Making Health and Welfare Decisions in Old Age: Challenging the Adequacy of Mental Disability Law and Theory

A thesis submitted to the University of Manchester for the degree of

PhD in Bioethics and Medical Jurisprudence

in the Faculty of Humanities.

2016

Laura Pritchard-Jones
School of Law
# Table of Contents

Abstract.................................................................................................................. 5

Declaration and Copyright Statement................................................................. 6

The Author............................................................................................................. 7

Table of Cases..................................................................................................... 8

Table of Legislation............................................................................................. 10

Acknowledgements............................................................................................. 11

Dedication............................................................................................................ 13

Chapter 1: Introduction....................................................................................... 14

Chapter 2: Why ‘Old Age’? .............................................................................. 19

Chapter 3: Legal Background and Approach.................................................... 27
  3.1 The ‘Vulnerable’ Adult: Law, Policy, and Critique....................................... 27
  3.1.1 Stigma...................................................................................................... 32
  3.1.2 Responses............................................................................................... 36
  3.1.3 A New Way Forward for Vulnerability? ............................................... 39
  3.2 Mental Capacity.......................................................................................... 43
  3.2.1 The Law Before the Mental Capacity Act 2005.................................... 44
  3.2.2 The Mental Capacity Act 2005.............................................................. 47
  3.2.3 Criticisms of the Act and its Implementation....................................... 50
  3.3 Conclusion................................................................................................. 67

Chapter 4: Theoretical Background and Approach............................................. 68
  4.1 What Theories, and Why? ......................................................................... 68
  4.2 ‘Relational’ Autonomy............................................................................... 71
  4.3 Vulnerability............................................................................................... 79
  4.3.1 Universal and Particular Vulnerability............................................... 81
4.3.2 Sources of Vulnerability.................................................................87
4.4 ‘Othering and Dementia.................................................................91
4.4.1 ‘Othering’.....................................................................................92
4.4.2 An Intersubjective Approach......................................................98
4.5 Conclusion.....................................................................................105

Chapter 5: Abstracts of Papers.................................................................107
5.1 Ageism and Autonomy: Explorations Through a Relational Lens........107
5.2 The Good, the Bad, and the ‘Vulnerable Older Adult’.....................107
5.3 “This Man with Dementia” – ‘Othering’ the Person with Dementia in the Court of Protection..............................108

Chapter 6: Ageism and Autonomy in Health Care: Explorations Through a Relational Lens.................................................................109
6.1 Introduction.....................................................................................109
6.2 Individual Versus Relational Autonomy........................................112
6.3 Ageism in Care and its Impact on Self-Relations............................119
6.4 The Problems of Relational Autonomy: Putting it into Practice........127
6.5 Concluding Remarks.....................................................................133

Chapter 7: The Good, the Bad, and the ‘Vulnerable Older Adult’...........135
7.1 Introduction.....................................................................................135
7.2 The Legal Context of the Vulnerable Adult....................................138
7.2.1 The Historical Background.......................................................138
7.2.2 Who is the ‘Vulnerable’ Adult?..................................................141
7.2.3 (Re-)conceptualising Vulnerability..............................................145
7.3 Vulnerability and Older Adults.......................................................148
7.3.1 The Cases...................................................................................148
7.3.2 Outdated Vulnerability...............................................................150
Chapter 8: “This Man with Dementia” – ‘Othering’ the Person with Dementia in the Court of Protection.........................................................................................................................169

8.1 Introduction..................................................................................................................169
8.2 ‘Othering’ the Person with Dementia........................................................................173
8.3 Integrating the Person with Lacking Capacity into Best Interests Decision-Making: An Attempt to Avoid ‘Othering’? .................................................................179
8.4 ‘Othering’ the Person with Dementia Through Best Interests.................................188
8.4.1 Creating the Comparator.......................................................................................188
8.4.2 Deviance and Marginalisation..............................................................................190
8.5 “I Was Ever a Fighter, so – One Fight More” – The Potential of an Intersubjective Approach...............................................................................................................195
8.5.1 ‘Unifying’ the Person with Dementia...................................................................199
8.5.2 Understanding the Effects of Dementia...............................................................203
8.6 Difficulties with this Approach..................................................................................205
8.7 Conclusion....................................................................................................................207

Chapter 9: Conclusion........................................................................................................208

9.1 Ageism and Autonomy.............................................................................................211
9.2 The ‘Vulnerable Older Adult’...................................................................................213
9.3 Dementia in the Court of Protection.........................................................................215
9.4 Concluding Comments.............................................................................................218

Bibliography.....................................................................................................................220

Appendix............................................................................................................................246

Word count (main text including footnotes): 77,959.
ABSTRACT

University of Manchester

Laura Pritchard-Jones

PhD in Bioethics and Medical Jurisprudence

Making Health and Welfare Decisions in Old Age: Challenging the Adequacy of Law and Theory.

Submission Date: July 2016

Old age – and particularly the increasing numbers of older people globally and within the United Kingdom - is becoming a social and political phenomenon. Yet despite this, very little has been written on how the law – and especially mental disability law – intersects with old age. This is notwithstanding the fact that many older people may encounter conditions that impact their mental or cognitive abilities, and proportionally, may therefore be greatly affected by this area of law.

By drawing on a number of theories – sometimes termed ‘relational’ theories – which are derived predominantly from feminist theory, this thesis seeks to explore the adequacy of mental disability law for safeguarding health and welfare-related decision-making of older adults in three areas; where an older person has been subjected to ageism, where they have been the victim of interpersonal abuse, and where they have dementia and may lack mental capacity.

Within this broader goal, this thesis has two specific aims. First, to explicitly critique and challenge the adequacy of the law as it is applied in these circumstances. It is suggested in particular that a deeper analysis of the law in both its previous and current forms betrays the liberal and unduly individualistic roots of the legislative framework. These are roots that are predicated on non-interference, and an idealistic paradigm of the rational, autonomous, and healthy bodied individual. This – it is contended throughout – is an unsuitable philosophy to underpin the law, particularly where the law engages with older adults.

