the question can be raised as to its aim. If it is committed to a denial of closure, the question of why would such an approach be utilised is legitimate. It is this seeming antithetical position to directing practice that makes a narrative bioethics approach relevant and required in the context of mental capacity theory and practice. The MCA has recently received political approval in both the House of Lords and in the Government’s response and yet issues with implementation and application are prominent. The reclamation process of the legal concept of mental capacity, originating in the late 1980s and resulting in the passing of the Act, was itself premised on an unquestioned conviction that incapacity is a problem and one which must be addressed. The rhetoric surrounding the Act, focused on empowerment and protection, places emphasis on the individual potentially lacking capacity. Finally, the Act and the Code of Practice naturalise the position that mental capacity is intrapsychic and a feature of an individual, discrete to them at a particular time. A narrative bioethics approach

encourages the challenging of these dominant narratives through the offering of alternative accounts and perspectives.

3.4 A Narrative Bioethics of Mental Capacity

Building on this understanding of Narrative Bioethics as grounded in a concern with subjectivities and context, the approach taken in this thesis will draw on Lindemann’s call to offer “counterstories”. A narrative bioethics approach allows for mental capacity to be considered from different perspectives. As noted above, alternative narrative accounts provide the possibility for healthcare and bioethical practices to be viewed as contingent and open to possible negotiation.

One of the central ideas emerging from narrative bioethics is the idea of resisting closure and in doing so challenging consensus. A narrative bioethics approach thus legitimizes alternative readings which seek to destabilize traditional accounts, by attending to alternative perspectives. The aim of this thesis is to critically examine the Mental Capacity Act and this is performed through the offering of counter narratives on two themes. The questioning of whether the current understanding of the MCA is sufficient and coherent draws on narrative bioethics approaches. In chapter six the appropriateness of the MCA’s narrative of incapacity as intrapsychic is subjected to a critical reading, which draws attention to limitations and otherwise silenced dimensions of contemporary mental capacity practice. Chapter Eight practices the narrative bioethics approach of telling stories to highlight the role others use stories for, in speaking about, of, or in place of others. The questioning as to whether mental capacity should be identified as related to personal identity engages in narrative bioethics on a few conceptual levels. In chapter five a way of practicing narrative bioethics is outlined, situating narrative bioethics as confronted with the challenge of postmodernism. In chapter seven the reading of narrative identity in personal identity debates is challenged through the proposing of a rereading of narrative identity approaches. Here, a narrative bioethics approaches attends to the varying approaches to narrative identity. The chapters five through eight are emplotted arguments across a wider narrative central to this thesis.

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namely that of calling for an intersubjective model of the self in mental capacity law, in place of an intrapsychic approach.

The invoking of narrative to offer an alternative account of mental capacity practice can allow for a response to mental capacity practice grounded in narrative identity. A central feature of Ricoeur and Schechtman’s accounts is the idea that personhood is achieved, alongside others, through the negotiation of narrative. The sensitivity offered by attending to narrative allows for individual and relational factors to be acknowledged but also to the means narrative can be used, to posit and maintain differences. The use of narrative identity approaches to respond to limitations of informed consent, call for a greater sensitivity in practice of different dimensions of selfhood. Framing mental capacity practice as related to narrative dimensions of selfhood allows for the relations and identities central to assessment to be acknowledged. Mental capacity commentary however must seek to go further. Appreciating that context must always be attended to, both out of humility and sensitivity to the limitations of how any one perspective privileges perspectives. Accordingly, mental capacity practice must be understood in its historical context. The challenge of an ahistorical understanding is that mental capacity practice may be framed simply through the naïve rhetoric of empowerment and protection or that which privileges an intrapsychic definition of mental capacity.

Such an understanding will underpin this thesis. Narrative bioethics will be taken as providing an opportunity for the critical consideration of mental capacity theory and practice. Adopting this approach acts to put the issue of responding to cases of incapacity in to abeyance, identifying the concept of mental incapacity as worthy of scrutiny.

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Chapter 4

Outline of Papers

1. Toward a Postmodern Bioethics

In this article, postmodernism is presented as posing a challenge to the role of philosophy within bioethics. It is argued that any attempt to develop a postmodern bioethics must respond to arguments concerning power, relational responsibility, and violence. Contemporary work on the topic of relational autonomy and naturalized bioethics is interpreted as engaging with the postmodern challenge. This article proposes that the role of philosophy in bioethics should be not to provide moral guidance but rather to adopt a critical approach to the possible consequences of privileging any position or understanding over others.

2. Conceptual and Ethical Problems in the Mental Capacity Act 2005: An Interrogation of the Assessment Process

Central to the Mental Capacity Act 2005 (MCA) is the claim that a conferral of incapacity may not be based on the wisdom of a decision alone. This paper problematizes this position. Values-based medicine is drawn on to explore the process of capacity assessment, highlighting the presence of preconceptions throughout assessment. Two cases before the Court of Protection are examined to bring into focus the complexity of conducting assessment without reference to wisdom. The paper proposes that every stage in the assessment of capacity is undertaken with reference to preconceptions and that an acknowledgement of these, along with transparency about when they are to be employed, would allow for greater clarity about what the MCA demands of practitioners.

3. Situating Narrative Identity in the Bioethics of Personal Identity

In recent years bioethical consideration of personal identity has faced the challenge of how to situate narrative identity within debate. In response to Mary Schechtman’s critique of traditional metaphysical approaches and the associated preoccupation with the issue of continuity through time has emerged a subjective interpretation of narrative identity. A subjective interpretation is held to encompass approaches that understand narrative identity as distinctly first personal. In this paper David DeGrazia and David Shoemaker are identified
as adopting subjective interpretations. The adoption of a subjective interpretation allows for a limited scope to be afforded to narrative in personal identity and ethics debates. In contrast, Paul Ricoeur is identified here as offering an alternative inter-subjective interpretation of narrative identity, which complements Schechtman’s interpretation. Critically, narrative identities cease to be just an object of bioethical concern, but rather bioethics becomes a practice that avails of narrative identity. Bioethical discourse, in providing available schemas and narratives for individuals and healthcare professionals to make sense of experience, is co-authoring, alongside many other discourses, the way healthcare and patients are understood. The narrative challenge confronting bioethics can be understood as posing the question as to how bioethics is to understand the individual or patient in relationship. Bioethical discourse can impact on how practitioners and others understand ethical issues, but also invite them to treat and understand individuals or patients in particular ways. The choice of how to understand the individual, which lies at the centre of bioethical inquiry, finds one expression in the distinction between subjective and intersubjective approaches to narrative identity.

4. Negotiating Relationality: Mental Capacity as Narrative Congruence

The concept of capacity that emerges from the Mental Capacity Act (2005) is conceptually flawed and places practitioners in an impossible situation regarding its application. The continued support by the UK government and others for the Act strengthens the idea that the capacity/incapacity distinction is natural and that incapacity is an intrapsychic feature of an individual. This paper proposes an alternative model for understanding capacity and its assessment based on a narrative theory that recognises the role of the practitioner and identity negotiation. Although this more nuanced approach may at first appear more complex, it avoids the conceptual and practical difficulties raised by the notion of mental capacity.
Chapter 5
Towards a Postmodern Bioethics

5.1 Introduction
Any suggestion that the role of philosophy within bioethics is not to provide justification or support for conduct is likely to be rejected by some bioethicists. If philosophical approaches fail to provide objective guidance for practice, the purpose of philosophical contributions will be questioned.334 I aim to show that, in adopting a postmodern approach, the role of philosophy is to continually question the presuppositions of and accepted practices within healthcare. As such, a postmodern approach invites practitioners and philosophers to be accountable for what practices they support. For a postmodern bioethics, the ethical lies not in doing the proposed “right thing,” whatever that may be, but in adopting a critical perspective toward healthcare, acknowledging that practices invariably privilege some people over others.

The adoption of a postmodern approach requires at first an acknowledgement of the difficulties postmodernism presents. Three specific difficulties—as outlined by David Wood, Michel Foucault, and Sheila McNamee and Kenneth Gergen, respectively—provide an opportunity to acknowledge (1) the potential for violence in philosophy, (2) philosophy’s role in shaping subjectivity, and (3) the complex nature of identity. Two anthologies—Relational Autonomy: Feminist Essays on Autonomy, Agency and the Social Self335 (referred to from here on as Relational Autonomy) and Naturalized Bioethics: Towards Responsible Knowing and Practice336 (referred to from here on as Naturalized Bioethics)—call into question the privileged ideal of the autonomous self in bioethics and medicine. I suggest that these two works can be viewed as introducing a crisis, one that a postmodern philosophical approach would seek to maintain. The uptake of a postmodern philosophical approach is difficult, as it asks us to recognize that all understanding is perspectival and situated. In

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healthcare, the practitioners’ work environment is shaped by conceptions of justice, health, and the individual that have been privileged over others. In bioethics, peers and institutions that privilege particular theoretical approaches over others are responsible for evaluating contributions. The novelty of a postmodern philosophical approach lies in acknowledging the limits of any perspective and calling for a stepping back from the offering of theories to guide practice. Instead, the imposition of particular theories on practice is identified as ethically significant, as to do so serves to exclude or relegate the importance of other perspectives. In seeking to question and disrupt accepted approaches and theories in healthcare, a postmodern approach attempts to acknowledge the limitations that healthcare practices impose on practitioners, while calling on theorists to take responsibility for their contributions.

Before advancing the argument, it is necessary to preface this work with a comment on language and method. First, any engagement with postmodernism succumbs to the difficulty of language usage, namely, the need to speak in the language of the audience one is seeking to address. In providing only a brief outline of postmodernism and deconstruction, a disservice of sorts is imposed on these two traditions. Second, the “toward” in the title of this article signals uncertainty as to whether a postmodern approach will ever be adopted in mainstream philosophical bioethics, as to do so challenges the role philosophy plays in bioethics.

5.2 Postmodernism

In his 1979 book *The Postmodern Condition*, Jean-François Lyotard offers an account of postmodernity. At its most basic, postmodernism challenges or invites us to focus our attention on the conditions, production, and use of knowledge. This turn, referred to by Fredric Jameson as beckoning a “crisis of representation,” offers an approach that postmodern bioethics seeks to maintain. Lyotard’s understanding of postmodernity could be understood as involving three steps. The first stage occurs when we think about the conditions and requirements of knowledge claims. Underpinning a science or discipline of

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338 *ibid*, viii.
knowledge at any time is an already established source of legitimation, “meta-narratives.” The realization that these metanarratives are produced at a particular time in history undercuts their legitimacy, representing a fracturing of knowledge from justification. The second stage, in response, attends to the production of knowledge, identifying performativity and power as characteristics of science. To be afforded legitimacy, knowledge claims must conform to established practices, and if successful, the performer and the knowledge will gain “power.” The issue of the legitimacy of knowledge is accordingly inseparable from the legitimacy of the institution that maintains standards of legitimization. The third stage, that of crisis, acknowledges that individuals are a product of intersubjective contexts and that each of these contexts has its own language and rules. The issue of legitimation signals the condition of postmodernity, in which the subject is implicated in and can only be encountered through multiple language games, each with its own established set of rules. A person or a knowledge claim is already situated in a series of narratives.

Jacque Derrida’s idea of deconstruction refers to a possible way of engaging with a text, one that seeks to draw out what has been obscured or silenced. Echoing Lyotard, Derrida’s deconstruction is not a method exterior to knowledge that may be applied to a topic; rather, deconstruction, like postmodernism, is latent within the text or knowledge claims. Deconstruction takes as its focus truth claims or objective—often metaphysical—descriptions. It is only in the disrupting of these truth claims, the realization that this truth is a production of a particular time in history, that the opportunity to encounter or relate to people ethically opens up. The opportunity for ethics or justice emerges from the discrediting of any attempted universalizing description or imposed “homogenized whole”. Traditional moral theories that demand the observation of principles already presuppose a particular description of the world. These theories, however, in describing the world, omit or afford more importance to particular concepts than others. The possibility of ethics requires an acknowledgment that all our experiences are located in a particular situation and perspective.

339 ibid, xxiv.
340 ibid, 46.
342 ibid, 13.
what Maurice Merleau-Ponty refers to as the most important lesson of phenomenology.\textsuperscript{343} The construction of a moral theory based on a particular experience and then applied to or expected of others is an attempt to privilege one perspective over others.

In practice, postmodernism invites healthcare practitioners to recognize that the guidelines they work under, the knowledge that guides practice, and the protocols they follow have been developed in the light of particular theories, at a particular time in history and within a particular cultural setting. The perspective within which practitioners operate—based on guidelines, knowledge, and protocols—privileges some over others but also demands the adherence of practitioners. This may lead to dilemmas in practice.

5.3 Three Postmodern Challenges for Bioethics

\textit{Stepping Back}

David Wood,\textsuperscript{344} in examining the possibility of ethics after deconstruction, identifies the challenge confronting theorists as one of philosophical humility. Deconstruction as a philosophy of the limit invites philosophers to step back from the will to overcome or impose/uncover foundations. Instead, the task of philosophy is to affirm the “necessity of ambiguity, incompleteness, repetition, negotiation and contingency.”\textsuperscript{345} As such, a language and method that accepts philosophical limitations is required. To facilitate this, philosophers working in bioethics must acknowledge the potential violence of philosophical contributions. The first form of violence, the violence of “concepts,”\textsuperscript{346} calls to attention how the categorizing and imposing of boundaries potentially permits a double violence. That individuals can be considered to have or lack capacity allows for individuals to be considered through that lens alone. Following from this, the distinguishing of individuals according to the presence of capacity may justify violence being performed on individuals. In ruling that an individual lacks capacity, practices including force-feeding of patients or forced caesarean sections are justified. The second form of violence may occur in “philosophical dialogue”\textsuperscript{347}


\textsuperscript{345} \textit{ibid}, 3-4.

\textsuperscript{346} \textit{ibid}, 44.

\textsuperscript{347} \textit{ibid}, 46.
and highlights the potential treatment of other people’s work in philosophy. When philosophers fail to acknowledge the views of another, they risk confusing their difference of opinions with the idea that the other’s position is irrelevant or wrong. The third form of violence, the “silent violence of humanism,”\textsuperscript{348} refers to treatment of others that is frequently justified or is not often condemned. Wood is referring here to the treatment and use of animals by the human species, as part of which animals are subjected to violence. This third violence draws attention to the focus of ethical thinking and more importantly to what is permitted generally in everyday life.

The call to step back allows practitioners and theorists to reflect on the potential consequences of their actions. The use of diagnostic tools to identify and distinguish patients from others risks viewing patients through those perspectives only. The identification by ethicists of what is of ethical importance in a particular context risks performing violence. Alternatively, the failure to impose limits on ethical responsibility in a context implies a limitless responsibility. The step back advocated for by Wood acknowledges this impossible demand placed on philosophy, and that philosophy is in a position of infinite responsibility. As philosophical bioethicists offer theories to map the ethical landscape of medicine and science, they support the privileging of particular interpretations, which facilitates violence in the form of differentiation.

\textit{Attending to Power}

In “The Subject and Power”\textsuperscript{349} Michael Foucault argues that power influences an individual’s experience of the world. “Power” here refers to the ability to bring to bear on a particular practice a meaning or interpretation. Power can only be observed or identified in situations in which the uptake of a particular meaning might have been rejected but is maintained because it has been afforded a truth status. Therefore, compulsion, violence, and necessity do not equate with power.\textsuperscript{350} Power relations, as the effects of a particular “knowledge” coming to bear on a practice, invite individuals to understand things in a specific way. The relationship between philosophy and the disciplines of medicine and science can be observed

\begin{footnotesize}
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\item \textsuperscript{348} ibid, 47.
\item \textsuperscript{349} Michel Foucault, ‘The subject and power’, (1982) 8(4): Critical Inquiry 777–95.
\item \textsuperscript{350} “Slavery is not a power relationship when man is in chains”; \textit{Ibid}, 790.
\end{enumerate}
\end{footnotesize}
as an exercise of power. Philosophy, notably ethics, provides healthcare practices as well as future practices with frameworks and interpretations. The uptake by medical practitioners or politicians of these interpretations serves to influence how medical practices are evaluated. When an approach is adopted, however, it can become the lens through which practitioners or individuals evaluate action.

In considering power, Foucault also invites readers to consider the strategy of exercises of power. In offering justificatory schemas to healthcare and science, philosophy within bioethics can be challenged about its aim. Foucault identifies three types of strategy: the “means employed to achieve a particular end,” the “manner in which a partner in a certain game acts,” and “the procedures used in a situation of confrontation”.351 Philosophical bioethics may be asked to account for the consequences of its strategies as it engages with medical practice. Foucault’s consideration of power and subjectivity when applied to bioethics asks questions as to the fundamental aim or purpose of philosophical bioethics but also emphasizes the role philosophical contributions can have in shaping institutional and individual practices. Healthcare practitioners who have been exposed to bioethical theory or approaches, who may then draw on such theory in practice, become complicit in the means by which individuals are evaluated by a specific philosophical gaze.

Relational Responsibility

In Relational Responsibility,352 Sheila McNamee and Kenneth Gergen call for the adoption of an understanding of relationality. Because any theory offers meaning to those who accept it, the production of theory can be viewed as a relational practice. Any theory can become a means by which individuals make sense of the world; however, the adoption of a theory can serve to permit certain actions while rejecting others. Philosophical approaches in bioethics can be viewed as invitations for healthcare to be understood in a particular way. In advocating for a relational approach, the idea of holding a person solely responsible for action is disrupted; instead the actions attributed to individuals are examined relationally. This call is

351 ibid, 793.
not for a movement away from individual responsibility but to acknowledge that individual actions are informed and influenced by relationships.

McNamee and Gergen suggest four forms of relations that allow for the appreciation of the implication of other people in an individual’s action. The first form, “internal others,” signals that an individual’s actions or views at a given time are products of relationships with others and the meanings that emerge in these relationships. In acting or speaking within a context, an individual adopts one of many positions available to him or her from the multiple contexts in his or her life. In doing so, however, other positions are silenced. When patients make a decision about their healthcare, they may be influenced by professional, family, economic, and religious contexts. The acknowledgment that these have been constituted relationally troubles the attribution of personal blame or approval. The second form, “conjoint relations,” offers an understanding of individuals within their context. An individual action is part of a relationship, in which any act is part of a larger project or relationship. Any decision that an individual makes about his or her healthcare is not an isolated decision but is related to several relations within his or her life. The third form, “relations among groups,” signals the use of traditionally individualist language in discussing collective units. According to this line of thinking, the action of a nurse can be viewed as the accepted professional behaviour of a nurse rather than as an isolated individual decision. This type of reasoning serves to underscore the environment in which action takes place but can be criticized for replacing individual blame with group blame. The fourth concept, that of “systemic process,” invites us to see that nothing occurs outside of a system. All actions are connected to other actions, and individuals who act within a system are complicit with it. As acknowledged in the public inquiry of the Mid Staffordshire NHS Foundation Trust, the failures of a hospital can be attributed to systemic failures rather than the actions of discrete individuals.

353 ibid, 11.
354 ibid, 13.
355 ibid, 15.
356 ibid, 16.
If we accept the challenges of McNamee and Gergen, philosophical bioethics must attend to the relational contexts in which any decision is made, recognize that any action is one within a series of actions, and understand that individuals act as representatives of the groups they are part of and that wider systemic views need to be taken on board. This adds to the complexity of healthcare decisions and suggests that the multiple contexts surrounding any decision need to be acknowledged.

The Three Challenges: Overview
The three challenges invite philosophers working within bioethics and healthcare practitioners, who work in a context informed by philosophical ideas, to question the practical use of philosophical ideas and to enquire as to the specific role of philosophy in bioethics. Both Wood and Foucault ask us to consider the impact of philosophical ideas in practice, the potential for violence, and the possible justification that philosophy can afford action. However, Foucault and McNamee and Gergen invite a secondary question about the role of philosophy in bioethics and in relation to healthcare more generally.

5.4 Emerging Postmodern Approaches in Bioethics
In *Relational Autonomy* and *Naturalized Bioethics*, numerous authors advance deconstructive readings to challenge the importance afforded to the ethical and legal notion of autonomy. In critiquing this notion, both anthologies reveal the presuppositions and biases that underpin the notion that an individual is “fundamentally individualistic and rationalistic”. In demonstrating that certain perspectives or ways of viewing a patient are prioritized over others, both anthologies invite readers to acknowledge that ethical approaches affect how the world is understood.