Second, this thesis aims to navigate a more suitable pathway within the law as it currently exists. While operating as a tool to critique the legislative framework and its underpinning philosophy, it is argued that the theories drawn upon throughout the thesis also have the potential to highlight how the law could be implemented in such a way so as to emphasise the importance of the realities of the lived experiences of old age, and particularly the experience of ageism, abuse, and dementia. Crucially, it is also suggested that such theories can help the law pay greater attention to the complex web of relationships – both positive and negative; personal and societal – that an older person may find themselves embedded within, and that frequently take on an added significance in old age.
DECLARATION AND COPYRIGHT STATEMENT

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DocuInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on Presentation of Theses.
The Author

Laura Pritchard-Jones graduated in 2006 from the University of Nottingham with an LLB (Hons). She subsequently completed her LLM in Human Rights Law, also from the University of Nottingham, in 2007. She then went on to study for a Post-Graduate Diploma in Education Studies from Bangor University in 2012. She was awarded a three-year Graduate Teaching Assistant scholarship from the School of Law, University of Manchester, to complete this doctoral research. She is currently a Lecturer in Law at Keele University.

PhD Publications:


L Pritchard-Jones, “‘This Man with Dementia” – ‘Othering’ the Person with Dementia in the Court of Protection’ Medical Law Review (forthcoming)

Other Publications:


Table of Cases

A Healthcare NHS Trust v P and Q [2015] EWCOP 15
A Local Authority v A [2010] EWHC 1549 (Fam)
A Local Authority v DL [2011] EWHC 1022 (Fam)
A Local Authority v JH [2011] EWCOP 2420
A London Borough v VT [2011] EWHC 3806 (COP)
Aintree University Hospitals NHS Foundation Trust v James [2013] EWCA Civ 65
Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67
Airedale NHS Trust v Bland (1993) AC 789
An NHS Trust v Dr A [2013] EWHC 2442 (COP)

Bedford Borough Council v C [2015] EWCOP 25
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Cardiff County Council v Ross [2011] Case No. 12063905

CC v KK [2012] EWCOP 2136
City of Sunderland v PS and CA [2007] EWHC 623 (Fam)

DL v A Local Authority [2012] EWCA Civ 253
Dorset County Council v EH [2009] EWHC 784 (Fam)
Dudgeon v UK (1981) 4 EHRR 149

E v Channel Four News [2005] 2 FLR 913
EM v SC & CM [2012] EWHC 1518 (COP)
Essex County Council v RF [2015] EWCOP 1

F v West Berkshire Health Authority [1990] 2 AC 1

HL v UK [2004] ECHR 471

IIBCC v LG [2010] EWHC 1527 (Fam)
IM v LM [2014] EWCA Civ 37
In the Matter of G (TJ) [2010] EWHC 3005 (COP)
ITW v Z [2009] EWHC 2525 (Fam)

KC v Westminster City Council [2008] EWCA Civ 198

LBL v RYJ [2010] EWHC 2665
LLBC v TG, JG and KR [2007] EWHC 2640 (Fam)
Local Authority v Health Authority [2004] All ER 480
Local Authority X v MM and KM [2007] EWHC 2003 (Fam)
London Borough of Redbridge v G [2014] EWCOP 17
London Borough of Redbridge v G [2014] EWCOP 485
London Borough of Redbridge v G [2014] EWCOP 959
London Borough of Redbridge v G [2014] EWCOP 1361

Milton Keynes Council v RR [2014] EWCOP B19
NCC v PB and TB [2014] EWCOP 14
North Yorkshire County Council v MAG [2016] EWCOP 5

PC v City of York [2013] EWCA Civ 478

R (McDonald) v Royal Borough of Kensington & Chelsea [2011] UKSC 33
R (Nicklinson & Anor) v Ministry of Justice [2014] UKSC 38
R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458
Re A (Mental Patient: Sterilisation) [2000] 1 FLR 549
Re AJ [2015] EWCOP 5
Re B (Secure Accommodation: Inherent Jurisdiction) (No. 1) [2013] EWHC 4654 (Fam)
Re BKR [2015] SGCA 26
Re C (A Patient) [1992] 1 FLR 51
Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290
Re DM [2014] EWHC 3119 (Fam)
Re F [2000] EWCA Civ 192
Re G [2004] EWHC 2222 (Fam)
Re GC [2008] EWHC 3402 (Fam)
Re MB (Medical Treatment) [1997] 2 FLR 426
Re MM [2011] 1 FLR 712
Re MN [2015] EWCA Civ 411
Re NRA [2015] EWCOP 59
Re P (Statutory Will) [2009] EWHC 163 (Ch)
Re Peter Jones [2014] EWCOP 59
Re S [2002] EWHC 2278 (Fam)
Re S [2003] EWHC 1909 (Fam)
Re S and S (Protected Persons) [2008] EWHC B16 (Fam)
Re SA (Vulnerable Adult with Capacity: Marriage) [2005] EWHC 2942
Re SK [2004] EWHC 3202 (Fam)
Re T (Adult: Refusal of Medical Treatment) [1993] Fam 95
Re X [2014] EWCOP 25
Re X [2015] EWCA Civ 599
Re Y (Mental Patient: Bone Marrow Donation) [1997] Fam 110

SCC v LM [2012] EWHC 1137 (COP) [84]
Shtukaturov v Russia (2012) 54 EHRR 27
Somerset County Council v MK [2014] EWCOP B25
Spencer v Anderson [2016] EWHC 851 (Fam)
Stoke City Council v Maddocks [2012] EWCOP B31

Watts v United Kingdom (2010) 51 EHRR SE5
WCC v GS [2011] EWHC 2244 (COP)
Westminster City Council v Sykes [2014] EWHC B9 (COP)
Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB)
Winterwerp v The Netherlands [1979] 2 EHRR 387
Wye Valley NHS Trust v B [2015] EWCOP 60

X County Council v AA [2012] EWHC 2183 (COP)
### Table of Legislation

**Domestic Legislation**
- Adult Support and Protection (Scotland) Act 2007
- Care Act 2014
- Court of Protection (Amendment) Rules 2015
- Criminal Justice and Courts Act 2015
- Domestic Violence Crime and Victims Act 2004
- Mental Capacity Act 2005
- Mental Health Act 1983
- National Assistance Act 1948
- Safeguarding Vulnerable Groups Act 2006
- Serious Crime Act 2015
- Social Service and Well-being (Wales) Act 2014
- Youth Justice and Criminal Evidence Act 1999

**International Legislation**
- United Nations Convention on the Rights of the Child
- European Convention on Human Rights and Fundamental Freedoms
- United Nations Convention on the Rights of Persons with Disabilities

**Other**
- Charter of Rights for People with Dementia and their Carers in Scotland (2009)
- Declaration of Rights for Older People in Wales (2014)
ACKNOWLEDGEMENTS

First and foremost, my unreserved thanks go to my supervisors, Kirsty Keywood and Simona Giordano. Thank you for your patience, guidance, encouragement, and constructive criticism on multiple drafts of my work, as well as the continuous personal, professional, and academic support you have provided me with during my studies. I have been incredibly lucky to benefit from your expertise.

I am also indebted to the School of Law at the University of Manchester for funding me with a Graduate Teaching Assistant scholarship. But for the scholarship, it would not have been possible to complete this thesis.

I have also been lucky enough to make a number of great friends during my time at Manchester, in particular Beverley Clough, Mark Eccleston-Turner, Chris Kay, and Paul Skowron. Thank you for the countless coffees and chats, for reading and re-reading different versions of the same piece of work, and for your patience and for lending an ear when I needed to rant. More importantly, thank you for talking me down from a metaphorical ledge on more than one occasion when I was hell-bent on throwing the towel in!

A large number of other colleagues and friends at both the University of Manchester and further afield have also been a continual source of support, advice, and encouragement over the last three and a half years – and for which I am incredibly grateful. Special thanks in particular go to my fellow students on the Bioethics and Medical Jurisprudence PhD, to Jackie Boardman for being so helpful and answering my many queries, to Margot Brazier for her professional support and encouragement, Alex Mullock and Neil Allen for their thought-provoking comments on my work, and to Peter Tyldesley for being the font of much sensible (and some not-so-sensible!) advice, and more importantly, for being a much needed source of sarcastic and light-hearted relief!

I turn finally to those members of my family who have been so fundamental to this piece of work. Mum – simply put, thank you for your belief in me over the last 31 years, even when I had little of it myself. I cannot do justice in writing to the many ways you have supported and encouraged me – but thank you for all of it. Taid – my wonderful grandfather – although you passed away before I had even secured a place on a PhD, you have inspired the dedication, the
commitment, and the work that I have put in to this thesis. I am lucky enough to know that you would have been incredibly proud to see it get to this stage. Thank you for 25 years of your unrivalled sense of humour, of dedication and profound loyalty to your family, and for just being ‘Taid’. My thanks also go to my Nain – Dilys, my Dad - Gwyn, as well as my brother Andy, and my sister Kate, and their respective partners for their encouragement.

I cannot end without mentioning my beloved best friend and partner in crime - my Great Dane, Lilah. Thank you for keeping me company, for being a constant source of laughter and amusement, for reminding me to leave the desk and go for a walk, but most of all - for your unconditional love.
For Taid
Ernest Holmes
06/03/1931 – 11/11/2010

“For hearts of truest mettle
Absence doth join and Time doth settle.”

- John Donne (1572-1631)
CHAPTER 1: INTRODUCTION

‘…the old person was of no interest – no one took the trouble to study him as he really was.’

Most people will be familiar with the rhetoric around the ‘problem of’ - and problems associated with - old age. The proportion of the population that is aged 60 and over is increasing at a fast pace both in the United Kingdom, and globally. Dementia is becoming a ticking ‘time bomb’ and is a ‘fight’ that needs to be won. Reduced budgets and changes to working conditions have increased the fear of the rise of ‘ageism’ in health and social care.

There is, furthermore, increasing concern over the treatment of older people with dementia and other cognitive impairments – concern that they are marginalised from decision-making processes where they may lack capacity, for example.

Large-scale incidences of the abuse of older persons, both in institutions and at home, have also gained recent prominence in the

---

public domain, and have culminated in wide-ranging reports in to events at the Mid-
Staffordshire NHS Trust, a number of south Wales care homes, as well as reports by the Older
People’s Commissioner for Wales, the Equality and Human Rights Commission and the
Joint Committee on Human Rights. Concerns such as those listed here have even translated
on to the international arena – with both academic and policy discussions recently opening on
the potential for a new international human rights convention for the protection of rights of
older people, given the widespread global violation of rights that they experience.

Despite this increasing social and political focus on old age, little has been written from a legal
perspective on old age, and particularly the experiences of making health and welfare related
decisions in old age. As Newdick wrote in 1996, “[t]he elderly” have never commanded
sufficient political attention. It might be just as easy to exchange the word ‘legal’ for the
word ‘political’ in this statement – the elderly have never commanded sufficient legal attention.
This is despite the Law Commission noting long ago that the rise in the older population was
one of the impetuses for reforming mental disability law.