Jackie Leech Scully observes, in bioethical thinking, two strategies used to allow for certain perspectives to be excluded. A “move of commonality” suggests that people have

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360 *ibid*, 23.
so much in common that it permits one to speak for everyone. A “move of marginality”\textsuperscript{361} seeks to identify a perspective as so insignificant or rare that it need not be afforded importance in ethical discussions. These strategies permit individuals to speak on behalf of others, assuming that any differences are minor. The task confronting bioethics is that it must continually address the assumptions that underpin theorizing and must develop ways of understanding everyone’s perspective. Hilde Lindemann\textsuperscript{362} draws attention to the risk in healthcare settings of focusing on one aspect of a patient, namely his or her decision making ability. In doing so, key aspects of his or her identity, be it relationships with others or certain projects, are afforded less significance. Naomi Scheman\textsuperscript{363} argues that the focus of medicine and research on the individual fails to acknowledge the role of communities, which in practice are the contexts in which identity is continually developed. In examining a study of women’s contraceptive choices, Natalie Stoljar\textsuperscript{364} argues that theories of autonomy fail to acknowledge the role of oppression and the effect it can have on decision making. Paul Benson\textsuperscript{365} argues that, on examining characteristics typically attributed to individuals, such characteristics are revealed to be relational concepts. In stating that someone has autonomy or moral responsibility, what is being claimed is that an individual demonstrates particular behaviours, which are associated or equated with autonomy or responsibility by other people.

I argue that a similarity can be observed between these five approaches and deconstruction. Deconstruction, in its most basic form, attends to accounts that offer “absolute descriptions.” These descriptions, referred to as “closures,” can be subjected to a secondary reading. In performing a secondary reading, the assumptions or that which has been omitted from a description is identified. These readings, however, disrupt and dislocate that attempted

\textsuperscript{361} \textit{ibid}, 24.


original finite definition. Scully, Lindemann, Scheman, Stoljar, and Benson offer to the proposed description of an individual as autonomous secondary readings revealing that which is omitted or assumed. These approaches allow for an acknowledgment of a secondary meaning for closure, namely, the impossibility of imposing an absolute description. It is only in accepting that absolute descriptions are impossible that the possibility of acting ethically is offered. These five authors respond to Wood and Foucault’s respective calls for an awareness of the consequences of philosophizing.

5.5 Beyond Deconstruction
In acknowledging the critique of autonomy offered in both anthologies, two possible approaches emerge. The first, the practical strand, seeks to return to healthcare practice. Therein healthcare can attempt to reconcile that which has been omitted or sidetracked in a focus on the decisionmaking individual. Practicing patient-centered care demonstrates this attempt to care for the individual patient, rather than focusing on a discrete aspect of the individual. The second response, as theoretical, attends to the questions asked of philosophy by Foucault and McNamee and Gergen. The development of a theoretical approach seeks to address the role philosophy plays in its engagement with healthcare.

Tod Chambers366 and Eva Feder Kittay367 engage with the theoretical approach. Chambers holds that bioethics as a “sociopolitical endeavor” can be subjected to narrative examination. Read as a form of storytelling, bioethics attempts to provide a lens through which medicine and science can be encountered and understood. When bioethical narratives are subjected to a series of questions, the attempted universality implicit in the narrative is understood as a construct. The turn to narrative allows for philosophy to refute any imposition of a bioethical maxim or truth. Feder Kittay, addressing the role of individual philosophers, holds that we

need to be aware of the limits of our knowledge. She warns philosophers of the dangers of
idealization, particularly in relation to persons. This movement toward idealization, toward
conformity, toward an imposed commonality, demonstrates poor practice. The challenge for
philosophers in bioethics is to avoid succumbing to a reductive philosophy; to this end, Feder
Kittay suggests four commitments philosophers can uphold:

1) “Epistemic responsibility: know the subject that you are using to make a
philosophical point.”
2) “Epistemic modesty: know what you don’t know.”
3) “Humility: resist the arrogant imposition of your own values.”
4) “Accountability: attend to the consequences of your philosophizing.”

The approaches of Chambers and Feder Kittay can be considered as engaging with the
strategic questions about the role of philosophy as identified in the discussion of Foucault
and Gergen and McNamee. In calling for limits to be adhered to and for an awareness of the
contextual nature of philosophical approaches in bioethics, Chambers and Feder Kittay offer
interpretations of what philosophical bioethics should be. For Chambers, the development of
narrative analysis skills allows for philosophers to address their engagements with healthcare,
the strategies underpinning their engagements, and the broader strategies in which
philosophers work. Feder Kittay, in seeking to foster awareness of limits and to encourage
philosophers to work within these limits, attempts to define what the role of philosophical
contributions should be.

However, the respective calls of both these theorists for philosophers to utilize certain
approaches and to act with humility fail to provide an account of the overall role or purpose
of philosophical bioethics. For the philosopher engaging in bioethics, knowing how to act
and what methods or approaches to employ is important, but clarification is required as to
the object of philosophical bioethical enquiry.

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368 ibid, 227-232.
5.6 A Postmodern Philosophical Bioethics

I propose an understanding of postmodern philosophical bioethics as an approach that is resistant to and draws attention to the attempted imposition of absolute definitions or universality on healthcare. In outlining this approach, which responds to the three postmodern challenges discussed, I draw on Simon Critchley’s understanding of ethics and deconstruction.\textsuperscript{369} A postmodern philosophical approach allows for the strategic role of philosophy to be acknowledged and offers a practical role for philosophy in addressing healthcare but acknowledges a difficulty in identifying the object of philosophical bioethics.

When philosophers turn their focus to practices in healthcare, they encounter a practice already established within an ethical framework. This practice can be understood as a product of a tradition, which has justified its use by appeal to some ethical view. The philosopher, in engaging with the issue, is also a product of a tradition, as the methods he or she employs to make an argument have been considered acceptable. The philosopher is also constrained by the context in which he or she is seeking to contribute. Depending on the context, the philosopher might be funded and supported by institutions that support specific philosophical approaches over others, may be working in conjunction with practitioners or legal theorists, or may be seeking to challenge how a particular issue is understood by either the public or practitioners. In each case, the philosophical contribution occurs within a context; what is offered, although attributed to the philosopher, is influenced by the context in which he or she is working, the philosophical approach used, and the healthcare practice addressed. These variables help in understanding why the questions posed by Foucault and McNamee and Gergen are challenging.

The practical application of a postmodern bioethics can be considered in regard to what it offers practitioners and what issues it addresses. In addressing healthcare practitioners directly, I propose that a postmodern bioethics would not seek to give normative advice for practice, or to offer alternative absolute descriptions to replace others. Instead, what philosophy can offer is a space to recognize that absolute descriptions of persons may be

required in healthcare but that this imposes on practitioners a particular way of encountering people. A postmodern philosophical approach could provide a space in which attempted descriptions can be scrutinized, highlighting that which has been excluded or bracketed in practice. In drawing out the dislocations in practice, that is, the privileging of a view of the autonomous self in medicine at the expense of relational practices, alternative strategies may be outlined. The role of such a philosophical approach is not to provide a definition or account of the individual in healthcare but to disrupt notions of certainty or truth in healthcare. In continually questioning the presuppositions of healthcare, the potential violence that any approach may permit is sought out.

Besides asking what a postmodern bioethics would offer to practitioners, the question may be asked as to what issues in medicine it should address. Here, a postmodern bioethics faces difficulties. In examining one issue at the expense of another—for example, in challenging the notion of autonomy and not the distinction between somatic and mental health—philosophers could be accused of prioritizing one issue over others. I suggest that this possible reproach is an inevitable criticism of any postmodern approach; however, it merely highlights the fact that contemporary healthcare is influenced by absolute descriptions. That philosophers attend to one description at the expense of another acknowledges the thrust of Wood’s argument. In differentiating issues, and in responding to or treating things separately, we run the risk of doing violence to them. The object for philosophical inquiry in bioethics, as suggested previously, can questionably be attributed to philosophy alone. The context in which philosophers are working in bioethics influences how and why issues are examined. Although a philosophical examination of any aspect of healthcare is possible, in practice, influence is exerted on the direction of philosophical inquiry.

5.7 Conclusion

The adoption of a postmodern bioethics, identified previously as a possible approach in which the limits of knowledge have been acknowledged, calls for a particular relationship to be developed between healthcare and philosophy. The movement toward this philosophical perspective, I suggest, can be noted in the two anthologies *Relational Autonomy* and *Naturalized Bioethics*. However, philosophers might not have the ultimate say as to whether
this approach is considered a rival of traditional moral theories. As philosophers in bioethics find themselves implicated in relationships with healthcare, science, law, and also institutions that provide funding, limits can be identified on the relative freedom of philosophy.

The challenges of postmodernism to bioethics are threefold. First, as philosophers engaging in ethics, we must step back and acknowledge the provisionality of all our contributions. The act of framing an action as ethical or unethical is, in itself, imposing a limit, which may involve violence. Second, Foucault’s thinking invites us to consider the role philosophy plays in practices of power. In attending to or offering interpretations of action, philosophers run the risk of colluding with particular practices. If philosophy offers interpretation only to some existing practices, it is privileging interventions that are already operating but in doing so may be perpetuating dominant discourses that have privileged the interest of some over others. Third, Gergen and McNamee, in introducing the challenge of relational responsibility, draw attention to the web of relationships in which the philosopher in bioethics operates.

A postmodern approach to bioethics characterized by a resistance to the imposition of closures responds to the three challenges of postmodernism. In foregoing any attempt to guide practice but providing a space to acknowledge the impossibility of closure, the philosopher is wary of the violence that attempted closures can justify. Arising from this postmodern approach is a critical awareness that underpinning modern medicine are closures that have served to exclude and disqualify. The philosopher engaged with various actors in the medical field must acknowledge the system in which he or she is acting, the relationships that are constituted in that system, and the expectations within that system.
6.1 Introduction

On coming into force in October 2007, the Mental Capacity Act 2005 (MCA) formalised an approach for the categorising of personal action. Therein a distinction is made between individuals who have the capacity to make decisions and those who lack the capacity to make decisions. To facilitate the identification of an individual’s action(s) as either capacitous or incapacitous, a definition of mental capacity is established, a set of principles governing the categorisation process is proposed, and a best interests procedure is established for decision-making where an individual’s decision is found to be incapacitous.\(^{370}\) Central to the understanding endorsed in the MCA is a distinction between the perceived wisdom of a decision and a determination of a lack of capacity to make a decision.\(^{371}\) The fourth principle holds “a person is not to be treated as unable to make a decision merely because he makes an unwise decision”.\(^{372}\) Thus any determination of a lack of capacity must rely on some additional requirement or issue other than a judgement about the relative wisdom of the decision. This requirement, however, does not imply that the wisdom of a decision plays no part in determining whether a person has capacity or not, simply that there is no direct equivalence.

In this paper, the continued support for the MCA and therein the distinction between wisdom and capacity is identified as ethically questionable in two regards. Firstly, what is this “other than wisdom” quality in any determination of capacity and how is the quality distinct from a judgement about the perceived wisdom of the decision? As the MCA allows for the actions of individuals to be interfered with, the basis on which such interference is permitted is of ethical significance. If the additional requirement goes unstated then the justification for such classification is obscured but also the basis on which individuals may challenge determinations of capacity is curtailed. Secondly, the proposed distinction between the

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\(^{372}\) MCA, s1.
wisdom of an action and the capacity of an action places a demand on healthcare practitioners to adhere to such a distinction. If capacity determinations are to rely on a judgement distinct from the wisdom of the decision then how the assessment of this “other than wisdom” quality must be achievable. Otherwise, the requirement that assessors comply with the MCA seems unclear at best and perhaps impracticable.

This paper begins by proposing an understanding of capacity in which legal capacity is distinguished from mental capacity. An awareness of this distinction allows for different approaches to capacity to be understood by the relationship, if any, they propose between legal and mental capacity. The approach adopted in the MCA, as situated in a historical context, is characterized by prohibitive and prescriptive aspirations. A disjunction is proposed between these two aspirations, whereby the MCA is clear in identifying what practice it seeks to relegate to the past but is unclear in how practice in the future should proceed. The distinction between wisdom and capacity and the requirement set out in the explanatory notes of Section 2(3) that the assessment of capacity is to be free from “preconceptions and prejudicial assumptions” are evaluated from the perspective of values-based medicine.\(^{373}\) The MCA is interpreted as endorsing a distinction between sanctioned and unsanctioned preconceptions. Two cases before the Court of Protection, which concerned the capacity of two women diagnosed with severe Anorexia Nervosa, are examined. The purpose here is not to engage with the question of how the actions of individuals diagnosed with Anorexia Nervosa should be responded to. Rather it examines whether in practice the distinction between capacity and wisdom is maintained.

In response to difficulties in achieving compliance with the prescriptive aspirations of the MCA, the paper calls for greater transparency and a change in the language used in relation to capacity. The contention that action can and should be differentiated in to categories of capacitous and incapacitous action is itself a value judgement. How differentiating regimes such as the MCA chose to identify action as incapacitous is a further value judgement. Through changing the way capacity is spoken about, the values that first underpin the concept

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of capacity and the values that permeate capacity determinations may be brought to the fore, allowing for a better understanding of how we differentiate action and how would be assessors are to act in accordance with the MCA.

6.2 What Is Capacity?
The term capacity, as well as variants such as mental capacity and legal capacity, offers an approach for the categorisation of action and by extension persons. Legal capacity references the power an individual is afforded in a specific legal context ([4], note 6). Where a person is considered able to make decisions and is permitted by other to make such decisions, they hold legal capacity. Accordingly, the presence of legal capacity entitles a person to personal freedom, to script their engagement with others in legal relationships. A distinction can be observed between the passive capacity to have legal rights and the active capacity to exercise such rights. Legal capacity as such is the lens through which people are differently permitted to act in the world. Mental capacity in contrast, commonly refers to the ability, which individuals may or may not have, to make decisions. How mental capacity is defined is varied, reflecting diverging attempts to define what makes up the decision-making process. The concepts of mental capacity and legal capacity can be linked to each other as seen in cases where mental capacity is a prerequisite for legal capacity. The understanding of mental capacity and legal capacity endorsed in any jurisdiction influences how the actions of persons can be categorised.

In 1989, the existing approach to categorising action in England and Wales was found to be lacking, leading to a period of debate addressing the nature of capacity. Although distinctions could be made between capacitous and incapacitous action, only where an incapacitous decision related to therapy, or property and analogous affairs, could others make a decision. The case of Re F (Mental Patient: Sterilisation) demonstrated this legal lacunae stemming

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376 *Gillick v West Norfolk and Wisbech AHA* [1984] QB 581.
from the passing of the Mental Health Act 1983, after which there was no mechanism for deciding what should be done where a patient is incapacitated and the issue in question is non-therapeutic. In response to a perceived gap in the law, the Law Commission of England and Wales (hereafter, Law Commission) initiated an investigation into how legal procedures relating to incapacity could be reformed. In considering three approaches to defining capacity, the Law Commission examined how the relation between mental and legal capacity should be understood.

A status approach allows for legal capacity to be determined on the basis of whether a particular characteristic can be attributed to a person. This approach holds either a correlation between the presence of a characteristic and decision-making ability: i.e., the presence of a certain characteristic impairs or compromises decision-making ability. Alternatively, it holds that the presence of a characteristic should exclude persons from applying their decision-making ability: i.e., people with that particular characteristic are not permitted to make decisions, regardless of whether they have the ability or not. The first relies on a link holding between mental capacity (as status) and legal capacity, the second on a link between status and legal capacity, disregarding mental capacity. A practical difficulty for such an approach lies in the determination of which characteristics should be associated with incapacity. Examples of a status approach would be the direct association of characteristics such as gender, sexuality, religious faith, race or disability with incapacity. The Law Commission in its 1995 document “Mental Incapacity”, however, demonstrated opposition to a status approach on that basis that it failed to recognise capacity as decision specific. A status approach would be considered “out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take”.

An outcome approach allows for a determination of legal capacity on the basis of the decision made. What a person chooses to do in a situation can be assessed in terms of its appropriateness or acceptability. Such an approach is constrained in a similar way to the

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377 Re F (Mental Patient: Sterilisation) [1990] 2 AC 1.
379 The Law Commission, Mental Incapacity (Law Com No. 231, London: TSO,1995)
380 ibid, para 3.3.
status approach, in that a framework is required to govern the evaluation of the appropriateness or acceptability of actions. The approach, as distinct from one based on status as legal capacity, hinges on what others think of the action and not what others think about the actor performing the action. A refusal to adopt an outcome approach is found in Re C (Adult: Refusal of Medical Treatment), where the diagnosis of schizophrenia and the decision to forego medically advised treatment were not equated with a lack of capacity. The Law Commission in principle expressed opposition to this approach as it “penalises individuality and demands conformity at the expense of personal autonomy.”

A functional approach breaks from both status and outcome approaches, by placing mental capacity as central to any determination of legal capacity. Accordingly, capacity hinges not on the outcome or who has made the decision, but on the individual’s action being preceded or accompanied by a set of tasks. Defining which tasks make up functional capacity vary from a focus on cognitive tasks such as expressing, understanding, appreciating and reasoning, to approaches focused on practical rationality. The benefit of a functional approach lies in establishing a complex threshold before individuals can be found to lack capacity. In understanding cognitive or rational processes as indicators of capacitous action, functional approaches attempt to move away from determining capacity based on external factors (status and outcome) to an approach based on what is discrete to the individual, to what has been referred to as an individual’s “actual functioning”.

6.3 The Mental Capacity Act 2005
The understanding of capacity adopted in the MCA proposes a fusion of functional and status approaches, whilst also rejecting approaches based on status or outcome alone. In Section 1, principles are set out underpinning the use of the Act, which reflect principles already

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381 Re C (Adult: Refusal of Medical Treatment) [1994] 1 WLR 290.
established in common law. Principle 2 holds that all persons over 16 are held to have capacity until it has been established that they lack capacity. Principle 4 reads a person “is not to be treated as unable to make a decision merely because he makes an unwise decision”. This principle suggests that a conferral of a lack of capacity must be based to a degree on an aspect that is not related to a judgement about the perceived wisdom of the decision.

In Section 2 a diagnostic requirement is established as a condition for any determination of a lack of capacity. For a person to lack capacity in relation to an issue, at a material time, they must be unable to make a decision “because of an impairment of, or a disturbance in the functioning of, the mind or brain”. In limiting the possible attribution of a lack of capacity to individuals who meet the diagnostic threshold, the MCA contributes to the understanding that capacity or its lack is a property or feature of a person, as opposed to a judgment of an individual’s actions by others. Where an individual fails to meet this diagnostic criterion, they may not be considered to lack capacity.

Section 3(1) clarifies the impact that a disability must have on decision-making ability. A person is considered unable to make a decision if they are unable to perform the following functions:

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

For a person to be found to lack capacity under the MCA they must be unable to perform one or more of the functional tasks of understanding, retention, use of or weighing, or communicating. Furthermore this inability must be caused by an impairment of their mind or brain. The requirement of a causal link reflects the view of the Law Commission in

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385 MCA, s2.
386 MCA, s3(1)
387 Although temporary impairments of the mind or brain, such as the result of alcohol or drug use, are sufficient to meet the diagnostic requirement, Principle 3 and subsection 3 require that where capacity is likely to be regained in the future then the decision can be delayed if doing so would be in the individual’s best interests.
1995 that a diagnostic threshold would prevent a large number of people being found to lack capacity under a functional approach alone.\textsuperscript{388}

In addition to adopting a functional-status approach the MCA also rejects an outcome approach to capacity, echoing the position at common law that individuals may not be found to lack capacity simply on the basis of making an unwise decision.\textsuperscript{389} This rejection demonstrates a recommitment to the distinction in law between the mental capacity of the decision maker and the wisdom of the decision made.\textsuperscript{390} Section 2(3) of the MCA reinforces Principle 4, prohibiting value judgements that associate particular characteristics with a lack of capacity. Accordingly a person may not be found to lack capacity simply on the basis of age, appearance, a condition, or an aspect of behaviour.\textsuperscript{391} As stipulated in the MCA, any judgement about capacity on the basis of a status or behaviour alone “might lead them [assessor] to make unjustified assumptions about capacity”.\textsuperscript{392}

The process for categorising action contained within the MCA can be viewed as comprised of prescriptive and prohibitive aspirations. Admirably, the MCA seeks to prohibit the labelling of individuals as lacking in capacity on the basis of status or outcome alone. Therein the MCA seeks to move capacity legislation away from practices in which individuals could have their actions interfered with on the basis of the wishes or interests of others. In contrast, the practice prescribed for determining capacity in the MCA is not as easily discernible. A lack of capacity is not to be conferred on a person’s actions simply by reference to the perceived wisdom of the action, or the person’s age, appearance, condition, or behaviour. In the explanatory notes to Section 2(3) this demand is clarified, placing significant constraints on any would be assessors: “Any preconceptions and prejudicial assumptions held by a person making the assessment of capacity must therefore have no input into the assessment of capacity”.\textsuperscript{393} From here on in, the paper considers whether the prescriptive aspirations of the MCA are achievable.

\begin{footnotes}
\item[390] \textit{Re B} [2002] EWHC 429 (Fam) ; Masterman-Lister v Jewell [2002] EWHC 717 QB.
\item[391] MCA, s2(3)
\item[392] \textit{ibid}.
\end{footnotes}
6.4 The MCA’s Challenge

Whilst considerable political focus has been placed on assessing the implementation of the MCA,\textsuperscript{394} it is argued here that any such considerations must be informed by an examination of whether compliance with the MCA is possible. The characterisation of some professionals or bodies as failing to comply with the MCA is of little significance, if compliance itself is impossible. The approach adopted in the MCA places demands on any assessors of capacity to view capacity as a time specific judgement, referring to a person’s functional ability at a given time in regard to a specific decision. Would be assessors of capacity are required to act free from preconceptions or prejudicial assumptions they may hold.

In this context of competing demands any would be assessor seems confronted with a double bind. In the first they are tasked with upholding the MCA’s understanding of capacity as a time specific, functional assessment of an individual who meets the diagnostic requirement. In the second, as clarified in the explanatory notes, an assessor must not only put to one side prejudicial assumptions, which might take in personal values, but also preconceptions. We may assume that such a bind is not intended; as to do so would make the implementation of the MCA impractical. Accordingly then what is covered by the term preconceptions must exclude the conceptions central to the MCA itself. If this charitable interpretation is to be maintained, then the MCA seeks to distinguish between types of preconceptions, those endorsed in the MCA and those which must be put to one side and have no bearing on the assessment process. What initially appears to be a double bind imposed on assessors is in fact a call for a distinction between types of preconceptions. The task confronting assessors of capacity can be examined by drawing on values-based medicine. The requirement that a distinction is maintained between sanctioned and unsanctioned preconceptions can be viewed as akin to the distinction between wide and narrow descriptive criteria.

A Values-Based Medicine Perspective

Bill Fulford proposes a framework for making sense of values in medicine. In response to attempts to distinguish between objective bodily illness and value-laden mental illness, Fulford proposes that all concepts in medicine rest on a set of values. Differences between medical concepts vary by the relative acceptance or credence afforded to values. On the one hand, where there is general acceptance of values a definition has “narrow descriptive criteria”. On the other, where there is considerable disagreement about the values underpinning a definition, there is “wide descriptive criteria”. Such a differentiating framework allows for differences in the relative acceptance of medical concepts to be recognised while acknowledging that all concepts rest on a set of values.

The approach for differentiating between values outlined by Fulford can be applied to the distinctions maintained between preconceptions in the MCA. The MCA is both expressive of and reliant on sets of preconceptions that have been afforded significance. At the outset the definition of mental capacity endorsed in the MCA is a product of a series of consultations led by the Law Commission, which itself relied on the preconception that action should be distinguished into capacitous and incapacitous action. In practice the application of the MCA relies on the preconceptions or values of medicine at various stages in the assessment process. Both these sets of preconceptions can be read as corresponding to “narrow descriptive criteria” for the MCA, representing that which is taken as generally accepted or factual. Outside of these sanctioned preconceptions are those that the MCA seeks to curtail and remove from the assessment process. An assessor’s preconceptions and prejudicial assumptions correspond to the “wide descriptive criteria”. The aim to remove contested values, such as religious perspectives, from the assessment process, is a laudable endeavour in seeking to prevent a healthcare professional imposing their will on a patient.

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398 ibid.
The MCA’s Challenge: Overview

In advocating that mental capacity is not to be determined by a simple evaluation of the relative wisdom of the decision, the MCA requires an additional component on which assessments can be based on. This additional component is provided in the MCA by a two-stage understanding of mental capacity, which requires the presence of impairment in mental functioning, which contributes to an individual’s inability at a specific time to perform certain cognitive tasks. As proposed here, the two-stage process of assessing mental capacity is itself a sanctioned preconception drawn from medical, psychiatric and legal discourses. The difficulty for the MCA in evaluating an action from the perspective of sanctioned preconceptions is to do so in a way that is clearly distinct from a judgement by others about the wisdom of a decision.

6.5 Anorexia Nervosa and Mental Capacity Assessment

The cases of Ms E399 and Ms L400, respectively, considered whether two young women diagnosed with severe Anorexia Nervosa had the capacity to make decisions relating to their care. At the time of her hearing in late May 2012 Ms E, aged 32, was diagnosed as suffering from unstable personality disorder, alcohol dependence syndrome, opiate dependence and debilitating and lifelong physical consequences of long-term malnutrition. Jackson J identified two questions regarding capacity to be addressed by the court. Firstly, did Ms E, at the time of the hearing, have the mental capacity to make decisions about her treatment and secondly, whether Ms E had capacity when she made an advance directive in October 2011. At the time of her hearing in August 2012, Ms L, aged 29, weighed almost three stone, was diagnosed with end stage organ damage and was generally expected to die in a matter of weeks regardless of what actions were carried out. King J considered whether Ms L had capacity in relation to decisions about serious medical treatment, including nutrition and hydration and dextrose in the event of hypoglycaemic episodes.

399 A Local Authority, E (by her Litigation Friend the Official Solicitor) v A Health Authority, E’s Parents, [2012] EWHC 1639 (COP).
As both cases adhered to the MCA’s two-stage approach to capacity assessment they allow for an examination of how Principle 4 and Section 2(3) are complied with. Two questions guide this examination. What are the sanctioned preconceptions at play in the assessment of capacity? Is the assessment of functional capacity distinct from an evaluation of the action from the perspective of sanctioned preconceptions? Of ethical importance here is the identification of what preconceptions are central in the assessment process thus allowing for the actions of some individuals to be interfered with. These questions raise the issue of what role judgements about the wisdom of a decision should play in the assessment process. Wisdom is a second order expression that is underpinned by a set of values and made from a particular standpoint. Therein when an action is considered wise or unwise the evaluation is underpinned by a set of values. An action can, however, be considered from a particular perspective of values without the evaluation taking the form of a wisdom judgement. One such alternative would involve evaluating an action in relation to its compliance or adherence with the values of a particular perspective.

The first step of the assessment process, the diagnostic threshold, requires that an individual have an “impairment in the functioning of the mind or brain”. The inclusion of this requirement for any finding of incapacity reflects the upholding of a proposal from the Law Commission in 1995 [10]. In the cases of Ms E and Ms L the diagnosis of severe Anorexia Nervosa achieved compliance with the diagnostic threshold. The understanding that somatic and psychiatric disorders meet the diagnostic requirement does not negate the reliance such disorder categories have on values. The evaluation of whether individuals meet the diagnostic requirement simply demonstrates the deference to and sanctioning of medical and psychiatric descriptions.

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401 The Law Commission, Mental Incapacity (Law Com No. 231, London: TSO,1995)
Turning to the functional definition of capacity, the second of the two-stage approach, we find a further resource for identifying sanctioned preconceptions in the determination of capacity. The fourth requirement of the functional test, the ability “to communicate his decision” is understood in the MCA as external to the decision-making process and capacity per se, representing the simple requirement that the decisions can be expressed and acknowledged. Communication is considered a conduit through which a decision can pass but is not itself considered a critical aspect of the decision-making process. Its relevance is clarified in the explanatory notes where the requirement is considered a “residual category and will only affect a small number of persons” ([3], para. 27). Where it is possible that an individual can communicate their decisions Principle 3 requires that “all practicable steps to help him to do so have been taken”. The communicative abilities of an individual should thus not limit the recognition of their actions as capacitous but in fact place a requirement on assessors to tailor their communication styles to the individual. The requirement that practitioners exhaust all practicable communication styles coupled with the notion that communicative ability provides a conduit for a decision to be passed, are both sanctioned preconceptions for the MCA.

The first requirement of the MCA’s functional definition, understanding, relates to the individual’s understanding of the information relevant to decision they are tasked with making. Although the decision the individual is tasked with making is the central issue on which capacity determinations are based, there is insufficient guidance provided on what decisions individuals can have their capacity assessed in relation to. In both cases, Ms E and Ms L were assessed in regard to their understanding of the information relevant to the specific decisions that were put to them. What the requirement of understanding explicitly requires is unclear. One approach suggests that understanding refers to tacit acknowledgment

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405 This seeming oversight suggests that the decisions put to individuals within a healthcare context are not problematic, however a recent case concerning male sterilisation might draw attention to the issue. See A NHS Trust and DE (Appearing by his Litigation Friend the Official Solicitor) and FG & JK and C Local Authority and B Partnership Trust, [2013] EWHC 2562 (Fam). If therapeutic interventions are offered to certain groups of people and not to others, such as the intervention of sterilisation to a recent father who have a mental disability and not to fathers generally, there is a risk that the MCA could support the offering of particular interventions if capacity is used to facilitate the intervention to take place.
of the information. Accordingly one can be held to understand information, without believing the information.\textsuperscript{406} An alternative interpretation as set out by Munby J in Local Authority X v MM & KM (2007) holds that understanding, in the context of decision-making requires a subjective endorsement.\textsuperscript{407} As such, belief is a precondition of understanding.

Shifting back to the cases, both Ms E and Ms L were found to demonstrate an understanding of information and Ms E a subsequent retention of the relevant information. Jackson J found that Ms E could clearly understand and retain information and also held the external ability to communicate her decisions with others.\textsuperscript{408} In the case of Ms L medical professionals disagreed as to the scope and depth of Ms L’s understanding. For one doctor Ms L lacked “deep understanding”,\textsuperscript{409} whereas for the treating psychiatrist Ms L demonstrated understanding but lacked “motivation”.\textsuperscript{410} What is significant about the assessment of understanding and retention is that individuals are being evaluated against the preconceptions of medicine and psychiatry, respectively. The two individuals in question were required to demonstrate an understanding of and subsequent retention of information in regard to a decision that was put to them by others. The permissibility of putting decisions to an individual and the identification of information that is relevant to such a decision demonstrates the MCA’s sanctioning of specific approaches in care and in regard to what information is significant.

A finding that an individual fails to meet the requirements of understanding and retention would seem to demonstrate compliance with Principle 4. Individuals are not found to lack capacity simply because they make an unwise decision. Rather they lack capacity on the basis of a failure to endorse, accept, or remember a set of sanctioned preconceptions endorsed by the MCA. What is assessed is an individual’s compliance or adherence to the perceived

\textsuperscript{407} \textit{Local Authority X v MM & KM}, [2007] EWHC 2003 (fam), para 81.
\textsuperscript{408} \textit{A Local Authority, E (by her Litigation Friend the Official Solicitor) v A Health Authority, E’s Parents}, [2012] EWHC 1639 (COP), at [48].
\textsuperscript{409} \textit{The NHS Trust v ‘L’ by her Litigation Friend the Official Solicitor}, \textit{The Psychiatric NHS Trust, Mrs ‘L’, Mr ‘L’}, [2012] EWHC 2741 (COP), at [49].
\textsuperscript{410} \textit{ibid}, at [48].
wisdom of medicine and psychiatry that have been sanctioned as relevant in such considerations.

Preconceptions and the Assessment of the Ability to Use or Weigh Information

The third requirement of the MCA’s functional approach, “to use or weigh information” is the final stage of the process where capacity determinations may be capable of complying with Principle 4. To restate, Principle 4 holds that an individual is “not to be treated as unable to make a decision merely because he makes an unwise decision”. In both the case of Ms E and Ms L the inability to use or weigh information provides the basis on which a lack of capacity determination is reached. For Ms E, Jackson J holds “there is strong evidence that E’s obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way”.411 Ms E is considered to lack the ability to weigh up information as her “need not to gain weight overpowers all other thoughts”.412 In regard to the advance directive made by Ms E in October 2011, as that directive was made without a simultaneous assessment of Ms E’s capacity, sufficient doubt can be raised as to whether she had capacity at the time.413 In the case of Ms L, King J drawing on the views offered by Ms L’s treating doctors as well as consultant psychiatrists, holds that she lacks capacity in relation to treatment decisions “on the basis that she is unable to weigh up the risks and benefits”.414 Ms L’s “profound and illogical fear of weight gain” is considered to impinge on her ability to critically evaluate information relating to eating.415

Any determination that an individual is unable to use or weigh up information in relation to a specific decision, however, requires a method by which executive and deliberative faculties can be assessed. It is argued here that there are two possible approaches that can be taken to this assessment. Either an individual’s values and beliefs, as that which guide and influence action, are considered to have a direct impact on the ability to use or weigh up information or they do not. In the case of Ms E, Jackson J adopts the former approach and is echoed in

411 A Local Authority, E (by her Litigation Friend the Official Solicitor) v A Health Authority, E’s Parents, [2012] EWHC 1639 (COP), at [44].
412 ibid, at [49].
413 ibid, at [65].
415 ibid, at [53].
the case of Ms L, where King J maintains that the values and beliefs characteristic of an individual suffering from Anorexia Nervosa cause a “deficit in capacity specific to issues relating to food and weight gain”.\textsuperscript{416}

Two concerns can be raised in response to the approach taken. First, while this assessment of the ability to weigh or use information may appear to reject an outcome approach, as it is the inability to perform such actions rather than the decision made which is significant, the distinction is less clear on examination. If there is a presence of an irrational belief which prevents any decision being made which would be inconsistent with the belief, then the presence of the belief will invariably determine the outcome of an action. Observing this connection Jackson J notes Ms E is in a “catch 22 situation concerning capacity: namely, that by deciding not to eat, she proves that she lacks capacity to decide at all”.\textsuperscript{417} While the focus is on the process that underpins the decision and not the decision itself, Jackson J acknowledges the presence of the obsessive fear, which is held to impair deliberation, can only be surmised from the decision made by the individual. This is not to suggest that an outcome approach of sorts is being applied, or that obsessive fears should not be held to be incompatible with deliberation but rather that the ability to assess deliberative processes in these cases seems weakened by the need to include the outcome.

Tim Thornton proposes that this inability to separate the outcome from the process is a feature of the MCA’s appeal to the notion of a mental mechanism.\textsuperscript{418} While intuitively it might be appealing to infer two distinct mental processes underpin two differing attempts at a similar act, for example between a native speaker reading a text and a student learning the language, reading the same text, Thornton holds that the idea is limited in its application. Drawing on Wittgenstein’s observation that mechanisms are only hypotheses developed in response to what is observed, Thornton argues that the outcomes of the action observed influences the explanatory force we attribute to mental mechanisms.\textsuperscript{419} The inability to remove a consideration of the outcome from the assessment of the process leads Thornton to claim that

\begin{flushright}
\textsuperscript{416} ibid, at [54].
\textsuperscript{417} A Local Authority, E (by her Litigation Friend the Official Solicitor) v A Health Authority, E’s Parents, [2012] EWHC 1639 (COP), at [53].
\textsuperscript{419} ibid, 130.
\end{flushright}
the assessment of weighing and use of information is in practice the assessment of “an ability generally to make the right decision relative to that information”.420

Second, the reliance on the description of the beliefs of an individual diagnosed with severe Anorexia Nervosa as irrational introduces an additional sanctioned preconception. Clarification is required as to whether the deliberative and executive faculties are being assessed here and if so how, or whether the preconception that irrational beliefs prevent deliberation in cases of severe Anorexia Nervosa is being endorsed and applied. There is a difference between a philosophical view that irrational fears obscure the ability to reason and the interpretation or claim that an individual diagnosed with severe Anorexia Nervosa has an irrational fear that prevents deliberation. The basis on which the later claim is endorsed is critical. If the sanctioned preconception is being applied because the individual decides not to eat and is diagnosed with severe Anorexia Nervosa then the question can be asked if anyone in such a situation would have the sanctioned preconception applied? If it is possible for an individual diagnosed with severe Anorexia nervosa who refused to eat to be found to have capacity then the question can be asked as to when is the sanctioned preconception to be applied?

The second approach to understanding the relationship between values and beliefs and the ability to weigh information maintains that a person’s values and beliefs do not impact on the use or weighing up of information. In this situation the proposed mental mechanism would weigh information free from the individual’s values and beliefs, although the information being weighed might be done so against the individual’s values and beliefs. While this approach is not adopted in either cases discussed, if it were to be adopted similar difficulties would exist. For such an approach to be coherent, as Thornton claims, it would have to be possible to demonstrate the difference between a weighing of information that guides decision-making and a weighing of information which although performed does not influence the decision made.421 Furthermore this approach to mental mechanisms would be confronted by the inability to separate a consideration of the mechanism or process from the outcome. How these difficulties would be overcome in practice would seem to require a

420 ibid, 131-132.
421 ibid, 129.
series of sanctioned preconceptions, as was the case in the first approach to evaluating capacity.

The two approaches to assessing the ability to weigh and use information present difficulties for the assessor. The limitations of assessing the process alone require a coupling of process and outcome. Where this difficulty is overcome in practice by appeal to sanctioned preconceptions, questions remain as to the basis on which these preconceptions are applied. If the alternative approach to the relationship between values and a mental mechanism were adopted, similar problems would emerge.

*Preconceptions and the Assessment of Capacity: Overview*

The requirement that capacity determinations rest on an “other than wisdom” component is achieved by way of a reliance on sanctioned preconceptions. These preconceptions provide the framework against which individual decisions are evaluated for adherence. This demonstrates a reversal from an approach that evaluates the wisdom of a decision, as gone is a set of preconceptions structuring the appraisal of a decision and in place a decision is considered against a set of preconceptions. These sanctioned preconceptions, as that which allow for compliance with Principle 4, however remain evaluative judgements or perspectives. As such the achievement of compliance with Principle 4 demonstrates an “other than wisdom” component where this component is achieved through accepting and privileging certain evaluative judgements.

As it has yet to be shown how the assessment of capacity can achieve a separation of the process of weighing and using information from the outcome, an understanding of an appropriate or acceptable relation between process and outcome is necessary for the process to be assessed. What constitutes or fails to constitute these appropriate relations represents further sanctioned preconceptions. One such sanctioned preconception is drawn on in the cases of Ms E and Ms L where the values and beliefs of an individuals diagnosed with severe Anorexia Nervosa are considered to impair deliberation in relation to matters concerning weight gain and nutrition. The issue in practice for any assessor is to ascertain which sanctioned preconceptions are to be applied, on what basis and more fundamentally from where are these preconceptions derived from or stored.
In line with Section 2(3) assessors of capacity must maintain a distinction between sanctioned and unsanctioned preconceptions so that they may assess capacity in the absence of preconceptions and prejudicial assumptions. As the cases examined above demonstrate the array of preconceptions permitted in the assessment process, it is reasonable to suggest that the examination of other cases would yield further sanctioned preconceptions. Quite how would be assessors are to assess capacity in the absence of preconceptions and prejudicial assumptions requires clarification. Which preconceptions specifically are to have no bearing on the assessment process and subsequently how are these preconceptions to be put into abstention? Furthermore, is there a process by which a prejudicial assumption can come to be accepted as a sanctioned preconception and thus be permitted in determining capacity?

The examination of two cases before the Court of Protection helps demonstrate considerable procedural difficulties affecting any would be assessor. At each stage of the two-stage assessment process are sanctioned preconceptions that determine how the actions of individuals are to be assessed. While Principle 4 fails to call for a value neutral account of capacity, it does require that a determination of capacity rest on something other than a judgement about the perceived wisdom of the decision. In achieving this through a distinction between sanctioned and unsanctioned preconceptions further difficulties arise. The requirement that assessors carry out their assessments free from preconceptions and prejudicial assumptions, when preconceptions are central to the assessment process itself, seems problematic. What the MCA requires an assessor to bring to the assessment process is decidedly vague.