---

8 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Stationery Office 2013). This Report
is not a public inquiry into the abuse suffered by older persons specifically, however a large proportion of the
evidence received by both this inquiry - and its predecessor, the independent inquiry - directly relates to treatment
of older persons within the setting of the Mid-Staffordshire NHS Trust.
9 Margaret Flynn, ‘In Search of Accountability: A Review of the Neglect of Older People Living in Care Homes
Investigated as Operation Jasmine’ (Welsh Government 2015).
10 Older People’s Commissioner for Wales, Dignified Care: The Experiences of Older People in Hospitals in
Wales (Older People’s Commissioner for Wales 2011)
11 Equality and Human Rights Commission, Close to Home: An Inquiry into Older People and Human Rights in
Home Care, (2013)
12 Joint Committee on Human Rights, The Human Rights of Older People in Healthcare: Eighteenth Report of
13 See, for example, Kwong-Leung Tang and Jik-Joen Lee, ‘Global Social Justice for Older People: The Case for
International Legal Instrument to Promote and to Protect the Rights and Dignity of Older Persons’; United Nations
Office of the High Commissioner for Human Rights, ‘Normative Standards in International Human Rights Law
14 Christopher Newdick, ‘Patients, or Residents?: Long-Term Care in the Welfare State’, (1996) 4 Medical Law
Review 144-170, 146.
15 Law Commission, Mental Incapacity, (Law Com No 231, 1995) paras 1.3 and 2.35.
This area of law – particularly concerning health and welfare decision-making – is a fast-paced one; recent and on-going developments in this area will continue to significantly impact on older people. Legal developments in the Supreme Court extending the scope of the meaning of ‘deprivation of liberty’ and the associated complexity of the deprivation of liberty safeguards, for example, have led to a consultation on reform by the Law Commission into aspects of the Mental Capacity Act 2005, and it looks likely that legislative change will be forthcoming in this field in the near future. There is also a clear commitment to retaining the inherent jurisdiction of the High Court to ‘[mend] holes in the legal fabric that would otherwise leave individuals bereft of a necessary remedy’, and, more specifically, to deal with situations where a person has been unduly influenced in making a decision and where they do not fall within the provisions of the Mental Capacity Act 2005. Indeed the Court of Appeal recently explicitly stated that the abuse of older adults is one justification for the retention of the jurisdiction.

On a theoretical level, there is an increasing call to view mental disability law, and issues that impact on decision-making - particularly for older people - from a more ‘relational’ perspective. In effect, there is a need for the law and the principles that underpin it to be more cognisant of the fact that all people are embedded in a complex web of relationships with the state and other organisations and individuals, which can have both positive and negative

---

19 Spencer v Anderson [2016] EWHC 851 (Fam) [59].
impacts on the persons within those relationships. Given that old age frequently brings with it a decline in cognitive and physical capabilities, and therefore an increasing need for relationships – especially relationships of care – a recognition of this, that everyone is relationally situated, is perhaps particularly important for older people. While some of the theoretical literature in this area has focused on old age, the extent to which such an approach can be translated into practice in understanding and shaping the law of England and Wales as it applies to - and has been implemented in respect of - older people, has not yet been forthcoming. This thesis will consider whether such approaches can also better inform the application of the law and its underlying principles in decision-making across three distinct areas: for older people who have been the subject of ageism, victims of domestic elder abuse, and persons with dementia who are deemed to lack capacity under the Mental Capacity Act 2005. The originality of this thesis, then, lies in two areas. First, it represents an attempt to develop the literature as to how mental disability law and policy applies to older people - an area that has had comparatively scant attention in academic legal scholarship. Second, it develops this critique of the law and its application in old age by drawing on feminist and contextually-focussed theories that emphasise the importance of understanding, and as Jonathan Herring argues, upholding valuable relationships.


In light of these aims, chapter 2 begins by considering some of the common characterisations of old age – but more importantly, why it is necessary to consider these legal and theoretical issues specifically in the context of old age. Chapter 3 outlines the predominant legal context and approach that forms the basis for the remainder of the thesis by focusing on two particular legal paradigms – the concept of the ‘vulnerable adult’, and mental capacity – specifically the legal framework under the Mental Capacity Act 2005. Chapter 4 outlines the background to the theoretical approaches adopted in the rest of the thesis. It focuses in particular on four aspects: what features characterise ‘relational’ accounts of autonomy; the conceptual theoretical shift in understanding vulnerability as both universal and particular and how such an analysis can better inform legal responses to vulnerability; the notion of ‘othering’, which has long since been expounded by both feminist and disability theorists; and finally, the potential of an intersubjective approach to subvert the process of ‘othering’. Finally, chapter 5 provides a brief summary of each of the research questions and the three chapters that form the remainder of the thesis.
CHAPTER 2: WHY OLD AGE?

‘Old age is an autumn, filled with ripe fruit: it is also a barren winter, and we hear of its coldness, snow and frost. It has the sweet gentleness of a lovely evening. But it is also associated with the dark sadness of twilight.’

What is old age? Why does it matter? Are there certain features associated with old age which make it important to look at this particular area of law? Before moving on to a discussion of the legal and theoretical backgrounds in the following chapters, it is necessary to confront these somewhat difficult questions, which this chapter aims to do. In doing so, this chapter does not seek to provide a ‘definition’ of old age, but rather seeks to elucidate and explain some of the features associated with old age that may impact on the way older persons make decisions, and which form the factual basis for chapters 6, 7, and 8. More importantly, this chapter seeks to highlight the importance of being aware of such aspects of old age in order to critique and analyse the law. It is suggested throughout that older age is characterised to some extent by certain biological features, but that these may, in turn, lead to negative social interactions. As such, old age - for the purposes of this thesis - is not a one-dimensional state-of-being, but is characterised by both distinctive biological and social features.