6.6 Classificatory Problems
In seeking to ground the determination of capacity on an “other than wisdom” component, the MCA relies on the privileging of certain preconceptions. The significance afforded sanctioned preconceptions and declined to other preconceptions and prejudicial assumptions structures the categorisation of action. Examining the cases of Ms E and Ms L allows for three features that flow from this distinction to be highlighted: medical deference, unobservable mental procedures, and selective pathologising.
As the preconceptions of medicine are present at multiple stages in determining whether an individual has capacity, the MCA can be read as deferential to medicine. The requirements that individuals meet the diagnostic threshold, understand and retain the proposed relevant information, and articulate a decision in regard to a proposed intervention, each reference the role medicine plays in establishing the context for a capacity assessment but also contribute to the substance of the assessment process. This deference is reaffirmed in the Code of Practice’s support for a distinction between a doctor’s ability to assess capacity and the ability of other assessors. Doctors are identified as having “more skill then somebody without medical training” for the purpose of capacity assessment. As the assessment process draws on sanctioned preconceptions from medicine the notion that doctors have greater skill may simply refer to a greater familiarity and understanding of what the sanctioned preconceptions in any case are.

The four part functional understanding of capacity assessment, in which a failure in any one element may be indicative of a lack of capacity, contributes to the idea that the ability to “use or weigh information” is a key aspect of the decision-making process. Although the separation of capacity assessment into four aspects may be considered to add clarity by breaking down component parts of the process, the assessment of the deliberative faculty alone is problematic. That sanctioned preconceptions scaffold the assessment of capacity reveals the presence of a prior understanding of what decisions follow from the performance of the functional process in a specific context. The process against which the decisions individuals are considered and the assessment of that process rely on already established accounts of the relationship between a process and outcome. This practical reliance on preconceptions, however, is not clearly outlined in the MCA. Principle 4, which calls for an “other than wisdom” component to underpin capacity assessments, fails to identify from where that component is derived. Principle 4 could be amended to acknowledge the role other values and preconceptions play instead and read “A person is not to be treated as unable to make a decision merely because he makes an unwise decision. However an examination of the decision against an established understanding of the process and outcome of a decision,

alongside repeated unwise decisions may be sufficient for a finding of an inability to make a decision”.

The third issue, selective pathologising, draws on the first, namely that the MCA is deferent to medical opinion. This deference allows for specific preconceptions to influence and shape the potential use of the MCA. In relying on the insights of psychiatry to provide accounts of impairments of the mind or brain, the MCA coalesces with the biases of psychiatry more generally. That the MCA supports a discipline, which selectively pathologises the behaviour of some individuals, in this case two young women with Anorexia Nervosa, while not identifying the behaviours of others as pathological, is problematic. The decision of elderly patients to refuse food, of victims of domestic violence to stay in violent relationships, or of individuals to engage in dangerous sporting activities could potentially be understood similarly to how Ms E and Ms L’s respective views about weight gain were considered. For example might the decision of a woman in a violent relationship who is committed to staying in the relationship at all costs, such that she is incapable of acting in anyway incommensurate with that belief, be considered irrational or obsessive? Similar arguments can be developed about elderly patients who avoid food or individuals who engage in risky sporting endeavours. The scope of the MCA’s ability to be applied to individual action is limited to the conditions within medicine and psychiatry that are held to result in impairment in the mind or brain. Any affording of power to other professionals such as social workers or psychologists, as able to confer on individual’s a diagnosis of an impairment of mind or brain, although perhaps welcomed, would not remove the role of values within the assessment process.

6.7 Moving Forward
The question of how the role of values and preconceptions within the MCA and the assessment process may be responded to, it is argued here, can be both forward looking and historical. Two approaches can guide such a response, a call for greater transparency and a change in the language used to discuss capacity. Two questions can direct the call for greater transparency. Firstly, what are the sanctioned preconceptions of the MCA and capacity assessment and on what basis are these preconceptions to be applied in specific cases?
Secondly, how are sanctioned preconceptions derived or established and following from this, is it possible for new sanctioned preconceptions to be established?

That values and preconceptions are inherent in notion of mental and legal capacity, the MCA and the assessment process, can be acknowledged. A statement in regard to what the sanctioned preconceptions are and when they are to be applied could provide clarity as to how assessors are to comply with Section 2(3) but also aid the population at large in understanding from what perspective their actions can potentially be evaluated. Where certain behaviours and actions are to be associated with a lack of capacity, such as the decisions relating to weight gain made by individuals diagnosed with severe Anorexia Nervosa, this understanding could be made explicitly clear to individuals and practitioners. This association would have to be supplemented with guidance concerning the timing of doubting. As demonstrated in the cases of Ms E and Ms L, the Court of Protection supports the equating of severe Anorexia Nervosa with an inability to make decisions concerning weight gain, however further guidance is required addressing when individuals diagnosed with severe Anorexia Nervosa should be assessed. The furnishing of normative guidance would allow would be assessors of capacity to account for their actions related to capacity, by appeal to criteria, as opposed to ideals of acting outside of preconceptions.

Greater transparency in regard to why and how certain preconceptions are afforded significance while others are not could provide further clarity for both practitioners and the public. The continued privileging of particular medical perspectives as the perspective from which actions are evaluated means that where an individual’s values, actions and decisions correspond to that which has been considered symptomatic of a mental disorder, they risk having their individuality penalised. Conversely, individuals whose values and behaviours have not been considered symptomatic of mental disorder are permitted under the MCA to continue making decisions. The engagement in dangerous sports, the decision to stay in a relationship where one is a victim of violence and the decision to radically curtail calorific intake can each be considered unwise to a degree, however the degree to which these decisions are pathologised and institutionally responded to is different. Consequently the opportunity for any individual engaged in such activities coming under the remit of the MCA is reliant on the association of their behaviour with a disorder of the mind or brain.
Additionally, the acknowledgement that sets of values inform any conferral of incapacity could provide an opportunity to discuss what types of behaviours or actions should be interfered with, but might also inform the more fundamental question of why we differentiate between the actions of people in the first place. Debate could be opened up around why some unwise decisions are considered irrational or obsessive and impacting on the decision-making ability, while others are not. Such a process might provide a counter practice to the reliance on medical opinion in capacity determinations and assist in developing a process for differentiating individuals who need support to exercise their legal capacity and those who do not.

The recognition of the role sanctioned preconceptions play at various stages of capacity assessment can be seen to contribute to the call for a change in how capacity is theorised and understood. One such change has been proposed here to the wording of Principle 4 of the MCA such that greater recognition is giving to the role established preconceptions play in the assessment process. This change in language echoes the call of Gerard Quinn for a “new vocabulary” in relation to mental capacity. The language and way capacity is discussed can move to acknowledge the role others play more explicitly. A focus on the proposed cognitive features of decision-making exclusively can be at the expense of an acknowledgement of the role others play and have played in scaffolding the practice of categorising action as capacitous or incapacitous. The language used to talk about capacity can be altered to acknowledge the role-sanctioned preconceptions play and in doing so highlight the context in which capacity determinations take place.

A movement towards greater transparency and a change in the language used in relation to capacity could provide not only a resource for present and future understanding and practice. It may provide the basis on which previous determinations of capacity as well as decisions not to use capacity legislation may be examined.

6.8 Conclusions

This paper raises the complexities in adherence to Principle 4 and Section 2(3) of the MCA in an effort to ascertain the grounds on which capacity determinations are made. It is argued that fundamental to the MCA is the idea that capacity determinations can rest on an “other than wisdom” component. This is achieved in practice by evaluating actions against a set of sanctioned preconceptions concerning functional processes. The identification that preconceptions scaffold the assessment process raises further questions. What these sanctioned preconceptions are, when they are to be applied, and from where they are derived, remain unspecified. As such the basis on which individuals are found to lack capacity, as well as the grounds on which such determinations can be challenged, is somewhat obscured. In the cases of Ms E and Ms L these issues are highlighted in the inability to assess the process of decision-making without reference to the outcome and the application of the sanctioned preconception that individuals with severe Anorexia Nervosa who refuse to eat lack the ability to make decisions about nutrition. The paper suggests that for classification of action in accordance with the MCA to be practised and understood requires greater transparency and a more nuanced use of language.
Chapter 7
Situating Narrative Identity in the Bioethics of Personal Identity

7.1 Introduction
The idea that a relation exists between personal identity and ethics remains a key issue of debate in philosophical and bioethical discourse. The difficulty in achieving consensus in debates arises due to the varying methodological approaches adopted. One approach can start with the question of what constitutes personal identity. Associated with this approach are traditional metaphysical approaches which seek to address the problem of continuity through time, namely what is it that allows for identity to be conferred over time. An alternative approach can start with ethical or practical issues and seek clarity or guidance on these issues by appeal to theories of personal identity. How practical issues are understood can also lead to further complexity, with some seeking to privilege the question of survival, whereas for others practical concerns encompass a larger set of issues.

Since the 1980’s the discipline of bioethics, like other academic disciplines, has faced the challenge of making sense of narrative’s scope. In personal identity discourse, the site of the narrative challenge is commonly cited as Marya Schechtman’s *The Constitution of Selves*, in which a critique of traditional metaphysical approaches is articulated. Traditional approaches, in seeking to ascertain the ‘criterion of personal identity’ that allows for identity to be conferred over time, are open to the criticism of considering the subject passively. In these approaches, what allows for continued identity through time is something a person has or is. Personal identity can be read however as referring to more than just ‘what I am’ and ‘who I am’ but how these two aspects of personal identity are responded to by persons.

This paper examines the receptivity to this broader concept of personal identity within bioethical discourse concerning personal identity, situating the receptivity as impacting upon how bioethics understands human subjectivity and bioethical discourse itself.

importance of the reception given to narrative approaches in bioethics relates to how persons are understood in two ways. Firstly, personal identity theory provides a lens with which to interpret and acknowledge the complexity of experience and this can impact upon healthcare practice. Secondly, bioethical discourse can be interpreted as an activity of personal identity and as such bioethics is part of the phenomenon of personal identity that it comments on. Where bioethical discourse offers an incomplete or inadequate understanding of the self, it risks that such an understanding may become influential in how persons are treated but it may also blind bioethicists to the significance of their own practice.

The paper begins with a brief overview of the narrative challenge to traditional personal identity approaches. A ‘subjective’ interpretation is proposed as encompassing of approaches that understand narrative identity as distinctly first personal. Two strategies are identified which support such an understanding: a *move of obfuscation* and a *move of limitation*.

An alternative ‘inter-subjective’ approach developed from a reading of Paul Ricoeur understands narrative identity approaches as drawing attention not just to the personal narratives of individuals, which are first, second and third personal, but crucially for a recognition of the agentive, embodied and relational dimensions of experience which individuals both draw on and respond to with narratives. Narrative identity here refers to the activity through which individuals negotiate their existence. It is not simply reducible to offering an alternative criterion for consideration, against others such as memory, consciousness, body or psychological connectedness. The availability of subjective and inter-subjective approaches to narrative identity is identified as presenting a choice for bioethicists and others concerning how the human subject in medicine and biomedicine is understood.

### 7.2 The Narrative Challenge

In *The Constitution of Selves*, Schechtman proposes a theoretical orientation for the personal identity debate which focuses on the question of characterization. The traditional understanding of personal identity as concerning the question of reidentification is identified

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427 The idea that attention should be given to conceptual moves in bioethics and the exclusion such moves endorse is argued for by Jackie Leach Scully, ‘Moral bodies: Epistemologies of embodiment’ in Hilde Lindemann Marian Verkerk and Margaret Urban Walker (eds), *Naturalized Bioethics: Towards Responsible Knowing and Practice*, (New York: Cambridge University Press, 2008).
as limited in its ability to inform or capture common intuitions about practical and ethical issues. The framing of the issue of personal identity as related to continuity is associated with a reading of Locke’s understanding of continuity of consciousness as being none other than memory.\footnote{See John Locke, \textit{An Essay Concerning Human Understanding}, Roger Woolhouse (ed) (London: Penguin Books, 1997).} This orientation underpins the adoption of psychological and biological approaches to continuity as well as the approach which denies the relevance of identity for practical issues. In drawing attention to the characterization approach, Schechtman can be read as proposing a fourth approach to personal identity, yet crucially it is one that denies the primacy given to continuity. The characterization approach is concerned with the question of attributing “actions, experiences, beliefs, values, desires, character traits” to a person.\footnote{Marya Schechtman, \textit{The Constitution of Selves} (Ithaca: Cornell University Press, 1996) 73.} Engaging in characterization questions thus involves questioning what should be attributed to a particular person. This questioning however is not limited to a first personal perspective, in which I alone ask question about myself but necessarily is a third personal activity as well. Personal identity in this sense is made up of characteristics which are attributed in different strengths or degrees to people and the significance of these attributions is the role they play in a person’s “life” and “story”.\footnote{\textit{ibid}, 77.}

For Schechtman, the activity of characterization underpins a “narrative self-constitution view” of personhood.\footnote{\textit{ibid}, 93.} Personhood is an achievement, a further fact of an individual, that is dependent on the individual consciously thinking of themselves as persisting through time with certain characteristics and experiences belonging to them. This disposition is distinctly narrative whereby events and discrete events are incorporated into an account in which they are a character. Significantly for Schechtman, the activity of narrative self-constitution need not be one that a person is conscious of, what is important is that the constituting function is operative. Accordingly, persons have either an explicit or implicit narrative understanding of themselves, which serves to both script their past but also their view of themselves and their orientation towards the future. Narrative understanding provides the lens through which experience and action in the midst of action and life is interpreted.
The achievement of personhood however is not simply achieved by virtue of the narrative organizing principal. The incorporation of one’s experience into a narrative while necessary for personhood, it is not sufficient. Schechtman identifies “articulation” and “reality” constraints which reveal that personhood is a “social concept”.\textsuperscript{432} As persons need not be consciously aware of their narrative identity in cases of ‘implicit self narrative’, nor can persons be fully conscious of all aspects of their narrative identity, there is always a dimension of blindness in how persons understand themselves. At times, persons are required to give an account of themselves, to make explicit and share their narrative identity so as to reveal how they make sense of and organize their life and their world. As a certain degree of one’s narrative identity goes unquestioned or remains unknown at any time, the degree to which one’s narrative identity can be attributed solely to the person is limited. The articulation constraint holds that where individuals are unable to sufficiently articulate their narrative identity then personhood is compromised. The articulation constraint is comprised of both internal and external dimensions. The inability to articulate one’s identity or organizing principal may be due to an actual inability to do so. The failure to sufficiently articulate however could be determined or conferred from the perspective of others.

The reality constraint requires in contrast that persons organize their life and experience with some regard to the shared world they live in. For a person to be held as a person, they must cohere in some fundamental respects with the established understanding of reality. Persons are required, to a certain degree, to avoid “errors of fact” about the world, otherwise their narrative is considered deficient.\textsuperscript{433} Where persons violate such conventions, they may be classed as not-ordinary, and are treated in different ways to others. A failure in terms of interpretive inaccuracy comes about where a person, although appreciative of the facts, violates interpretive rules or conventions in terms of how to make sense of experience and their identity.

\textsuperscript{432} ibid, 95-123.
\textsuperscript{433} ibid, 122.
7.3 The Subjective Interpretation

In two texts, David DeGrazia’s *Human Identity and Bioethics* and David Shoemaker’s *Personal Identity and Ethics*, the reception afforded to Schechtman’s approach can be examined. These two texts are not considered exhaustive of the bioethical approach to narrative identity in personal identity debate but simply representative of a ‘subjective interpretation’ of the narrative approach. These subjective accounts can be examined in three regards: 1) The relationship between narrative constitution and continuity, 2) The role given to others and other agential possibilities, and 3) The significance narrative identity has for ethical reasoning.

Shoemaker approaches the question of narrative identity like Schechtman in a broader discussion of the relation between personal identity and ethics. The discussion begins with a consideration of practical issues and is followed by an examination of the two sophisticated theories of identity, those based on a psychological and biological approaches. A narrative identity approach however is considered one of two radical approaches to personal identity. Shoemaker acknowledges that his understanding of the narrative approach is taken from Schechtman and presents a reading of narrative identity which he holds follows her steps. Narrative identity is associated with the practice of characterization whereby actions and characteristics are attribution to persons. Despite the association of narrative with everyday use, the narrative aspect of identity is intensely private, corresponding to Schechtman’s notion of the implicit. In the act of self-constitution, whereby actions, experiences and characteristics are appropriated to oneself, they become part of the individual’s “self-told story”. That individuals have open to them the possibility of self-constitution and appropriation allows for an acknowledgement of agential possibilities of individuals. In telling our own self-stories certain experiences and characteristics take on a degree of ‘mineness’, becoming significant for the understanding we have of ourselves and as such our identity.

Although narrative accounts correspond to a first personal understanding of ourselves, they are constrained by the world. For Shoemaker there must be “some significant correspondence

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435 *ibid*, 90.
between the narrative one constructs and reality". Narrative identity here addresses two relations, our understanding of ourselves and our understanding of the world (which constrains possible accounts of ourselves). Narrative identity is considered to highlight an aspect of identity that is used in everyday life and which is omitted from continuity through time approaches. The achievement of identity through time without the ability of narrative to attribute action and experience to a self would result in a person foreign to everyday experience. Accordingly, narrative identity corresponds to the ‘who’ of identity, whereas discussions based on continuity focus on what it is for that ‘who’ to be able to persist through time. For Shoemaker, narrative identity corresponds to what unifies experiences and characteristics to one person and it is what establishes meaning for persons. Crucially for Shoemaker acts of self-constitution are reliant on and can only come after identity through time is secured. Narrative identity as such presupposes either a biological or psychological criterion which provides for continuity through time.

In construing self-constitution of narrative identity as an inner process and also distinct from the issue of continuity, Shoemaker limits the role of agency and others in narrative identity. Narrative is considered secondary to experience and the activity of appropriating or incorporating an experience to one-self places “an event in the self-told story of one’s life”. Narrative identity becomes radically subjective, omitting Schechtman’s emphasis on others in the constitution process. Acts of narration by an individual are limited solely by whether they “fit” coherently into the existing self-story and “approximate reality”. The individual becomes the sole author of their life-story and the social dimension of personhood is denied. The contention that narrative identity is reliant on continuity through time being established either by a biological or psychological criterion breaks with Schechtman’s contention that the narrative self-constitution approach challenges the idea that continuity is a question confronting personal identity debates. A characterization approach “presupposes an implicit understanding of oneself as an evolving protagonist”.

436 ibid, 92.
437 ibid, 90.
438 ibid, 221.
439 ibid, 91.
The inclusion of David DeGrazia as a proponent of a subjective account of narrative identity is questionable. Arguably his approach is receptive to the broad range of influence others have in narrative. However, there is sufficient justification for classifying DeGrazia as adopting a subjective approach. In Human Identity and Bioethics DeGrazia addresses the identity of human persons and contends that in addition to existing through time, human persons also develop narratives. He argues that while narrative identity is often neglected by traditional analytic approaches to personal identity, philosophers who have focused on narrative identity have had little to say about numerical identity. Human personal identity can be read as an attempt to unify the characterisation and reidentification approaches to personal identity. DeGrazia understands narrative identity as corresponding to the “who” of identity. It is in this domain that practical concerns with identity are addressed. Critically narrative is discussed under the term “self-creation”, a break with Schechtman’s notion of self-constitution.\footnote{David DeGrazia, Human Identity and Bioethics (New York: Cambridge University Press, 2005) 78.} If identity was limited to discussion of survival or continuity however, DeGrazia contends persons would be considered primarily as passive. Identity through time is something that happens to us. The other side of identity however corresponds to the capacity for action and must be identified in approaches to identity. In this context of passive and agential aspects of identity, “self-narrative or inner-stories” are introduced.\footnote{ibid, 80.} Self-narratives feature characteristics and perspectives which affect how the past is remembered and the future intended. The inner story, now considered a mental autobiography is something which all persons have and is what allows for you to be a person.

DeGrazia’s examination of narrative identity however takes a distinctive turn in which he seeks to examine the relation between the question of “who am I” and the questioner’s inner story or self-narrative. He argues an inner narrative is authoritative about “who I am”.\footnote{ibid.} DeGrazia understands inner story however to be distinctly first-personal and sets the inner-story in opposition to inter-subjective third personal perspectives. The place of others in DeGrazia’s account shifts considerably. The activity of narrative activity however is constrained to act “within reason”.\footnote{ibid, 84.} Stories that fail to conform to the world or the persona in question are held not to be identity constituting. DeGrazia’s engagement with the influence...
of other people over narrative identity is significant. He distinguishes between “other people’s knowledge” and “other people’s distortion of relevant facts”.445 Where other people have knowledge, they can provide the basis for reality checks so that a narrative identity account is realistic. As such others can play a role in setting limits on whether a self-narrative constitutes identity. However where other people distort relevant facts then the perspectives of others may have no authority over the person. This distinction between knowledge and distortion is left unqualified. Accordingly, others may have a role in determining whether a narrative identity is self-constituting but where others are distorted their perspective carries no authority. Although others are implicated in self-narratives and can offer alternative narratives, DeGrazia proposes that in the context of identity the first-person perspective should be privileged.

DeGrazia’s understanding of narrative identity as principally first personal and secondary to the achievement of continuity through time, limits the role of others and agency in ways Schechtman avoided. The understanding of the role or significance of others for DeGrazia is unclear and rests on a distinction between knowledge and distortion which is unexamined. However he is in favour of distinguishing between first personal and third personal aspects of narrative identity. Such an understanding is rejected by Schechtman, as the emphasis is placed on how narrative identity and personhood are innately social. The belief that narrative identity is secondary to the question of continuity, such that the question of who I am is secondary to that I am through time, affords primacy to the question of continuity. This limiting of the narrative approach to something which depends on continuity, deprives the activity of narrative identity of being a basis for continuity through time or denies the narrative position which presupposes persistence through time

7.4 The Subjective Approach and its limitations

The reception afforded to Schechtman’s argument by DeGrazia and Shoemaker can be regarded as illustrative of a subjective narrative approach. The reliance of the subjective account of narrative identity on either a move of limitation in respect of agency and a move of obfuscation in respect to the role of others, allows for the identification of weakness in the

445 ibid, 86.
narrative approach. The *move of obfuscation* brings the notion of narrative identity as an interpersonal phenomenon negotiated between the self and others to a more subjective phenomenon and at times it is associated with a purely first person-perspective. Narration as the act of giving meaning and allowing for action and experience to be appropriated to the self, is performed by the person either consciously or not. Both DeGrazia and Shoemaker view self-narratives as first personal with a role for others only if permitted by the individual. What acts to constrain narratives is coherence within stories, reason or the world. In affording little to no significance for others, the idea that narrative identity is an interpersonal activity is challenged. In contrast, Schechtman views acts of self-constitution as only ever subjective in name, as in practice the achievement of personhood, the result of self-constitution, is “intrinsically social”. The constraints placed on narrative constitutions reveal the role others play in constructing permissible narratives of identity. It is this role of others that allows narrative identity to relate to both other regarding issues as well as self-regarding issues.

The *move of limitation* acts to place constraint on the significance of narrative agency in personal identity debates. Both De Grazia and Shoemaker limit the scope of agency to acts of self-constitution, thus reducing agency to self-constitution, whereby individuals view themselves as an agent. This is compounded by the reliance on a non-narrative criterion to provide continuity through time: psychological or biological for Shoemaker and biological for DeGrazia. The activity of narrative identity or self-constitution is overlooked as providing a criterion for continuity through time. What makes an individual continue to exist through time then is limited to what an individual has or is, not what they do. The broader claim of Schechtman, which dismisses the primacy of the continuity question by positing that persons persist in narrative, is denied as the question of continuity is privileged for both Shoemaker and DeGrazia.

The adoption of a subjective interpretation of narrative identity allows for the identification of three internal weaknesses of narrative identity accounts, as well as practical limitations as it applies to ethics and bioethics. Considering the former first, Shoemaker observes that narrative accounts often involves experiences or end points which lie beyond an individual’s

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experience. That life before or after one’s death, as well as experiences yet to happen, make up an individual’s narrative suggests that “narrative identity isn’t necessarily about the identity of persons at all”. The second problem relates to the subjective interpretive limits of narrative self-constitution. If narrative is a first personal activity than any coherent theory of narrative must be able to decipher false or error-ridden narratives from correct ones. The third weakness relates to the remit of narrative identity. Echoing Galen Strawson’s critique of narrative approaches, Shoemaker argues that narrative approaches are either making an empirical claim such that the nature of existence is narrative or the prescriptive claim that narrative is “how we ought to live our lives”.

The significance of narrative identity approaches for practical ethics is markedly different among the subjective theorists. However, in respect of survival or continued identity, each approach views the act of narrative self-constitution as having limited importance. Continuity through time is provided by a criterion of sameness, where this is achieved then narrative identity can provide an account of one’s existence and ground the experience of self-concern and anticipation. For Shoemaker though, first personal narratives are of limited relevance in practical issues of moral responsibility and reidentification. As narrative identity corresponds to a first personal perspective, Shoemaker considers it as incapable of aiding aspects of consideration that are third personal. In contrast DeGrazia understands narrative’s significance more broadly, avoiding reducing narrative identity to an object of third personal consideration, but rather as corresponding to the domain of everyday life. As narrative comprises what persons are essentially, it should be considered alongside the question of sameness in any issue relating to personal identity.

7.5 An intersubjective Alternative
The reading of narrative identity in personal identity debates need not adhere to a subjective interpretation. In considering human beings, to limit the consideration of personal identity to

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the issue of sameness is to overlook the first personal perspective and the activities people engaged in, what Paul Ricoeur refers to as “identity as selfhood”. The understanding that narrative identity calls to attention something neglected in personal identity debates is accepted by subjective theorists. An alternative understanding of narrative identity can be developed from reading Schechtman alongside Ricoeur. A Ricoeurian reading of narrative identity emphasizes the centrality of others in narrative activity but also rejects the limited role afforded to narrative activity. Whereas subjective approaches understand narrative identity as an aspect of personhood neglected in traditional accounts of personal identity, an intersubjective approach builds on this and claims that narrative identity provides or allows for continuity through time.

In *Oneself as Another*, Ricoeur observes that discussion of personal identity focuses on “identity as sameness” (idem) often at the expense of a consideration, save an acknowledgement, of “identity as selfhood” (ipseity). In selfhood Ricoeur finds two alternatives to a focus on the substance which provides continuity. “Character and keeping one’s word” provide a first personal/third personal and a first personal model for permanence in time. Character refers to those dispositions by which a person is recognized and represents both ipse and idem. The acquired dispositions and habits, as an individual’s actions, provide a means for others and the person to identify the person. Keeping one’s word denotes first personal acts of self-constancy, where a commitment to act regardless of change is pledged. Identity as selfhood provides two ways, one fused with a third personal perspective, for identity to persist through time. Narrative identity offers a response to the two poles of identity offered in character and keeping one’s word. As such narratives elude being simply first personal as they offer a synthesis and response to one’s agential comportment and the third personal perspective which allows for others and a person to view themselves through. Narrative identity here addresses three relationships. it addresses “referentiality”, the world in which I live is disclosed through accounts of meaning, “communicability”, that I experience myself as both a subject and an object for others and

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451 *ibid*, 116.
452 *ibid*, 118.
myself, and “self-understanding”, that I act in the world.\textsuperscript{453} That the world is already disclosed and we find ourselves in dialogical relationships provides an account of why we come to talk about action, events, and characteristics.

The process of self-constitution for Ricoeur, like Schechtman, is thus a relational or social practice. Narrative constitution is not equivalent to some free form creativity but in fact a restricted practice. Prior to offering a narrative identity for oneself an individual must meet conditions of \textit{Mimesis}\textsuperscript{1}: “a pre-understanding of the world of action”.\textsuperscript{454} Individuals must be familiar with the available resources available to any would be narrator, the already established symbolic order and the temporal aspects of particular experiences which call for acts of narration. \textit{Mimesis}\textsuperscript{2} refers to the stage of emplotment where an individual can put forward an account of events, actors, etc. in to a story. This story offers a particular ordering of events brings together a range of different events, motives, and other interpretations and lastly offers a configurational order. Each act of emplotment takes place or is offered in a particular cultural setting which has its own interpretive order or “schematization”.\textsuperscript{455} This order places constraints on how individuals can talk about action and provides a means for identifying accounts between repetitive accounts or radically innovative or challenging accounts. The final stage \textit{mimesis}\textsuperscript{3} represents the stage of application, where narratives are either accepted or rejected. The projected world that any narrative offers provides a possible space for individuals to inhabit or live with.

The status of narrative identity under Ricoeur moves away from being considered a possession, a relation between events in the past and the present, and that which allows for a sense of mineness, becoming an inter-subjective mediation on the condition of human existence. In providing a response to one’s being in the world, narrative identity is ethical in nature. In acts of self-constancy, as the way in which an individual conducts himself with others, an individual provides others with the basis whereby they “can count on me”.\textsuperscript{456} Through such processes individuals make themselves both accountable to and responsible

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\textsuperscript{455} \textit{ibid}, 68.
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for their actions. Such actions, which through narrative identity can find possible expression, reflect particular ethical commitments. Furthermore, in adhering to the established meanings afforded specific actions in their own narrative plots, an individual’s commitment to others is expressed. This dynamic understanding of the relationship between narrative and ethics can be viewed as consistent with Schechtman’s account. Ethical considerations, as focused on issue of characterisation, find in narrative identity a synthesis that proposes an account of the character of an individual.

7.6 Reconsidering Narrative Identity’s limitations
The proposed limitations of narrative approaches in personal identity discourse, as set out above, are reliant on an understanding of others and agency achieved by the two moves. As an inter-subjective approach avoids both moves, these limitations may be reconsidered. In denying the move of obfuscation, the scope of others includes: the production and renewal of narrative accounts for others, the role of reading or audience for other’s narrative accounts, the transmission of cultural models and scripts for narrative construction and as providers of support and care for individuals. In rejecting the move of limitation, agency is considered: to provide an additional basis for continuity through time, to integrate and provide a unified sense of self, and as self-constitution, to underpin the activity of continually negotiating one’s personal identity through narrative.

Of the three internal limitations of a narrative approach, two can be resolved and the basis of the third challenged. The first holds that narrative accounts often extend beyond end points, life before birth or after death, and as such narrative identity relates to something other than personal identity. This criticism suggests that for a narrative to count as relating to one’s personal identity, then it must be constrained by a person’s experiences, which again reinforces the idea of a person as a passive subject of experiences. Narrative identity, as set out above, is not strictly a first personal account, or is it comprised of just an individual’s experiences, rather a narrative account can draw on the experiences of others as well as cultural ideals about experience and its narration. As narrative self-constitution is a social act and governed by cultural ideals around storytelling, the inclusion of events from beyond
one’s experiences in a resultant narrative is possible. Narrative identity is not reducible to the subjective interpretation of a person’s experiences.

The second weakness concerns the ‘truth value’ of narrative accounts and the associated contention that narrative theories must provide a mechanism for distinguishing between false or error ridden narratives from those that are identity constituting. To fail to do so would be to support the view that any account is sufficient for self-understanding. As narrative self-constitution is a social act, the creation of narrative accounts is limited both prior to and after the composition of a particular account. As individuals become habituated within their culture(s) they develop an understanding of appropriate and permitted schemas for self-understanding in narrative form.\textsuperscript{457} Personal narratives, like historical and fictional narrative, only find completion in the stage of readership by an audience. The challenge for narrative approaches to personal identity is identifying what the audience is for a narrative account and as such who has the ability to reject an individual’s account. Although narrative approaches traditionally avoid the language of truth or falsity in respect of narratives, constraints can be identified for any narrative account. As accounts are an interpretive act, drawing on first, second and third personal perspectives, they can be rejected or dismissed where they violate established conventions of meaning making.

The suggestion that narrative accounts must be truthful is to overlook a crucial social practice highlighted by a narrative approach. While the issue of the interpretive accuracy of any narrative is relevant, by virtue of other people’s role in appraising an individual’s narrative, of critical significance is which narrative accounts are socially endorsed and the consequences of such endorsements. False or error ridden narratives can be identity constituting when socially endorsed, as seen in cases of miscarriages of justice such as the Guilford Four. As narrative identity is intrinsically social, the endorsement or the failure to endorse some narratives can be oppressive and damaging.\textsuperscript{458} The classification and pathologizing of homosexuality in psychiatry, the imposition of gender categories on intersex

\textsuperscript{457} See the discussion of “innovation and sedimentation” in the context of narrative in Paul Ricoeur,\textit{ Time and Narrative Vol. I}. Trans. (Kathleen Mclaughlin and David Pellauer trs, Chicago: University of Chicago Press 1984) 68.

children and the failure to believe a disclosure of sexual or physical abuse can be understood as oppressive narrative practices.

The third criticism holds that narrative identity approaches must be either descriptive or prescriptive. If it can be revealed that individuals can live outside of narrative in a non-pathological sense, then both the empirical claim that individuals live a story of some sort and the claim that a narrative perspective is essential to a functioning life, are discredited. As part of this argument against narrativity, Strawson sets up a distinction between “episodic” and “diachronic” self-experience and advances an understanding of narrativity. Episodic self-understanding involves understanding yourself predominantly in the present, without consideration of yourself in the further past or in the further future. A diachronic self-understanding however understands oneself as having been there in the further past and in the further future. Strawson’s contention is that narrativity is a possible feature of diachronic self-experience, where narrativity refers to a form of self-understanding. Narrative self-understanding refers here to the conscious understanding of one’s life as having a narrative with concern for both the past and future.

The basis of the descriptive/prescriptive critique is itself subject to considerable criticisms. As noted by Marina Oshana, Strawson sets an “implausible” understanding that diachronic selves have of the past, a view which few narrative theorists can be seen to embrace. The claim that episodic self-understanding is free of narrative rests on a reduced understanding of narrative identity. Understanding narrative as the viewing of one’s experiences in a unified story omits narrative understanding in everyday activity and relies on an interpretation that narrative is only ever added to experience after the fact. Anthony Rudd argues that defenders of an episodic account would need to explain how an individual can engage in everyday activities outside of meaning making and understanding of the self. Finally, the suggestion that individuals can live non-pathologically without narrative is to be oblivious to the reality of the loss of the interpretive function that narrative serves.

7.7 Narrative Identity and Bioethics

The relevance narrative identity can have for practical issues in healthcare and bioethics more generally varies in accordance with the understanding and scope afforded to narrative identity. An impersonal approach to narrative identity considers the narrative identity of another as the object of concern. From Shoemaker’s perspective, consideration of a person’s narrative identity is not relevant in issues of reidentification or the attribution of moral or legal responsibility. Furthermore, even for personal issues of self-concern and anticipation, he holds that an individual’s own narrative is not the object of concern, rather it is something more basic.

A second approach understands narrative identity to be personal and corresponds to an individual’s understanding or perspective. Narrative identity here represents a challenge to a medical approach that fails to appreciate the lived experience of illness and healthcare. For bioethics, narrative identity here provides the possibility of complementing existing understanding or perspectives with that of the individual in question. Narrative identity is considered subjective but its value is not as an object of concern, as in the impersonal approach, but rather in how narrative identity can convey the subjective perspective.

The rejection of both the *move of obfuscation* and the *move of limitation* allows for an intersubjective understanding to emerge. Here narrative identity corresponds to both the subjective domain but also the relational sphere. Narrative identity refers to the continual activity whereby individuals simultaneously negotiate their own understanding of themselves and are involved in the same process of others. Critically, narrative identities cease to be just an object of bioethical concern, but rather bioethics becomes a practice that avails of narrative identity. Bioethical discourse, in providing available schemas and narratives for individuals and healthcare professionals to make sense of experience, is co-authoring, alongside many other discourses, the way healthcare and patients are understood. In addition to a patient’s narrative identity being of possible concern for healthcare workers, through their own actions they are engaged in negotiating their patient’s understanding of themselves. The risk that subjective approaches pose is not simply that they present a reduced subjective understanding of the self but they can obscure bioethicists and healthcare workers’ involvement in co-authoring the lives of others.
The narrative challenge confronting bioethics can be understood as posing the question as to how bioethics is to understand the individual or patient. Bioethical discourse can impact how practitioners and others understand ethical issues, but also invite them to treat and understand individuals or patients in particular ways. The choice of how to understand the individual that lies at the heart of bioethical inquiry, finds one expression in the distinction between subjective and intersubjective approaches to narrative identity. It confronts theorists and practitioners alike with their potential role in the lives of others. While bioethicists, or at least some, might understand that they seek to improve the situation or condition of others through their work, this belief in the possibility of change necessarily entails the chance that bioethicists might exacerbate or create conditions of vulnerability.

7.8 Conclusion
One of the principal decisions confronting any bioethical engagement is how the individual, in healthcare the patient, is to be understood. Narrative identity approaches, along with other philosophical approaches, challenge the understanding of the self, which permits a focus on the self at discrete times and views continuity through time as achieved passively. The subjective approach, characterized by the two moves, acts to blunt the challenge narrative identity poses and allow for a narrowed version of the individual in terms of agency and relationships with others to be promoted. Where bioethical approaches fail to acknowledge the human condition as embodied, relational, temporal and agential, the concern must be raised as to whether such approaches should speak to the domain of healthcare.
Chapter 8
Negotiating Relationality: Mental Capacity as Narrative Congruence

8.1 Introduction
The Mental Capacity Act 2005 (MCA) established a legal framework for the identification and classification of human action as either capacitous or incapacitous. This framework however can be understood in a broader context, as part of a movement in health and social care for greater protection of those experiencing vulnerability, whilst also empowering individuals to act with self-determination. In outlining the conditions under which an individual’s actions are to be respected but also under which interference is permitted, the MCA attempts to distinguish between autonomous and non-autonomous action. Where an individual is found to have capacity, they are permitted to have their actions respected and as such mental capacity is “gatekeeper to the right to autonomy”. The definition of capacity adopted in the MCA, the culmination of a lengthy deliberation, is but one of many definitions which could have underpinned capacity legislation. Although the Act has received political praise and support, at both its coming into law and by a House of Lords Select Committee in 2014, the argument can be made that for such a rigorously debated piece of legislation, considerable difficulties remain. The difficulty of achieving compliance or implementation is compounded by the non-binding status of the Code of Practice and the lack of a definitive guide for compliance with the MCA. The recommendation that greater effort needs to be placed on achieving compliance has beckoned in considerable emphasis on training. The issue of implementation is itself subject to a more serious concern, namely whether it is possible to achieve what the Act sets out in the first place. The allocation of considerable financial resources to raining and implementation would appear questionable at the least, if it is unclear whether a capacity assessment in accordance with the Act can be performed.

The MCA arguably can be read as adopting a Millian understanding of the liberal self, inviting capacity to be considered in regard to liberty and non-interference.\textsuperscript{465} The presence of capacity prohibits interference in an individual’s action. The establishment in the MCA of a cognitivist two-stage assessment process for the identification of incapacity in respect of a decision at a specific time, places constraints on the attempt to justify interference in the life of another. The two-stage process is comprised of diagnostic and functional elements. For an individual to be found to lack capacity they must have an “impairment of, or a disturbance in the functioning of, the mind or brain” which leads to an inability to “understand the information relevant to a decision”, “to retain this information”, to use or weigh this information”, and to “communicate his decision” or simply understanding, retention, weighing and communication (URWC).\textsuperscript{466} Where assessment is called for, individuals with impairments of the mind or brain must demonstrate all four abilities in respect of a proposed decision to be held capacitous. As Catriona Mackenzie and Wendy Rogers observe however, the expectation of the MCA for mental capacity to be assessed at a specific time, (synchronically), is challenged by the parallel commitment to understand the self and consequently mental capacity over time, (diachronically).\textsuperscript{467} In section 1 the principles for the application of the Act are set out. Principle 3 of the MCA requires that a person be engaged with over time and supported in making a decision, while in respect of best interests determinations in section 4(6) there is a requirement to consider the individual over time so that a best interests decision is founded on an appreciation of the individual’s values, beliefs, etc. Further challenges to the MCA’s understanding of the self cognitively and discretely are advanced in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and in approaches which view the MCA in a broader context of care and the promotion of self-determination.\textsuperscript{468} The tension in the MCA between viewing the self cognitively at a specific time and viewing the self as having values and beliefs through time, coupled with the acknowledgment that capacity assessments consider an individual over


\textsuperscript{466} MCA, s2(1) and 3(1).


time, suggest that incapacity is not located within an individual simply at a specific time. The MCA can be read as relying on particular conceptions or philosophies of the self, some of which are inconsistent with each other, the demands of practice and other legal frameworks including the UNCRPD.