It is not possible - nor arguably desirable - to distinguish precisely when someone has become ‘old’, or to try and define old age. Within policy, however, there are some commonly agreed ages as to when someone may be considered ‘older’. The United Nations (UN), for example, in the 1982 Vienna Plan of Action on Aging, and its successor, the 2002 Madrid Plan of Action

1 Simone de Beauvoir, Old Age (P O’Brien tr, Penguin 1977) 237.
on Aging\textsuperscript{3} – both of which were designed as policy guides on how UN states could prepare for a global increase in the number of older people – suggest the age of 60. The World Health Organisation (WHO), however, suggests between 50 (in developing nations) and 65 (in developed nations).\textsuperscript{4} Recognising the arbitrariness of trying to define old age, and in particular trying to define old age solely by reference to chronological age, however, the WHO goes on to suggest that ‘[t]he common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous.’\textsuperscript{5}

The idea implicit within the WHO’s statement suggests that in addition to chronological markers, there are other, more important aspects to old age that demarcate it from other stages of the life course. Noting these chronological markers of old age alone then, without reference to other aspects of old age, does not therefore assist much in answering the original question in this chapter – what is it about old age that marks it out as a distinct period of life that is worthy of study in relation to mental disability law and theory? To answer this more fully, there are two aspects in particular that we must turn to: biology – as per the WHO’s statement above - and society. Just as Phillippe Ariès argued in his seminal work on children and childhood,\textsuperscript{6} old – or older – age has no clear definition - it has both biological markers, as well as distinctive social aspects.

\textsuperscript{5} ibid.
\textsuperscript{6} Philippe Ariès, Centuries of Childhood: A Social History of Family (R Baldick tr, Pimlico 1996). Drawing on works of art, Ariès’ central thesis was that ‘children’ as a category – that is, biologically distinct from adults – existed for many hundreds of years, but that ‘childhood’ as a specific period in human life is a recent socially constructed phenomenon.
Biologically, as Giordano notes\(^7\), there are certain physical illnesses and conditions which become more likely past a certain age. For the purposes of this thesis, these conditions on their own may well impact on the ability of an older person to make a decision. Physical and neurological conditions such as strokes and diabetes become more prevalent as a person ages chronologically, and may lead to changes in a person’s cognitive abilities, for example. Similarly, some forms of dementia – particularly vascular dementia and Alzheimer’s - also become more prevalent as a person grows older. Approximately 800,000 of around 850,000 persons living with the condition in England and Wales are over the age of 65.\(^8\) Furthermore, two thirds of all persons with dementia are over the age of 80, and one sixth are over the age of 90.\(^9\) In addition to these, old age, and especially the ‘fourth age’ – extreme old age ‘where the infirmities and dependencies associated with ageing take their toll’\(^10\) – may also bring with it distinct physical changes not linked to particular medical conditions, such as frailty, poorer eyesight, hearing, and reduced mobility, for example. These changes may, in turn, lead to certain emotional responses, such as feelings of isolation, loneliness, and depression.\(^11\)

Biologically then, older age, particularly late old age, does bring with it differences – particularly changes in embodiment and cognition – that are statistically less present in younger ages.

---


\(^9\) King’s College London and the London School of Economics, ‘Dementia UK: The Full Report’ (Alzheimer’s Society 2007) para. 3.10.


Although biological or physical ageing is a shared experience for many people, albeit experienced differently by each individual, there is also a distinct social dimension to old age. This is not to say that old age is entirely a social construction or that old age can be defined by how society interacts with older persons. It does, however, mean that there may be certain social problems more frequently encountered by older persons, and that closer scrutiny of these is required. Certain social interactions are more likely to be experienced in later life – and, more invidiously, empirical research also suggests that such physical and cognitive differences that are more prevalent as a person ages - as outlined above - are a particular risk factor for these social interactions. As noted in the introduction to the thesis, research indicates that not only is the abuse of older adults – explored in more detail in chapter 7 - of increasing concern, but that the conditions discussed in the preceding paragraph - such as dementia, and physical frailty – are themselves risk factors for such abuse. Furthermore, ageism – attitudes about older people as being ‘doddery’ or ‘forgetful’ at one end of the spectrum, or as ‘big children’ or ‘worthless’ at the other end of the spectrum, explored further in chapter 6 - is now increasingly being recognised as a dimension of old age. Research also indicates that such physical and cognitive changes may also contribute to why older adults experience this ageism. As Carney and Gray argue:

Biological ageing, particularly physical signs of biological ageing, are used to socially impose an inferior status on people as they age. The impact and severity of this inferior status is cumulative; older people with impairments, dementia, disability, or few economic resources are among the lowest status in society. Ageism contributes to the oppression of older people as it is internalised, eventually impacting on the capacity of older people to speak for themselves.17

In effect, old age is not simply about chronological age alone. It is about the changes in embodiment and experiences of embodiment, as well as changes in societal interaction, experienced as a person ages chronologically. As Hall argues, ‘[o]ld age is not, of course, a uniform or identical experience. Through this theoretical lens, “old age” is defined by the confluence and interaction of its embodiment or corporeality with the social meaning of visible, embodied aging.’18 Although old age brings with it certain biological realities, it is also informed by how society makes sense of, understands, and responds to it.

Yet despite these changes experienced in old age – and particularly in extreme old age - many sociologists and lawyers disagree as to whether any purpose can genuinely be served by distinguishing ‘old age’ as a distinct category in the first place. Bill Bytheway, in his discussion of ageism from a sociological perspective, suggests that ‘a rethinking of ageism cannot be based upon the presumption that old age exists...we must critically examine the logic for creating a category of people and calling it the elderly, the old or the aged’.19 He goes on to argue that old age as a category serves no useful purpose and serves only to demarcate

18 Margaret Isabel Hall, “Old Age” (Or, Do We Need a Critical Theory of Law and Aging?) (2014) 35 Windsor Review of Legal and Social Issues 1-21, 11.
‘difference’ from ‘normality’ even further – as Andrews interprets his argument, ‘he believes [the category of old age] is the cornerstone upon which ageism is propped’.\textsuperscript{20} This argument has also found its way into the legal debate – more specifically, the debate on whether there should exist a specific international human rights convention for protecting the rights of older persons as there are for disabled persons,\textsuperscript{21} and children.\textsuperscript{22} In ‘sounding a note of caution’\textsuperscript{23} against a new convention, John Williams argues that ‘[t]o provide [older people] with a special convention is arguably ageist and risks infantilising older people’.\textsuperscript{24} In effect, the creation of such a convention may serve to reinforce ageist stereotypes and differentiate ‘older people’ from everybody else even further. Moreover, it has been suggested that delineating old age as a separate time of life is not only undesirable, but perhaps an impossible task given the heterogeneity of the group of people we frequently call ‘older persons’. Grouping all older persons together, to use Frédéric Mégret’s term, risks ‘essentializing’\textsuperscript{25} old age, when older people as a group are in fact diverse, and experience a number of intersecting identities.