The adoption of a narrative approach to selfhood allows for an interrogation of mental capacity practice and highlights inadequacies and limitations in the cognitivist approach of the MCA. Paul Ricoeur’s understanding of narrative identity, as developed in *Time and Narrative* and *Oneself as Another*, allows for mental capacity practice to be evaluated from a perspective distinct from both the cognitive model of the MCA and recent relational approaches to mental capacity.

Ricoeur argues that the activity of narrative identity, as something we engage in alongside others, is that which provides integrity or coherence to people’s lives by drawing together different aspects of experience. Crucially though, narrative is inter-subjective and can thus be seen as posing a challenge to the individualistic understanding of the self espoused in the MCA. The problems associated with implementing the MCA including instigating capacity assessment, assessing functional understanding, assessor bias and in particular the call for understanding capacity as internal to an individual and the requirement to view the self both diachronically and synchronically, places a burden and seemingly impossible expectation on practitioners. The narrative interpretation defended here makes two claims. First, capacity assessment can be considered as a mimetic activity and second, capacity assessment is a site of identity negotiation. This challenges the notion that capacity assessment is strictly about the individual assessed but calls for recognition of the social context and identity of the assessor and questions the idea that capacity is a claim about an individual. This narrative reading of mental capacity, comprised of mimetic and

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470 This paper does not seek to address the compatibility between the MCA and UNCRPD. For such a discussion see Lucy Series, ‘Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms’ (2015) 40 *International Journal of Law and Psychiatry* 80-91.


identity negotiation claims, challenges the coherence of the MCA’s cognitivist approach. The practice of conferring capacity or incapacity is not defended or critiqued here, rather a narrative approach is proposed as providing a more accurate description of practices in capacity assessment. In highlighting the inadequacies of the MCA’s approach, a narrative approach problematizes the instigation of capacity assessment, the nature of what is assessed and the conception that capacity is time-specific. Although this approach adds a complexity to understanding the assessment process, it identifies practical and conceptual difficulties and as such provides a more coherent account of practice.

In Part II a narrative approach to selfhood is developed from a reading of Paul Ricoeur and linked to the work of Marya Schechtman and Hilde Lindemann. Part III begins with a brief overview of difficulties in the application of the MCA. In Part III.1 four ways in which narrative identity can be applied to mental capacity practice are identified. In section III.2 a mimetic account of assessment is developed. The challenges such an approach poses to the functional model of the MCA are outlined in III.3. In Part IV the second claim of the narrative approach is proposed, namely that mental capacity assessment involves identity negotiation for at least two people. Finally, in Part V the narrative identity theory of mental capacity is set out and its relation to the functional model of capacity developed.

8.2 Narrative Selfhood
The opportunity to understand the self and selfhood outside of a liberal conception of the self is offered by vulnerability\(^{473}\) and relational approaches.\(^{474}\) In drawing attention to the role of others and context, purely internal approaches to understanding the self are challenged. Paul Ricoeur’s understanding of narrative identity echoes this concern with how the self is viewed and can be read as offering an alternative to internal accounts of the self. A reading of Ricoeur’s understanding of narrative leaves some ambiguity as to how narrative identity is


negotiated. Schechtman’s conception of narrative self-constitution and Lindemann’s account of the relational practice of identity negotiation it is proposed here complement Ricoeur’s understanding and provide additional support for the application of a narrative approach to mental capacity. In Part III, mental capacity assessment is considered through the lens of narrative identity.

In Time and Narrative (TN) Ricoeur develops his most detailed account of the function of narrative and crucially the mechanics of narrative practice. The practice of narrative, whether fictive, historical or personal, has as its theme time or the “temporal character of human experience”.\footnote{475} It is the mediating function of narrative that allows temporality to be accessible to consideration. The activity of narrative attempts to but does not resolve the “paradoxical nature of time”.\footnote{476} The first problem is the conflict between phenomenological and cosmological time, or between lived and objective time. The second problem is the dissociation or distention caused by the past, present and future in awareness that “the future is not yet, the past is no longer, and the present does not remain”.\footnote{477} The third problem is the ‘inscrutability’ of time, that for all the efforts of narrative, time evades constitution. In Ricoeur’s later works on narrative, the focus is on the primacy of narrative identity for lived experience, the function narrative identity plays in synthesizing two aspects of selfhood and an understanding of the relation between selfhood, narrative and narrative identity.

In Book One of TN, Ricoeur introduces his threefold understanding of mimesis as the process through which time becomes refigured and productive. Whereas the action of telling a story is often associated with narrative, Ricoeur develops a broader approach. Mimesis1, as the first stage of narrative corresponds to the preconditions for any act of narrative emplotment. Before an individual can narrate their identity there must be in play a “pre-understanding of the world of action”, comprised of structural, symbolic and temporal dimensions.\footnote{478} An individual must be versed in the “conceptual network” through which action can be talked

\footnote{478} ibid, 54.
about, understand that action is symbolically articulated and appreciate the temporal aspects of experience which are considered to require a narrative response.\(^{479}\) Mimesis2 refers to the stage of emplotting an account of action and serves to synthesise events and occurrences and impose a configurational order on to events. As a cultural practice, narrating is governed by a tradition of available schemas through which one can create a narrative account. Finally, Mimesis3 refers to the final stage where the proposed narrative is brought to the world. It is only at this stage of “application”, that narratives become complete.\(^{480}\) At this stage the text or narrative of the author intersects with the “world of the hearer or reader”.\(^{481}\) The narrative proposed projects a particular horizon or understanding of the world.

Ricoeur’s later discussions of narrative identity can be read as complementary to the exposition of the mimetic function and its relation to time. In ‘Life in Quest of Narrative’, narratives are considered to address three relations; man’s relationship with the world, others and himself.\(^{482}\) Narrative identity corresponds to the third and as such is self-understanding. It is in the activity of interpreting one’s experiences through narrative that human existence becomes lived. Life becomes meaningful and life itself through the activity of telling stories about it. Although narrative identity relates to self-understanding, Ricoeur is not suggesting that it is a distinctly first personal or private activity.

In two chapters of *Oneself as Another* Ricoeur advances an understanding of narrative identity as a response to difficulties in personal identity debates. Ricoeur proposes two poles of identity: “identity as sameness (idem)” and “identity as selfhood (ipse)”.\(^{483}\) The traditional approach to personal identity seeks to look for that which provides continuity through time or that which remains the same and allows for identity over time to be observed. The focus on identity as sameness at the expense of selfhood fails to appreciate the activities persons alongside others engage in to negotiate and maintain identities. Identity as selfhood corresponds to two aspects which allow for persons to persist through time. Selfhood as

\(^{479}\) *ibid*, 55.

\(^{480}\) *ibid*, 70.

\(^{481}\) *ibid*, 71.


character refers to “the set of lasting dispositions by which a person is recognized”. Selfhood as ‘keeping one’s word’ designates the activity of self constancy in the face of change. It refers to the who of identity. Between these two, the sameness of character by which individuals are recognised and the selfhood of keeping one’s word lies an interval in which narrative identity operates. It serves to unify both the way in which the self and others view the self as having a character, and the activities of selfhood through time.

In telling stories or offering narratives, individuals plot accounts that involve the identity of characters including their own character. Narrative provides a space where individuals talk about their character in the midst of action. In talking about one’s own character alongside events and other characters, the narrator imposes an imaginative account which seeks to bring a unity or coherence to their life. The activity of narrative identity acts to blur the lines between “author, narrator and character” and at times one is all three. However, as the ability to narrate is governed by tradition and the culture one inhabits offers ways of narrating, Ricoeur argues that at best one should be considered a co-author of their own narratives.

Narrative selfhood refers then to the narrative activity that selves are involved in as they seek self-understanding through the interpretation of experience and in doing so draw together identity as selfhood and sameness. Although Ricoeur fails to address the mimetic component of personal identity in his later writing it is evident from Part IV of TN that he intended narrative identity (both community and personal) to be read through a mimetic lens. In Part III of TN Ricoeur claims that fictional and historical narratives are preceded by a use of narrative in daily life. As co-authors, individuals are not just engaged by narrative selfhood in their own self-understanding but act as members of the culture that offer available narratives to others and provide critical readership of other’s narrative accounts. This approach to narrative selfhood allows for a distinction between individuals, narratives and narrative identities. Individuals exist within cultures with traditions of understanding and ways to make sense of personal experience. Alongside others, individuals tell stories or offer narrative accounts which project particular interpretations of their own character, their world

484 ibid, 121.
485 ibid, 159.
and relationships for readership. However, others are implicated in this process as both those who offer narrative schemas but also those who read their narratives. Furthermore, individual’s narratives must include not just their own selfhood but also their sameness, which involves both how others and they see and identify themselves. Narrative identity refers to that which acts to bring together the two poles of one’s identity and can be considered to include varying narratives which are continually being negotiated. The practice of narrative selfhood can be considered self-constituting, as it is through this activity that an attempt to make sense of one’s self is performed, which can then go on to inform how both the individual and others understand the individual.

Although a critical examination of Ricoeur’s account is not the aim of this paper, it is important to acknowledge that debates concerning the role of narrative as it relates to the self are common.486 Ricoeur’s work can be considered alongside others as calling for the primacy of narrative in understanding the self which itself is subject to sustained debate in philosophy and the medical humanities. Bringing the discussion back to personal narrative identity, further questions remain. At what point might it be appropriate to say an individual is engaged in narrative identity or narrative selfhood? This work proposes that the practice of mental capacity assessment can be understood through the language of mimesis and more generally as an activity of mimesis3, the stage of critical readership. At the point of application, where the proposed narrative meets the world, the basis on which narratives are accepted or rejected requires clarification. It is proposed here that Marya Schechtman’s The Constitution of Selves and Hilde Lindemann’s Holding and Letting Go complement Ricoeur’s understanding of the act of critical readership.487 Three questions can be raised about this critical stage of readership. Who gets to perform critical readership of another’s narratives and narrative identity? When do personal narratives and narrative identity receive critical readership? What are the criteria with which personal narratives and narrative identity are evaluated?

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The act of mental capacity assessment it is argued here can be considered to engage with the first and second question. This is not to suggest that mental capacity assessment is the only site of critical readership or that assessors are the only persons permitted to assess narrative identity. Echoing Ricoeur, Schechtman proposes a narrative self-constitution view which affords central importance to others. While narrative self-conceptions can be considered personal, Schechtman observes that individuals must comply with “The Articulation Constraint” and “The Reality Constraint”. This suggests that narrative accounts at times are required to be articulated and where this is not provided there is scope for one’s narrative identity to be questioned. A further constraint on the content of narratives is that they must comply with norms concerning narrative construction. Narratives must not violate clear facts about the world or be guilty of interpretive inaccuracies. Lindemann further complements this notion of identity being subject to critical readership in developing an account of the process of holding and letting go. Central to the development of identity, itself a process of personhood, is the importance of recognition by others. Lindemann argues that the performance of identity is itself a regulated behaviour wherein others can have four grounds on which identity can be denied. These are “malfunctioning mental states”, “misleading expressions”, “misfiring recognition” and “misshapen response”.

In the remainder of this paper, Ricoeur’s notion of narrative identity, narrative selfhood, mimesis and identity negotiation are applied to the practice of mental capacity assessment. The approaches of Ricoeur, Schechtman and Lindemann offer a vocabulary which allows for a new description of what happens in mental capacity assessment.

8.3 Capacity Assessments and Narrative Identity
The uptake of a two-stage diagnostic and functional approach to assessing capacity in the MCA is drawn from the Law Commission’s examination of different approaches to mental capacity. The Act requires that for a person to be found to lack capacity they must be

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‘unable to make a decision for himself in relation to the matter because of an impairment, or a disturbance in the function of the mind or brain’. The inclusion of a diagnostic threshold serves to forbid the use of capacity legislation to interfere in the lives of those without a disability. The two-stage approach establishes the need for a causal nexus between the inability and the impairment to be identified for a finding of incapacity. The two-stage approach gives rise to two interpretations about the order in which assessment takes place. On one reading of Section 2(1), the functional ability to make a decision is the primary concern and when lacking it becomes appropriate to assess whether it is caused by an impairment. An alternative reading is to follow the structure of the Act whereby the diagnostic threshold is first considered (Section 2) and when an impairment is present then an assessment of functional capacity (Section 3) is to be undertaken. The adoption of either approach to stages of capacity assessment however fails to clarify what triggers or instigates a capacity assessment. Unless all healthcare decisions are assessed through a diagnosis and then function approach or vice versa, then a justification for the initial decision to assess capacity in respect of some decision is required.

The functional model of capacity endorsed in the MCA constitutes decision making ability as composed of four abilities: understanding, retaining of information, use or weighing of information and communication. The first requirement holds that decision makers must have the ability to understand information relevant to the decision. The second requirement that persons retain information introduces complexity in relation to duration in two regards. Firstly, where a person lacks the time to retain information or that ability is inconsistent, then the notion of fluctuating capacity is considered to arise. The second issue relates to the duration of decisions to be made and the relevance of retention of information if capacity is always decision specific. Where a decision involves a duration such as where a person should live or whether to force feed a patient for a period of time, the role of retention of information concerns the decision making itself. The third requirement that persons use or weigh information expects decision makers not just to understand information but to be able to reflexively appropriate and endorse the decision. The fourth component of...

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491 MCA, s 3(1)(a).
492 MCA, s 3(1)(b).
493 MCA, s 3(1)(c).
communication is a residual requirement that speaks to situations where an individual is incapable of communication which prevents judgement on the other three abilities.\textsuperscript{494} Although the decision maker is required to demonstrate the functional abilities, they are entitled to support in respect of each ability as the second guiding principle of the Act requires that “all practicable steps be taken to help the person in making the decision”.\textsuperscript{495} These abilities correspond to the internal requirements the decision maker must demonstrate but the decision itself must be already identified as a matter which must be decided upon. Although this paper is unable to explore this question, the issue of the appropriateness of decisions put to persons seems central to discussion of capacity.

The implementation of the MCA, the move from theory to practice, can be considered both in regard to what practice is performed in its name but also what practice the MCA actually calls for. The application of the MCA is guided somewhat by the Code of Practice; however, it is non-binding. Critical discussions of the first four sections of the Act reveal several challenges facing would-be assessors of capacity. As noted by Mackenzie and Rogers, the Act appeals to a synchronic conception of capacity assessment as capacity is specific to a “material time”.\textsuperscript{496} This notion of time however is challenged as the person is to be considered through time in respect of retaining information,\textsuperscript{497} to be supported in making the decision with ‘all practicable steps’,\textsuperscript{498} to be evaluated in relation to the likelihood of having capacity at a later time,\textsuperscript{499} and to have their past and present wishes considered in relation to best interests decision.\textsuperscript{500} The feasibility of testing the four functional abilities in accordance with the MCA, which seemingly allows for a distinction between an incapacitous decision and a simply unwise decision, has received considerable scrutiny and outstanding questions remain as to how it is to be performed.\textsuperscript{501} The expectation that the assessor of capacity act with a degree of objectivity and to avoid preconceptions suggests either an unwillingness to

\textsuperscript{494} MCA, s 3(1)(d).
\textsuperscript{495} MCA, s 1(2).
\textsuperscript{496} MCA, s 2(1).
\textsuperscript{497} MCA, s3(1)(b).
\textsuperscript{498} MCA, s1(3).
\textsuperscript{499} MCA, s4(3)(a).
\textsuperscript{500} MCA, s4(6)(a-b).
acknowledge that capacity assessments might reflect the assessor’s values or that the person doing the judging is without perspective. At a more general level, the concern has been raised that “inherent tensions” exist between the MCA in law and theory and the assessment of capacity in practice. Manthorpe et al argue that for this tension to be overcome a more nuanced understanding of the Act to guide practice is required. A common feature of the difficulties confronting the implementation of the Act rather obviously is the role of the assessor. Difficulties in relation to how to see the patient, evaluate mental processes, act without bias and begin the capacity assessment need to be addressed if capacity assessment is to coherently enact the MCA.

8.3.1 Situating Narrative Identity

The adoption of a functional and diagnostic approach to capacity, coupled with insufficient guidance for the assessor, may be seen to leave little scope for applying a narrative identity approach to capacity assessment. Arguably the subjectivity or perspective of the assessor is avoided. The adoption of relational approaches to mental capacity in recent years, alongside the UNCRPD and associated claims for a social model of disability, challenge the traditional liberal conception of the self. The different uses of narrative identity in theorising mental capacity assessment offer both complementary and critical perspectives on the liberal/functional approach adopted in the MCA.

In the first approach, narrative identity can be considered a resource for assessors of capacity as they seek to identify the wills and preferences of a person found to lack capacity. As Jeffrey Blustein notes, a “continuer view” can understand the role of others as extending the

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504 Jill Manthorpe, Kritika Samsi, Hazel Heath & Nigel Charles ‘’Early days’: Knowledge and use of the Mental Capacity Act 2005 by care home managers and staff’ (2011) 3 Dementia 283-298.
individual’s narrative identity where the individual’s ability to do so is lacking. For example, where a person is diagnosed with advanced dementia and found to lack capacity about where to live, the person’s narrative identity could be viewed as limiting of potential choices, such that whatever choice is made is consistent with the person’s wishes as previously expressed. While this approach may be intuitively appealing for those seeking to honour a person’s narrative identity, a range of issues need to be clarified, including the issue of whether wills and preferences or an individual’s life narrative should have priority, how an individual’s narrative is to be discerned, that is if there is only one, how to deal with conflicting narratives and finally how to choose between actions which all are consistent with an individual’s narrative identity. This narrative approach however does complement contemporary attempts to distinguish between mental capacity and legal capacity. An appreciation of a person’s narrative identity in cases of mental incapacity allows for their legal capacity to be preserved as it is their values and identity guiding decision making.

A second approach is to view the capacity assessment process as the production of a narrative identity account, whereby the assessor is engaged in the co-construction of a patient’s narrative identity. Research drawing on this approach could seek to examine conventions and traditions informing how a patient’s narrative identity are articulated but also examine the reading that capacity assessors perform of a patient’s narratives. Carol Johnston and others draw attention to the role capacity assessors and judges play in determining what a patient’s narrative involves, which can then influence best interest decisions. This approach highlights how capacity assessors in asking certain questions and focusing on some issues over others, in effect, construct and/or limit the narrative identities of the person in question. The questions of assessors can be understood as having an editorial function.

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A third approach, as set out by Michael Bach and Lana Kerzner, proposes that a definition of decision-making ability should include a narrative component. In rejection of an individualist conception of selfhood, Bach and Kerzner argue that the assessment of decision-making ability should be based on whether an individual has the capacity to express their wills and intentions to others, who can then recognise and ascribe agency to the individual’s actions, and secondly, the individual’s ability to answer who they are, articulate a life story, and for that narrative account, to “direct the decisions that give effect” to a person’s intentions. Here, the adoption of a relational approach to agency and selfhood recognises narrative identity as central to deciphering decision making ability or its lack, crucially though by locating the ability within an individual’s interaction with their community. Therein inability to make decisions is a feature of the individual and community, not the individual’s mind or brain.

A fourth approach can view the capacity assessment process as a narrative practice in its own right. Therein it understands that the object of a capacity assessment is a person’s narrative or their narrative identity, that the determination of best interests or a substituted judgement can seek to continue an individual’s engagement in narrative identity, and that the resultant judgement is an act of co-authoring of a narrative identity. Furthermore, capacity assessment practices are made possible by narrative identity and narrative selfhood and such practices are in fact a stage of critical readership of the individual. This work now turns to developing the fourth approach, where capacity assessment is understood as a distinctly narrative practice comprised of mimetic (Part III.2) and an identity negotiation (Part IV) dimension.

8.3.2 A Mimetic Account of Mental Capacity Assessment

The practice of capacity assessment can initially be read as corresponding to mimesis, the stage of application, where a narrative is subjected to critical readership. A person’s decision or lack of a decision is read by the assessor of capacity and the action either rejected or accepted. This account of assessment as critical reading allows for four mimetic stages or periods of capacity assessment to be identified.

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510 ibid, 65.
Prior to any capacity assessment taking place however, there must already be two accepted narratives operative in the context. First, the assessor must have accepted and understood that the MCA is an appropriate symbolic, structural and temporal resource for categorising human action and secondly, there must be an accepted narrative which holds that a decision must be made. The presence of these two resources, however, is insufficient to account for the commencement of a capacity assessment. The origin of any capacity assessment can be seen to emerge because of the narrative context, of which there are three types. Where an individual’s own account of what action is to be taken is the only proffered narrative, a capacity assessment will not be triggered. Where there is no account offered by the individual, as in cases of an unconscious patient, there is a narrative deficit. In such cases, there is an absence of a perspective to guide action and so a capacity assessment can be triggered. The third situation arises where in addition to a patient’s proposed account, there are also other accounts proposed, resulting in narrative conflict. Only where the alternative narrative is considered to have weight or relevance does narrative conflict precipitate an assessment. The instigation of a capacity assessment in cases, save in cases of narrative deficit, is contingent on the possessor of the alternative account of action believing that it should be relevant and in doing so questions the authority of the patient’s account. An example of narrative conflict would be if a patient maintains that she is unwilling to have life-saving heart surgery and yet her nurse’s narrative includes the patient’s commitment to being at her own daughter’s wedding in five years.

The second stage of the process begins when, in the presence of narrative deficit or narrative conflict, the response of the assessor takes the form of a proposal of an alternative narrative, one which holds that the patient lacks capacity in respect of a decision. The acceptance of this incapacity narrative is dependent on the evaluation of the patient’s original account about the decision. In cases of narrative deficit, this activity often goes unnoticed, as the patient is found to not be able to communicate a decision, and by default the incapacity narrative is accepted. In cases of narrative conflict however, the patient’s engagement with the decision to be made is evaluated. The MCA requires that the basis on which someone can fail in this respect is where ‘impairment of, or disturbance in the functioning of, the mind or brain’ contributes to an inability to perform one or more of the tasks of understanding, retention,
weighing and communication (URWC). A mimetic account allows for a reinterpretation of what is being assessed under the label of URWC as whether an individual’s narrative account demonstrates congruence with established narrative conventions and as such avoids an “error of fact” or “interpretive inaccuracies”. Where an individual is found to have performed URWC (a cognitivist approach) or avoided ‘errors of fact’ or ‘interpretive inaccuracies’ (a mimetic approach), then their narrative account will be accepted and the proposed incapacity narrative will be rejected. Where an individual is found to have failed to perform URWC (a cognitivist approach) or demonstrated ‘errors of fact’ or ‘interpretive inaccuracies’ (a mimetic approach) then the proposed incapacity narrative will be endorsed.

The third stage of the mimetic process commences after the endorsement of the incapacity narrative. This in turn beckons in the issue of what narrative account is to be supported in place of either the discredited narrative, or in cases of narrative deficit, an absent one. Assessors are thus confronted with the challenge of how to negotiate “substituted decision-making”, of which best interests and wills and preferences are available guiding principles. In such cases the assessor can legitimately be considered a co-author of the individual whose decisions are being considered, as they are charged with identifying which narrative account should guide the individual in the future. Alternatively the role of the assessor can be minimised and instead a ‘continuer’ approach be endorsed. Therein the person’s narrative identity and/or wills and preferences guide the decision.

The fourth stage or final stage can be identified where the best interests or substituted decision has been endorsed. The activity of critically reading an individual’s narrative is complete, and where the individual is found to lack capacity, an alternative account endorsed. The conclusion of the activity of critically reading the individuals narrative results in the activity taking on the status of mimesis1, as an established fact, which may have relevance in respect of future decisions.

The reading of the mental capacity assessment process as a mimetic activity calls for a more nuanced understanding of capacity assessment and accordingly affords central importance to the role of the assessor. The adoption of a mimetic understanding of capacity assessment allows for greater recognition of those performing the assessment. The language and rhetoric of the MCA maintain that what lies at the heart of any determination is something ‘mental’, clarified in the Act as relating to ‘mind’ or ‘brain’, which contributes to a view that incapacity is a feature of a person, a functional inability. A mimetic account however allows for mental capacity to be identified as a concept which grounds a practice of critical readership. To claim that mental capacity is a relational term that corresponds to the relation between people and neither the assessor or assessed discretely, is arguably irrelevant. All forms of assessment by one person of another can be viewed as being relational in general and furthermore are liable to a narrative evaluation. The claim can however be made that what makes mental capacity practice, whether strictly in accordance with the MCA or not, an essentially narrative and relational practice, is the identification of three distinctly narrative features. First, mental capacity assessment, in cases of narrative conflict, has as its object the person’s own decision and self-understanding which may become part of their narrative identity but crucially is a product of either the person’s implicit or explicit understanding of themselves. Second, the assessment of the person’s decision by the assessor is an act of critical readership, of the third stage of mimesis, in which the assessor is permitted to appraise the self-understanding of another. As acknowledged by both Ricoeur and Schechtman, narrative self-constitution is an innately social activity. Third, the capacity assessment process requires the proposal of a narrative of incapacity by an assessor to instigate the process in the first place. What differentiates mental capacity assessment from some others forms of assessment is principally that it takes as its object an individual’s narrative selfhood, the performance of the assessment is an activity of narrative selfhood by the assessor, and the process requires an initial proffering of an alternative narrative for another. The continued use of the term mental capacity however poses a problem for theorists seeking to acknowledge the mimetic dimensions of capacity assessment. This problem echoes the challenge faced by relational theorists challenging the traditional conception of autonomy in philosophical and legal discourse.513

Practically, the mimetic reading invites consideration to turn to the initial period of concern leading to the commencement of a capacity assessment. Whereas the MCA in Sections 2-4 establishes a framework for assessing capacity and determining best interests in cases of incapacity, there is a failure to adequately explain when practitioners should assess capacity. This failure may stem from the historical context to which the MCA responds, in which it seeks to curtail or limit practices of interfering with and constraining the rights of persons. As such, the use of the MCA need not specify when the Act is to be applied, as there is a presumed set of persons to whom the Act relates. A further contributing factor to the failure to explain the impetus to doubt capacity can be traced to the limited space given to considering the role played by the assessor in the process. The mimetic interpretation invites readers to acknowledge that where neither an alternative narrative account nor an incapacity narrative is proposed, then an individual can never be found to lack capacity. As the MCA commits itself to a presumption of capacity, a decision on the part of an assessor is required before incapacity can be conferred. Accordingly, to adequately explain the assessment process, sufficient consideration needs to be given to the assessor’s role in instigating an assessment.

The everyday use of the MCA places a considerable responsibility, albeit unacknowledged, on assessors to initiate the capacity assessment process. In one set of cases, those of narrative deficit (stage four of the functional model), the assessor is required to propose a narrative of incapacity. Although this activity is not of concern here, the issue of whether all cases of narrative deficit are responded to with capacity assessment is worthy of further research. In cases where an individual offers a narrative account of action, however, the issue of what provides the impetus for the assessor to doubt an individual’s capacity and subsequently propose a narrative of incapacity is unclear. Not all individuals with an impairment of the mind or brain have their decisions subject to a capacity assessment. Assessors of capacity are thus tasked, in cases of people who have articulated their own narrative accounts or decisions, to recognise alternative narrative accounts of action but also recognise when in fact it is appropriate to privilege such an alternative account and thus trigger a capacity assessment. The failure within the MCA or Code of Practice to provide guidance on when alternative narratives are to be proposed might also stem from the historical context in which capacity
assessment is considered to apply. An additional issue arising from this requirement to commence capacity assessment is the seeming expectation on the assessor to both know the person and be able to identify an alternative narrative relevant to that person, or to be familiar with appropriate alternative narratives to offer in certain cases or classes of people.

The theorising of capacity assessment as a mimetic process also offers an alternative account of one of the cornerstones of the MCA. In accordance with the cognitivist model adopted, a judgement of incapacity is never considered global, binding on all the actions of an individual. Rather, it corresponds to a specific decision or issue and accordingly allows for accounts of simultaneous determinations of capacity and incapacity regarding different issues. The adoption of this decision specific approach contrasts with historical practices that deprived individuals of any right to partake in decision making based on status, a global determination. An alternative account of the move away from global determinations of incapacity is offered by a mimetic approach. As capacity assessments are cases of critical readership of an individual’s action, the assessment of some decisions and not others can simply be indicative of an assessor’s concern with some of an individual’s decisions, not all of them. The scope of capacity determinations such as those involving psychiatric inpatient treatment for a duration, financial matters, living arrangements and the relationships one can engage in, suggest while specific decisions might be considered, those decisions can have whole life or global impacts. Furthermore, as capacity determinations have the potential to impact on how individuals are understood and treated by others going forward, the impact of any capacity assessment can be considered greater than the decision in question.

8.3.3 Narrative Incongruence and the Spectre of Paternalism

The mimetic reading of capacity assessment allows for an understanding of the assessor’s role in conferring the status of incapacity to emerge. Whereas the MCA’s approach understands the assessor’s role as one of identifying incapacity by applying the two-stage test, a mimetic approach rejects the notion that incapacity necessarily involves an impairment of the mind or brain or a failure to perform a set of functional tasks. Lindemann’s theory of the interpersonal practice of ‘holding and letting go’ complements Ricoeur’s understanding of mimesis and provides a basis for mental capacity determinations to be considered from

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the perspective of the assessor.\textsuperscript{515} Lindemann contends that personhood is conferred on an individual by others. Others, in having the power to recognise or reject aspects of one’s identity on a series of grounds, are engaged in a process of holding and letting go. Thus, the ability to perform an identity is regulated through a social act of critical readership.

Lindemann sets out four grounds on which personhood is rejected. The first justification occurs in situations of “malfunctioning mental states”, whereby the individual can be considered incapable of maintaining a credible understanding of self due to a cognitive deficit.\textsuperscript{516} This approach echoes the MCA’s understanding of incapacity as having its root cause in a cognitive impairment. The second basis on which an account can be rejected is “misleading expression”.\textsuperscript{517} In such cases the individual violates established social norms or accepted understanding. One form of this is “errors of fact”, whereby an individual is wrong about a socially accepted fact.\textsuperscript{518} In proposing an understanding that is inaccurate, the individual demonstrates a failure to appreciate the world they inhabit. Here we can think of a person who maintains that the world is flat. Whereas some facts are seemingly non-negotiable, there are a range of beliefs about the world, such as religious convictions, where there is more flexibility. For example, a person’s belief in the existence or non-existence of god would not be deemed an error of fact.

The second form of misleading expression occurs where an individual violates an “interpretive” norm.\textsuperscript{519} In such cases the individual might have an appreciation of the facts but their interpretation of those facts is considered inappropriate or unjustified. Here we can think of an individual who maintains that they are invincible and immortal having survived a deadly train crash. Other forms of interpretive error can involve the concealing of, or failure to disclose, issues related to oneself. An example of this can be seen where a doctor refuses to endorse a patient’s understanding of themselves as clumsy or prone to falls, on the suspicion that the patient has refused to disclose incidents of domestic violence. The idea of misleading expression poses a challenge to the model endorsed in the MCA, as it separates

\textsuperscript{516} \textit{ibid}, 106.
\textsuperscript{517} \textit{ibid}.
\textsuperscript{518} Marya Schechtman, \textit{The Constitution of Selves}, (Ithaca: Cornell University Press, 996) 121.
\textsuperscript{519} \textit{ibid}, 125.
out the evaluation of a decision from a consideration of the functional abilities. The idea of misleading expression calls for contemplation of cases whereby an assessor might seek to classify the individual’s decision as incapacitous, where in fact the deficit is in their interpretation or understanding of facts alone. In accordance with the MCA such instances would not be grounds for a finding of incapacity. In accordance with Principle 2, assessors are required to provide all reasonable efforts to support an individual’s understanding and accordingly prevent a finding of incapacity on the basis of error of fact alone. Furthermore, Principle 3 prohibits the conferring of incapacity where there is an unwise decision, preventing a finding of incapacity based on interpretive inaccuracy alone.

The third basis on which identity can be denied, that of “misfiring recognition”, occurs when there is a failing on the part of one person to recognise or acknowledge another. Cases of non-recognition can be informed by an interpretive inaccuracy or error of fact, whereby they prevent an acknowledgement of another’s account or impose a particular account on the person. Practices of oppression can be considered failures to acknowledge the perspective of another, which result in a failure to accept or permit a person’s identity. The MCA can be considered to prohibit ‘misfiring recognition’ from guiding a capacity determination as principle 1 (section 1) requires that all individuals are presumed to have capacity until demonstrated otherwise and subsequently puts in place a framework for justifying a determination of incapacity, which relies on a concept of ‘malfunctioning mental states’.

The fourth form of identity denial, “misshapen response”, occurs when an oppressor refuses or denies a person of their very individuality and experience. Crucially this form of response involves recognition on one level, whereby the person is recognised by a particular status, whether it is woman, child, slave, teenager, disabled or refugee. Recognition however here serves to identify what form of response is appropriate or permitted. The form of response fails to acknowledge the experience or situation of the person and uses a category to justify practices. Lindemann proposes that misshapen response can take multiple forms from atrocities of “torture, enslavement, and rape”, practices of “segregation, lack of access

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521 *ibid*, 115.
to decent employment or education” to personal beliefs and attitudes towards particular
groups of people.\textsuperscript{522} The MCA, as an alternative to a status based approach to capacity, shifts
capacity assessment practice away from generalised responses based on the status of a
person, to an approach that considers the person on a decision by decision basis.

The MCA recognises a difference between denying narrative accounts on grounds of ‘mental
malfunctioning’, ‘misfiring expression and ‘narrative recognition’, permitting
malfunctioning as the only basis for a finding of incapacity. The difficulty confronting the
implementation of the MCA is whether this distinction is maintained. It is possible to imagine
cases of misfiring expression where an individual fails in respect of URWC or commits an
error of fact or interpretation, has an identified impairment of the mind or brain, but that the
former is not caused by the latter. For example, a patient with a brain tumour (an impairment
of brain) who refuses chemotherapy and is identified as failing the cognitive task of weighing
up of information, might be found to lack capacity on the basis of the two-stage test.
However, it may be the case that the brain tumour has no bearing on the decision which is in
fact related to the witnessing of a loved one undergoing chemotherapy treatment and a wish
not to experience something similar. To overcome such doubts, supporters of the MCA must
demonstrate how an impairment of the mind or brain is directly linked to the task of URWC
and how this causal nexus is to be observed.

A further concern could be raised as to whether individuals found to fail URWC, but as such
lacking the diagnostic requirement for a finding of incapacity, are subsequently submitted to
examination and assessment to find an ‘impairment’ which would allow for a finding of
incapacity. The failure of supporters of the MCA to explain the relationship between mental
activities of the mind and brain and subsequent decisions leaves open the possibility that
determinations of ‘mental malfunctioning’ may in fact be ones of ‘misfiring expression’. A
further difficulty might confront the MCA if the requirement for a cognitive impairment is
removed and the basis for a finding of incapacity is simply the URWC test.\textsuperscript{523} Here the
difficulty would involve the ability to distinguish between cases of misleading expression or
misfiring recognition. Even without any changes to the MCA, it is possible to imagine

\textsuperscript{522} \textit{ibid}, 116.
\textsuperscript{523} See the approach adopted in Ireland’s Assisted-Decision Making (Capacity) Act 2015.
situations where judges, nurses, doctors or carers, in positions of power by virtue of being able to commence a capacity assessment, label their own errors of fact, interpretive inaccuracies and failure to accommodate and support individuals, as cases of ‘misfiring expression’, when in practice they are cases of ‘misfiring recognition’.

One interpretation of the MCA holds that it responds to the fact that there is incapacitous and capacitous action and therein sets out means to distinguish between the two, which then recognises autonomous action, or calls for a substituted/supported decision making. An alternative approach could view the MCA as implicated in the act of categorising human action. Rather than being at a distance, it defines what is permissible action over others, and then labels this as soft paternalism. The MCA permits assessors to identify that a decision has to be made, question an individual’s capacity, perform the assessment of capacity and make a determination of best interests. Rather than simply identify what is capacitous or incapacitous action, it defines it, albeit somewhat unclearly. If this secondary understanding is adopted, then we can view the MCA as not simply permitting soft paternalist practice, but also opening up the possibility of cases of hard paternalism in situations of malfunctioning mental states, misfiring expression or misfiring recognition. This is disguised in the Code of Practice as the distinction between capacity and incapacity is presented as a natural distinction, rather than a product of a liberal understanding of personhood.524

8.4 Negotiating Relationality

The activity of capacity assessment can also be considered in the context of the therapeutic relationship, specifically in regard to the ongoing identities of the individual and the assessors involved. The performance of a capacity assessment necessarily involves participants engaging in a form of identity negotiation, whereby questions of “who am I” and “what do I do” are considered.525 Although the mimetic reading of capacity assessment reveals the limits of narrative identity for the individual being assessed, the activity can also be considered a site where the assessor’s identity is itself negotiated. The result of a capacity assessment is

not simply local and discrete to a particular event; rather the event can become pivotal for the individual and the assessor in how they make sense of their personal and/or professional identities. Where it is often recognised that capacity determinations are a site of balancing discourses of care and respect for autonomy, then a concern with how such determinations can impact on both individuals taking part seems justified.

In cases of narrative conflict, the requirement placed on individuals to give an account of one’s actions, in having that account subject to scrutiny and experiencing the proposal of an incapacity narrative, demonstrates how the narrative identity of an individual can become subject to critical readership and limitation. Where an individual is found to lack capacity and an alternative narrative account is put forward to guide the decision in question, the capacity assessment process can be understood to establish mimesis conditions for the future in three respects. In a most basic sense, a determination of incapacity establishes a fact about that patient. While a determination of capacity can be act specific, the act itself might be one that occurs over a lengthy period of time but also the fact of the determination can become a resource or feature of the individual’s identity going forward and of those in the individual’s life. Secondly, the determination of incapacity or capacity serves to establish guidelines around what are symbolically appropriate or inappropriate ways to talk about conditions, decisions, risk, as well as personal justifications and beliefs. Thirdly, in a determination of incapacity with a prescribed action or inaction, the individual is provided with the decision which may or may not be incorporated into their own understanding but also into the understanding of those around them going forward. Although the MCA sets an understanding of capacity as local, it should be acknowledged that determinations, the understanding of the process and the action or inaction prescribed, could have considerable global influence over the individual assessed.

Turning to the assessor’s experience of capacity assessment, the implications for their own life are considerable. The assessor, in providing an alternative account of action, in proposing an incapacity narrative, in assessing the individual’s capacity and determining a best-interests decision, is expressing an understanding of their professional identity. These activities, specifically in cases that lead to narrative conflict, are not something they do, nor can do, in every interaction they have as professionals. The activity of capacity assessment can be seen
to also establish mimesis conditions for the assessor. The performance of the assessment, as well as the relative success of the proposed incapacity narrative, can establish symbolic resources for the assessor to guide future capacity assessments. Secondly, the assessment of an individual can become part of the assessor’s own professional identity, a site whereby they can make sense of their professional responsibilities and reflect on the type of professional they are. Thirdly, a determination of incapacity can operate as a fact for the assessor in their understanding of the individual assessed going forward.

8.5 A Narrative Theory of Capacity Assessment

In drawing on the mimetic and identity negotiating dimensions of mental capacity assessment, a narrative theory of capacity assessment can be formulated. Such a theory however, is not supportive or critical of the practice of mental capacity assessment; rather it is a descriptive account of capacity assessment. The aim therein of a narrative theory is not to attempt to justify the practice of classifying an individual as lacking in capacity, but to interrogate what is happening in capacity assessment. Although a mimetic reading is possible in cases of narrative deficit, the adoption of a narrative approach is here confined to situations in which the individual articulates a narrative account of action. The three principles of a narrative theory of capacity assessment are:

i) Mental Capacity determinations are judgements arising from and sometimes relating to an individual’s personal identity but always in a relational dynamic.

ii) What is assessed in mental capacity determinations is the congruence between the narrative account of events or behaviours of the assessor and the assessed.

iii) The impetus to assess capacity begins where alternative accounts that can lead to narrative conflict are shared with or identified by an assessor of capacity. *

* Where capacity assessment is commenced at the request of a colleague or family member, the assessor may be considered not to instigate the process. Such an interpretation however is rejected. The mimetic precondition for capacity assessment is the acceptance of two narratives, the narrative of the MCA and the narrative that a decision needs to be made. Where the decision to commence a capacity assessment is at the request of another, the person who makes the request can be considered through the lens of the first two mimetic
stages set out above. The assessor who commences the assessment can be viewed as accepting the truth of narrative conflict or narrative deficit and the appropriate response of assessing capacity. The only difference from the original model is that the assessor here doesn’t observe or encounter narrative conflict or narrative deficit before deciding to assess. In accepting the recommendation of another and acting upon it, they instigate the assessment process.