There are, of course, differences between the argument advanced by Bytheway, and that advanced by Williams. Bytheway’s argument is based on a denial of old age completely as any sort of useful tool in the fight against ageism, while Williams suggests that old age in itself should not be used as a basis for a new legal convention. Yet both arguments rest, in part and to varying extents, on masking or denying the fact that old age may well bring with it

\textsuperscript{21} The United Nations Convention on the Rights of Persons with Disabilities.
\textsuperscript{22} The United Nations Convention on the Rights of the Child.
\textsuperscript{24} ibid. 141.
\textsuperscript{25} Frédéric Mégret, ‘The Human Rights of Older Persons: A Growing Challenge’ (2011) 11(1) Human Rights Law Review 37-66, 43. Despite this, Mégret continues by arguing that a new convention is necessary, given the widespread and systematic human rights violations experienced by older people, and that furthermore, such violations are different in nature to the violations suffered by other groups currently protected in international human rights law.
substantive and significant changes when compared against other stages of the life course. If the lived reality of old age, and particularly late old age, is characterised to some extent by changes and deterioration in biology, embodiment, cognition, and social interactions, then it is important to examine whether the law – and particularly mental disability law – is adequately equipped to recognise, respond to, and deal with the reality of such experiences. Indeed, if - as is suggested throughout this thesis - the law is based on an unduly individualistic premise that that takes the atomistic, healthy, and able bodied ideal as the paradigm, then it is entirely possible that the law is *not* enabled to respond to issues that face older people – whether these issues be biological or societal – and a rethinking of the law and its underpinning theory is required. If we cannot or should not envisage any category of ‘old age’ at all, as Bytheway suggests, then we have nothing by which to measure the adequacy of the law in dealing with those experiences that I have suggested above *are* more common in older age, and our hands are tied as to assessing whether the law functions so as to serve the interests of older persons, and the realities of their experiences. In effect, there is nothing by which to assess the correctness of Williams’ assertion that ‘[l]aw both creates and reinforces ageist stereotypes and seems inaccessible and unsuited to the needs of older people’.\(^\text{26}\) It is for this reason that an analysis of the law around decision-making in health and welfare in old age is required. If ageism, elder abuse, and dementia *are* a reality for some people in older age, then it is imperative that we can evaluate whether the law is adequately equipped to deal with these issues. In order to do this, however, we must acknowledge that these problems exist, and exist predominantly for older adults.

It is worth noting here that there are, of course, also positive aspects to old age identified within the literature. There has, for example, been much written on the ‘young-old’ - those that ‘are breaking down negative stereotypes of old age because they are relatively healthy, often well-educated and well-off, free from responsibilities of family, and politically active’.  

This, sometimes reflected in conceptualisations of ‘successful ageing’, or the ‘third age’, revolves around the avoidance of disease and disease-related disability, the preservation of a high level of physical and cognitive abilities, and maintaining an active engagement in life, and is ‘a time of leisure, self-realisation, consumption, activity and opportunity.’ If, however, as suggested in chapters 3 and 4, a central concern of this thesis is to expose and dispel the liberal underpinnings of the law that revolve around idealistic notions of autonomy and independence, then an analysis of the law in the context of ‘successful ageing’ or the ‘third age’, which may be a period of the life course where individuals are more likely to conform to such ideals of autonomy and independence, may not provide a particularly fruitful opportunity to challenge the law.

---

28 ‘The life phase in which there is no longer employment and childraising to commandeer time, and before morbidity enters to limit activity and mortality brings everything to a close...[when] they can, within fairly wide limits, live their lives as they please, before being taken over by a fourth age of decline’: Robert Weiss and Scott Bass, Challenges of the Third Age: Meaning and Purpose in Later Life (OUP 2002) 3.
CHAPTER 3: LEGAL BACKGROUND AND APPROACH

‘And as we write and talk passionately about what to do with the body of the incompetent, we should be careful not only about what we say, but also about the way in which we say it.’

There are two key legal frameworks that form the central focus for this thesis. The first is the notion of the ‘vulnerable adult’ as deployed in mental disability law and policy, and particularly vulnerability as it is understood within the context of the inherent jurisdiction. The second is the framework that has been used to make decisions on behalf of incapacitated adults since 1990 and is now statutorily enshrined in the Mental Capacity Act 2005. This chapter briefly considers how these two legal tools have developed thus far, and explores the debate surrounding them – particularly as the latter has been applied to older persons, as well as noting how the remaining chapters in this thesis build upon the existing literature in this area.

3.1 The ‘Vulnerable’ Adult: Law, Policy, and Critique

The notion of the ‘vulnerable’ adult is one that is deployed in various legal spheres, from groups considered ‘vulnerable’ in health care research and resource allocation, to witnesses.

---

1 Louise Harmon, ‘Falling off the Vine: Legal Fictions and The Doctrine of Substituted Judgment’ (1990) 100(1) Yale Law Journal 1-72, 71. One of the broad arguments presented in this thesis is that the courts respond inappropriately to issues that face older persons, both linguistically and in terms of the types of responses they invoke. It is for this reason that I use this quote here – that the courts should not only be aware of what they do with older persons, i.e. what the law is, but also the way in which they do it, i.e. how they implement the law.

2 The inherent jurisdiction is the authority of the High Court to invoke a remedy where it is not provided for by statute. This, according to Munby J, is ‘a jurisdiction in relation to incompetent adults which is for all practical purposes indistinguishable from its well-established parens patriae or wardship in relation to children’: E v Channel Four News [2005] 2 FLR 913 [55].