The interpretation of mental capacity assessment from a narrative approach to selfhood allowed for the identification of capacity assessment as comprised of a four-stage mimetic process and as a site of narrative identity negotiation. Together, a reading of capacity assessment as mimesis and the negotiation of narrative identity inform a narrative theory of mental capacity assessment. Critically, this theory does not seek to endorse or justify the practice of conferring incapacity on persons but rather proposes a descriptive account of the phenomenon of mental capacity assessment. Accordingly, a narrative theory is not a guide for mental capacity practice nor a call for particular practice. The narrative reading developed here reveals that the cognitivist approach insufficiently addresses the first stage of capacity assessment, leaving assessors unclear as to when their duties to doubt capacity emerge. Furthermore, the failure to clarify the relation between a cognitive impairment in the mind or brain and an inability to perform a task of UWRC raises questions about the basis on which capacity determinations are made, whether individuals are labelled as lacking in capacity based on simply holding an alternative understanding, and challenges the language of capacity assessment which views capacity as something intrinsic or discrete to an individual.

The narrative approach to selfhood developed here allows for mental capacity to be considered a relational term which is utilised in interactions in which people are sanctioned to offer alternative accounts of others’ lives and actions. The question may be raised as to whether mental capacity and incapacity, as features or aspects of a broader processes of narrative selfhood, are in fact relationally constituted. The response however is not so simple. A narrative approach supports understanding determinations of mental incapacity as relationally constituted through a mimetic process. A narrative approach however does not deny that there can be impairments that underpin determinations of incapacity, but rather that a mechanism for distinguishing cases of mental malfunctioning from cases of misshapen
response, misleading expression and misfiring recognition is lacking. Regardless of the basis for a determination of incapacity, the process is mimetic in nature. In regard to capacity, a narrative approach supports the claim that some aspects of capacity are relationally constituted. Where capacity requires the competencies to avoid committing errors of interpretation and factual errors, or violating the reality and articulation constraints, the acquisition of such competences can be identified as relationally constituted. The development of these skills emerges through the assistance of others, who through acts of critical reading, not just in relation to mental capacity assessment, but also less formally, guide individuals about acceptable ways of acting and developing self-understanding. The narrative approach however does not deny that such competencies are dependent on functioning mental states. The narrative approach to mental capacity proposed here both calls for mental capacity and incapacity to be acknowledged as relationally constituted while also acknowledging aspects of both are not so constituted. A narrative approach does not deny that individuals have and experience impairments. The narrative approach however challenges the confidence that mental capacity assessment is sufficiently developed to identify cases of mental malfunctioning and the claim that it simply evaluates decision making ability.

The appeal to narrative identity in theorising mental capacity, however, can vary from approaches which view narrative identity as something one has or that they express to those which view narrative identity as something performed and negotiated with others. As such, the appeal to narrative approaches in mental capacity discourse must be scrutinised as to whether it understands the individual in terms of what they have or are on the one hand, or whether it acknowledges the activity of individuals alongside others and the role narrative can play in this.526 In Re T (Adult: Refusal of Treatment) (1992), Lord Justice Donaldson stated that the capacity of a decision is not directly related to the “rational or irrational, unknown or even non-existent” reasons for making a choice.527 A narrative approach alters this understanding slightly. Mental capacity is not related to whether a decision is rational or irrational, but rather about the perceived rationality of a decision as considered from the

526 The call to acknowledge the role of narrative identity work through stories is not supporting the claim that narrative is the only means through which identity is negotiated. See Angela Woods, ‘Post-Narrative: An appeal’, (2011) 21(2) Narrative Inquiry 399.
perspective of an individual sanctioned to question the decisions of others, who in this performance negotiates both the identity of the individual assessed, as well as their own.

A narrative approach to mental capacity assessment can be viewed then as both an alternative to but also complementary to the functional approach of the MCA. As an alternative, it challenges the inadequate consideration of the assessor’s responsibilities in the assessment process, suggests that capacity assessment may focus on something other than functional ability and proposes that capacity assessment involves identity negotiation. Although more complex than the MCA’s functional approach as it problematises the instigation of assessment, what is assessed and the notion that capacity assessment is decision specific, it highlights areas which need to be addressed if a ‘wider’ account of capacity assessment is to overcome tensions between theory and practice. In this latter sense, a narrative approach can be read as complementary as it identifies areas which need to be addressed within a functionalist approach to mental capacity.
Conclusion

The approach and theories underpinning the preceding chapters provide a nuanced and novel basis for conceptualizing mental capacity theory and practice. The application of narrative approaches to bioethics in critiquing and commenting on bioethics and mental capacity, has revealed the limitations of approaches which privilege some perspectives over others. The identification of mental capacity practice within the history of the tutelary relation dating back centuries allows for the rhetoric of empowerment and protection associated with the MCA to be challenged. The impetus after Re F to legislate for mental capacity which resulted in the MCA itself, appealed to previous historical powers removed under the MHA 1983. The appreciation that notions of incapacity historically have served medical, legal and political agendas supports a theoretical approach which seeks to understand determinations of incapacity in the context of the power relations they serve. No more is the contingent and artificial nature of current approaches to mental capacity clearer, than in the consultation documents of the Law Commission which demonstrate that the contemporary approach to capacity was chosen and as such is political. A finding of incapacity, as feminist scholars argue, is a value judgement from a particular perspective which creates a notion of difference. Allowing this understanding of the artificial positing of difference to be acknowledged, whilst recognizing the significance that determinations of incapacity have in the lives of individuals and healthcare more generally, brings to the fore the question of how mental capacity should be understood and defined but also how it should be responded to in bioethical discourse.

The combination of these critical perspectives alongside a narrative bioethics perspective, conceptualizes the issue of mental capacity practice as a question relating to how bioethics chooses to endorse certain approaches to the self and specifically how bioethics should classify mental capacity practice. Whilst narrative bioethics approaches have been subject to criticisms of limitation and application in the bioethical domain, the fundamental elements

529 The Law Commission, Mental Incapacity (Law Com no 231, 1995).
of narrative approaches scaffold a bioethical examination of mental capacity. Narrative bioethics approaches can allow for the challenging of existing narratives, attending to subjectivities and finally to resisting closure in bioethical reasoning. It can allow for an examination to turn away from the issues which the MCA is considered a legal response to, namely those who lack capacity, to a focus on the understanding of mental capacity itself and the relational context and identities of those using and experiencing mental capacity practices. It is in this reorientation by way of narrative bioethics that the question of how bioethics understands mental capacity practice comes under consideration.

Going beyond the theoretical and meta-ethical consideration of the approaches developed in these papers, an important contribution to the emerging discipline of narrative bioethics is made here by identifying how legal and healthcare practices can be reinterpreted through a narrative lens. The contemporary understanding that the MCA provides an ethical response to the problem of incapacity, has allowed for the place of narrative identity to be downplayed and understood solely as a potential resource in adhering to the MCA. In critiquing and offering an alternative understanding of mental capacity, the papers set out here each seek to contribute to discussions in narrative bioethics. The argument developed in chapter 6, that bioethical discourse can be considered an activity of narrative identity, whereby bioethicists contribute to the tradition through which healthcare and bioethical practice is negotiated, suggests a central place of narrative in bioethics itself. An alternative reading of the capacity assessment process developed in chapters 6 and 8, wherein the limitations of the intrapsychic approach are challenged by the transparency of an intersubjective approach, represents a way of doing narrative bioethics. The proposal in chapter 5 of a postmodern bioethics, grounded in a commitment to humility and awareness of the potential violence of bioethical contributions, identifies the call of narrative bioethics as involving a reflexivity on the part of the bioethicist. Finally, in chapter 8, the inability to situate a narrative identity approach to mental capacity assessment as either supportive or critical of the practice of differentiating

532 This echoes the call of Howard Brody for a postmodern bioethics as aspiring towards “greater humility” in ‘Who Gets to Tell the Story? Narrative in Postmodern Bioethics’, in in Rita Charon and Martha Montello (eds.) Stories Matter: The Role of Narrative in Medical Ethics (New York: Routledge, 2002) 25.
individuals according to mental capacity, reveals the limitations of a narrative bioethics.\textsuperscript{533} The rejection of a closure, of the imposition of an ending, on how mental capacity is to be understood, reveals the commitment to provisionality and multivocality at the heart of a narrative bioethics.\textsuperscript{534}

Stepping back, as Wood invites us to,\textsuperscript{535} from the focus on the theories and approaches applied in this thesis, a significant contribution to the literature lies in the identification of what the MCA is silent on and what is omitted from discussion. The risk, as noted by Buchanan and Brock is that in the MCA becoming a necessary legal dimension of healthcare, that the ethical issues at the heart of capacity determinations become overlooked.\textsuperscript{536} The world can become one in which patients are understood either to have or lack capacity in respect of decisions and the task of a healthcare practitioner is to simply identify cases of incapacity and follow the Act to arrive at the appropriate decision. As Minow notes, in identifying the appropriate response to those who are different, we essentialise and accept that these people are different and engender discussion to focus on the response.\textsuperscript{537} A more nuanced approach steps back and questions the mechanisms and processes through which people become constituted and accepted as different in the first place. The uptake of a narrative bioethics approach allows for emphasis to be shifted to considering what perspectives are overlooked or not considered relevant in contemporary mental capacity practice. The aim of such an approach however does not lie in seeking a newly formed or more complete understanding to inform the right ethical response but rather to identify as ethical the attending to other perspectives, subjectivities and contexts which can go unheralded.

In accordance with a narrative bioethics committed to incompleteness and humility, this thesis can be understood to suggest three further areas of research, both on a theoretical and practical level. These three areas of research in respect of transparency, subjectivities and temporality can themselves ground a future concern with education and mental capacity. These will be examined by introducing first the insights and potential implications of the two themes running through this thesis. The thesis has developed two arguments in parallel, one concerning the understanding of mental capacity and the other concerning the bioethical understanding of mental capacity. Chapter 6 highlighted the insufficiency of the MCA in guiding the practice of mental capacity assessment. The failure to adequately explain the process of assessment, as well as what instigates assessment, results in a disjoint between the Act in theory and practice. The presence of values within capacity assessment, both historical and contemporary, challenges the narrative that capacity assessment is strictly about cognitive processes. The call for a ‘new language’ in how capacity is understood, is developed by proposing an understanding of mental capacity as narrative congruence. The rulings in cases CC v KK and STCC and Heart of England NHS Foundation Trust v JB reveal the judicial concern with the values and perspectives of practitioners inappropriately influencing capacity assessment. The dynamics of interpersonal “holding and letting go”, allows for the focus on the subject of assessment to be challenged by a call for recognition of the role of others. Although the possibilities offered by narrative in regard to capacity assessment are varied, a mimetic approach developed from the work of Ricoeur, Schechtman and Lindemann, allows for the activity of capacity assessment to be acknowledged as a form of narrative activity. Crucially however, this understanding points to the potential for oppressive practices performed under the name of the MCA.

The question of how bioethics should consider or classify mental capacity practice was developed in chapters 5 and 7. Chapter 5 can be seen to identify a problem, to which chapter 7 responds. In chapter 5, a bioethics that responds to the challenge of postmodernity was developed which requires a necessary turning back and questioning of the influence of bioethical discourse. Adopting such a perspective invites bioethicists to acknowledge the

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possible violence their work supports, that their work may collude with particular perspectives and fail to acknowledge the significance of others and finally to acknowledge the relational context through which bioethical thought develops. In chapter 7, debates concerning the significance afforded to narrative identity in bioethics were identified as a lens through which bioethics can confront its own understanding of the self. The invoking of an alternative account of narrative identity which responds to perceived difficulties identified in bioethical literature, allows narrative identity to be framed as a way in which bioethicists can come to critically reflect on their practice. Significantly, narrative identity is proposed as an activity in which bioethicists operate. This allows for bioethics to be identified as involved in the co-authoring of multiple identities, and as such implicated in the lives of others.

A commitment to greater transparency in the Court of Protection concerning mental capacity practice can be aided by the insights offered by the narrative approach developed here.\textsuperscript{540} The uncovering of the ubiquity of values throughout the capacity assessment process, from sanctioned preconceptions, assessor’s values underpinning assessment and the broader historical values influencing contemporary practice, point to an area in which there could be greater transparency. That such values vary case by case can perhaps explain why it is appealing to discuss mental capacity through an appeal to objectivity or neutrality. As set out in chapter 6, the failure to adequately address the space of values in practice is problematic. The assessment of Ms E\textsuperscript{541} and Ms L\textsuperscript{542} relied on a privileging of a set of preconceptions pertaining to diagnostic categories, definitions of capacity and relevant information, whilst simultaneously denying the relevance of judgements about wisdom. The role of values in the assessment process, albeit obscured from the text of the MCA, contributes to an incompleteness in the approach to capacity therein. The irreducible but unstated role that values play in assessment undermines the coherence of the MCA in respect of its “standards” of and the “tests for ascertaining” mental capacity.\textsuperscript{543}


\textsuperscript{541} A Local Authority, E (by her Litigation Friend the Official Solicitor) v A Health Authority, E’s Parents, [2012] EWHC 1639 (COP).


In chapter 8, the identification of a four-stage mimetic process that capacity assessment is performed through, provides a means to overcome the limitations of the MCA’s approach. Significantly, it points to a set of actions or practices which healthcare practitioners must be engaged in. Therein practitioners are bridging the gap between not assessing capacity and commencing an assessment. Further research with practitioners could seek to identify how practitioners navigate this lacuna in the MCA, and overcome the ambiguity concerning implementation. Such information could assist practitioners seeking to implement the Act as the basis on which to instigate capacity assessment is attested to. Furthermore, it can help the public and persons subject to capacity assessment to appreciate the process and justifications for capacity assessment. The commitment to transparency can also include the discipline of bioethics. How bioethics as a discipline understands narrative identity as discussed in chapter 7 and how mental capacity assessment can be framed as an activity of narrative identity as set out in chapter 8, represent an option which bioethicists may seek to engage with. The invitation of a postmodern bioethics to practice with humility can support a bioethical reflexivity about how the discipline or individual bioethicists, have addressed mental capacity practice.

Following on from a commitment to transparency in practice could be a narrative bioethics concerned with the broader context and subjectivities of those who are assessed and those performing capacity assessment. As Stefan calls attention to, determinations of incapacity are not claims about characteristics or features of persons but claims emergent in and features of relations in which some are in power or authority over others. All too common is the belief that mental capacity is a problem which calls for an ethical response, without acknowledging the notion of incapacity is a lens through which some chose to view others. In chapters 7 and 8 the reading of bioethical discourse and mental capacity practice respectively as activities of narrative identity serves to highlight the role of relations of power. They can support or fail to criticize mental capacity practice and therein are identified as supporting particular way of viewing the self. The activity of narrative identity is revealed as central to and pivotal in the conferring of capacity or incapacity on another. The

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identification of narrative identity dimensions of bioethical discourse and mental capacity practice need not stop here though.

Further research could be carried out seeking to hear and acknowledge the narratives and the narrative identity activities of those involved in the capacity assessment process. In attending to the subjectivities of both assessors and those assessed, a commitment to the narrative bioethics understanding of incompleteness would be attested. While some approaches consider the narratives of those being assessed may provide assistance in identifying best interest decisions, there is a risk there that the value of the subjectivity is to simply assist in the implementation of the Act. A concern with the subjectivities of those assessed provides a way in which to resist the bias and privilege Minow identifies in the positing of difference.\textsuperscript{545} If the perspective of those assessed are only afforded relevance in the best interest approach, whilst denied relevance in the determination of incapacity, any subsequent failure to value the experience and perspectives of those assessed only serves to continue a silencing of perspectives. In attending to the experiences and understanding of those who have been found to lack capacity and those who carry out capacity assessments, the narrative of the bioethicist or assessor of capacity as expert is challenged.

The narrative proposed across this thesis that mental capacity should be understood as intersubjective as opposed to intrapsychic can complement approaches which seek to problematize the temporality of mental capacity assessment. As observed by Mackenzie and Rogers, the MCA’s conception of the self is inconsistent.\textsuperscript{546} Assessment requires a conception of the self discretely, whereby capacity is decision relative at a specific time.\textsuperscript{547} This synchronic understanding of the self is contrasted with the diachronic commitments of the Act to view the self through time, to be supported in decision making and where best interests decision is grounded in the self over time. In chapter 8, the contention that mental capacity determinations relate to a specific decision is identified as inherently problematic. Where such determinations are orientated to the future, can impact on the person into the

\textsuperscript{547} MCA, s2(1)
future and influence the relationship they have with healthcare professionals, the attempt to view mental capacity as time specific is undermined. Further research could propose an alternative narrative account of the temporality of mental capacity determination, thus problematizing the period under which the principles guiding the Act are to be applied. Such an approach could challenge both the conception of capacity as time specific but also question what duty, if any, might be owed to an individual conferred with incapacity. Although capacity can be considered decision relative, the Act could require a longer commitment to those assessed for their capacity.

These three further areas of research, which problematize the issue of transparency, subjectivity and temporality as related to mental capacity, may call for a reconsideration of the purported ‘spirit’ of the MCA as empowerment and protection.548 The period following a determination of incapacity provides one area in which the spirit may be viewed to require a pedagogical response. The linking of education to the issue of mental capacity is made by Harris in 1986, just before the period of reclamation commenced.549 The use of a paternalist intervention where an individual lacks capacity or competence, Harris argues, must be such that the intervention acts to enable and support autonomy.550 Otherwise, there is the risk that there is a failure to support and develop an individual who has the capacity for autonomy. A commitment to transparency in each case of incapacity would allow for the basis on which incapacity is determined to be disclosed. Where this is coupled with an appreciation of the impact this may have on the person assessed and in the presence of a commitment to empowerment and autonomy, the question may be raised as to how incapacity should be responded to. If the failing is on an intrapsychic model (MCA) and related to a failure to understand, retain, weigh up or communicate, the provision of education or support in that respect could be provided. If, on the basis of a mimetic reading as set out in chapter 8, the failing is one of malfunctioning mental state, misleading expression or misfiring recognition on the part of the person assessed, an educational support could be provided. Here the individual found to lack capacity would have a deficit which education can seek to

550 ibid, 43.
ameliorate. Crucially these deficits would be relational and not discrete to the individual. Where an individual’s deficits are unresponsive to education, a historic distinction could be reclaimed, between those temporarily or permanently incapacitated. Where the determination of incapacity stems from a case of misfiring recognition or misshapen response on the part of the assessors, they too could receive educational support. The provision of such education supports would complement the purported commitment to empowerment and protection of the MCA.

A concern with the subjectivities and context of those who have been found to lack capacity and a commitment to an alternative conception of temporality however may call for an educational response predicated on humility. In chapter 5 the call of a postmodern bioethics requires individuals to acknowledge the potential damage and violence that privileged discourses and practices may contribute to. The understanding of mental capacity as a form of narrative identity activity, calls for those who support the MCA to acknowledge that determinations may not be based on a cognitive failing of an individual but may be related to misshapen response, misfiring recognition or misleading expression. In cases where incapacity is conferred on the basis of one of these three and which would constitute a violation of the MCA, the issue of unwarranted paternalism is present. An educational response to all those found to lack capacity could be predicated on a humility that any determinations may constitute unjustifiable paternalism. There in, an educational response could not target a specific individual failing, but rather would focus on relations of power. The work of Paulo Freire, in advocating a form of educational practice which seeks to challenge the dehumanization of persons and a commitment to liberation, could underpin such a response.\(^551\) The aim of such an education is simply to bring about freedom, while premised on the awareness that the role of the educator is to support the empowerment of persons,\(^552\) as the an education which denies people from being fully human is itself oppressive.\(^553\) The prefacing of such an educational response to incapacity would sit with the commitment to empowerment as freedom and the commitment to protection as a rejection of oppression.


\(^{552}\) ibid., 44.

\(^{553}\) ibid., 57.
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Appendix

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