3 F v West Berkshire Health Authority [1990] 2 AC 1.

4 There is, to the best of the author’s knowledge, no literature on the concept of the vulnerable older adult within law and therefore the ensuing literature review on vulnerability draws on broader mental disability law literature on this subject.

considered ‘vulnerable’ in the criminal justice system. This chapter - and chapter 7 - focuses on the legal contours of what makes a ‘vulnerable adult’ within mental disability and adult safeguarding law and policy in England and Wales. Generally speaking, a ‘vulnerable’ adult in this domain is an adult who has cognitive or physical impairments, and who may be compromised by virtue of some form of undue influence, coercion, or abuse. The Department of Health’s No Secrets guidance for example, implemented in 2000 to provide a policy framework for local authorities on safeguarding adults from abuse, defined a vulnerable adult as someone who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

This explicitly drew on the definition of a vulnerable adult provided in the 1990s by the Law Commission, which stated that:

Vulnerability is in practice a combination of the characteristics of the person concerned and the risks to which he is exposed by his particular circumstances. For some it will be the result of physical disability, where the people concerned cannot protect themselves from unwanted restraint. For others, a deterioration of memory or alertness prevents them from asking for the services which would enable them to live as independent a life as possible.

---

6 Youth Justice and Criminal Evidence Act 1999, ss 16-18, which makes available special measures for witnesses considered vulnerable through age, incapacity, or fear and distress about testifying.

7 Department of Health, No Secrets (Department of Health 2000).

8 This has now been superseded by the statutory safeguarding provisions contained within the Care Act 2014, discussed briefly later.

9 Department of Health (n 7) para 2.3.

10 Law Commission, Mentally Incapacitated and Other Vulnerable Adults: Public Law Protection (Law Com CP 130, 1993) para. 2.22. The report continued, in paragraph 2.29, to adopt the same definition of ‘vulnerable adult’ as the Ne Secrets guidance adopted subsequently: ‘A person is vulnerable if by reason of old age, infirmity or disability (including mental disorder within the meaning of the Mental Health Act 1983) he is unable to take care of himself or to protect himself from others.’
This approach to vulnerability is also replicated elsewhere. The offence of causing or allowing the death of a vulnerable adult under section 5 of the Domestic Violence Crime and Victims Act 2004, for example, applies only to an adult who is ‘vulnerable’ under its terms; ‘a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise.’\textsuperscript{11} A similar definition can also be found in the Safeguarding Vulnerable Groups Act 2006, which states that a person is considered ‘vulnerable’ if, \textit{inter alia}, he ‘has particular needs because of his age’\textsuperscript{12}, ‘has any form of disability’\textsuperscript{13} or has a ‘physical or mental problem of such prescription as is prescribed’.\textsuperscript{14}

More importantly for this thesis, this approach to vulnerability has also been increasingly adopted by the courts when faced with the issue of whether it is able to intervene in the decision-making of those who are considered ‘vulnerable’, but not necessarily \textit{mentally incapacitated}, by deploying the High Court’s inherent jurisdiction. \textit{Re SA}\textsuperscript{15} involved an application by the local authority to protect an 18-year-old girl who had communication difficulties from an arranged marriage despite the fact that it was agreed that she did in fact have capacity to marry. In deciding the case, Munby J provided an indication of when the jurisdiction could be deployed, and held that it could be invoked in respect of a vulnerable adult, who,

\begin{itemize}
  \item even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to
\end{itemize}

\textsuperscript{11} Domestic Violence Crime and Victims Act 2004, s 5(6).
\textsuperscript{12} Safeguarding Vulnerable Groups Act 2006, s 56(9)(a).
\textsuperscript{13} Safeguarding Vulnerable Groups Act 2006, s 56(9)(b).
\textsuperscript{14} Safeguarding Vulnerable Groups Act 2006, s 56(9)(c).
\textsuperscript{15} [2005] EWHC 2942 (Fam).
make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.\footnote{ibid. \cite{77}.} He continued with an oft-cited\footnote{This notion of a vulnerable adult has been cited in subsequent cases, including: \emph{LBL v RYJ} [2010] EWHC 2665 (Fam), and approved by the Court of Appeal in \emph{DL v A Local Authority} [2012] EWCA Civ 253.} notion of who could be considered a ‘vulnerable’ adult for the purposes of the jurisdiction:

In the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity. This, I emphasise, is not and is not intended to be a definition. It is descriptive, not definitive; indicative rather than prescriptive.\footnote{Above (n 15) \cite{82}. This wording replicates the wording of the National Assistance Act 1948, s 29(1): A local authority may…make arrangements for promoting the welfare of persons to whom this section applies, that is to say persons aged eighteen or over who are blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities…’.}

This, as argued further in chapter 7, is reflective of how ‘vulnerability’ has been conceived more broadly by the courts. Such an approach is also evident in the later case of \emph{Local Authority X v MM and KM},\footnote{[2007] EWHC 2003 (Fam).} for example, involving a woman with a number of cognitive impairments including a moderate learning disability, as well as paranoid schizophrenia, and who had also been subjected to sexual abuse as child. The issue for the Court in that case was whether, \emph{inter alia}, she had capacity to consent to residence, contact, and marriage, and if not, what would be in her best interests in respect of these issues. Again, Munby J adopts a similar approach to vulnerability as that taken in the earlier case, and states that ‘the appropriate role of the law
here is to protect the vulnerable, who as such may become easy targets for abuse or who may find themselves in exploitative contexts’. In effect, the notion of vulnerability as deployed within safeguarding and mental disability law, and drawn upon by the courts, is a status based on the presence of some form of internal characteristic, such as old age, or a physical or cognitive impairment, coupled with a risk of harm, abuse, coercion, or undue influence. It is a fusion of inherent vulnerability, which ‘resides in a person’s individual characteristics, defined by, inter alia, age, gender, or the presence of a particular illness or disability,’ with situational vulnerability - or the ‘risk of circumstances arising in which the ‘vulnerable adult’ will be subject to malign intentions or influence.’ More specifically, the situational vulnerability depends on the presence of an inherent vulnerability. As Sherwood-Johnson notes in the context of Scottish adult protection policy, the risk of abuse or harm, ‘is caused by factors inherent to ‘disability, mental disorder, illness or physical or mental frailty’’. For clarity, this approach to vulnerability is hereinafter referred to as the ‘status-based’ approach.

A number of criticisms of this status-based conceptualisation of vulnerability have emerged in the academic literature. These criticisms generally fall in to two mutually dependent themes. First, the potential of status-based vulnerability as a legal tool to reinforce the stigma associated with physical and cognitive impairments, or other inherent characteristics that may be seen as weaknesses, such as old age. Second, because of the reinforcement of this stigma, the types of legal responses it envisages for such vulnerability. While these criticisms do have merit, particularly in relation to the notion of vulnerability currently present under the inherent jurisdiction, in the next chapter I argue that some aspects of these criticisms may be overcome.

---

20 ibid. [130] (emphasis added).
22 ibid.
by drawing on the recent theoretical debate around vulnerability, which seeks to reconceptualise the term on a fundamental theoretical basis as being both universal and particular. In chapter 7, these two ideas are drawn together to argue that the courts’ current idea of the ‘vulnerable older adult’ remain rooted in the status-based approach to vulnerability, but drawing on the more recent theoretical literature may circumnavigate some of these criticisms. As such then, this section seeks to begin an argument continued later in chapter 7. This argument is that the retention of the ‘vulnerable adults’ inherent jurisdiction’ is not necessarily unwelcome as a tool to safeguard decision-making, as Hewson has suggested,24 nor should the notion of vulnerability be rendered defunct, as others have,25 but that a reformulation of vulnerability enables the jurisdiction to offer a more suitable forum for exploring the intersection of cognitive impairments and abuse in old age. Furthermore, it is possible - as both Clough,26 and Herring and Wall27 have argued, and as will be explored shortly - that it is perhaps a more suitable forum than the Mental Capacity Act 2005 given the flexibility of responses that it is capable of implementing. This may be seen from the fact that on a number of occasions, courts have had to resort to the use of the jurisdiction where the remedies sought have not been available under the Mental Capacity Act.28

3.1.1 Stigma

One of the main concerns regarding the current use of the term vulnerability as it has been historically deployed by the inherent jurisdiction, and by adult safeguarding law more generally, however, is its potential to reinforce the stigma that has traditionally been associated

with impairments, to the effect that persons with such impairments are seen as passive, helpless, and incapable. As Sherwood-Johnson notes, a particular concern in this area is that while the term ‘vulnerable’ can mean many things, it draws particular analogies with the state of childhood,\(^{29}\) which recent adult safeguarding policy has sought to move away from.\(^{30}\) Indeed it is indicative of the strength of feeling around this point that during the Department of Health’s consultation process on the reform of No Secrets,\(^{31}\) 90% of respondents to the consultation thought the existing definition of vulnerability in No Secrets – as noted above was of little use, and wanted a replacement term.\(^{32}\)

The predominant concern here, as Dunn, Clare, and Holland note in their review of the ‘vulnerable adult’ case law before the implementation of the Mental Capacity Act 2005,\(^{33}\) is that the approach to vulnerability deployed by the courts ‘reawakens the ghost of a ‘status approach’’\(^{34}\) to safeguarding, and to safeguarding decision-making – a concern that was shared by Donnelly in her earlier work.\(^{35}\) In effect, it potentially paves the way for the courts to intervene solely based on the presence of an impairment, with little or no analysis of other, intersecting factors that contribute to the experience of vulnerability, and is an approach that has been wholeheartedly rejected as unsuitable, paternalistic, and stigmatising for persons with


\(^{30}\) One of the six key principles underpinning adult safeguarding in the statutory provisions contained within the Care Act 2014 is empowerment: ‘people being supported and encouraged to make their own decisions and informed consent’: Department of Health, *Care and Support Statutory Guidance* (Department of Health 2016) para. 14.13. The Guidance later continues: ‘[w]hat happens as a result of an enquiry should reflect the adult’s wishes wherever possible, as stated by them or by their representative or advocate.’ (para. 14.79).

\(^{31}\) Department of Health (n 29).


\(^{33}\) Dunn, Clare, and Holland (n 21).

\(^{34}\) *ibid. 244.*

\(^{35}\) Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity, and the Limits of Liberalism* (Cambridge University Press 2010) 126-7. In her more recent work, Donnelly suggests that viewed through Fineman’s lens, ‘a focus on vulnerability offers the potential for an approach to law which seeks to address underlying impediments to agency rather than designating vulnerable subjects as ‘other’ in the way in which the traditional capacity-based approach responded to people lacking capacity’: Mary Donnelly, ‘A Legal Overview’ in C Foster, J Herring and I Doron (eds), *The Law and Ethics of Dementia* (OUP 2014) 279.
such impairments – particularly mental or cognitive impairments.\textsuperscript{36} As Brown summises, this approach to vulnerability is objectionable because ‘calling individuals or groups ‘vulnerable’ can act to exclude and stigmatise them’.\textsuperscript{37} Furthermore, as will be shown later in this section, such a regressive approach sits out of step with the progress made by the Mental Capacity Act 2005. The Act - although retaining a diagnostic element in the assessment of mental capacity\textsuperscript{38} – now places greater emphasis on a functional assessment of capacity – the functions and skills required in order to make a decision.\textsuperscript{39}

The possibility of ‘reawakening a status-based approach’ to vulnerability is also problematic from the viewpoint of the relational theories advocated in the next section. If, as Nedelsky notes,\textsuperscript{40} a relational approach necessitates and facilitates attention to detail, and in particular a contextualised focus on a person’s relationships, then a status-based approach in fact mitigates against this by only inviting a one-dimensional appraisal of their status that purportedly renders them ‘vulnerable.’ As Nedelsky argues, ‘...when a “syndrome” is recognized it invites individual psychological analysis – rather than systematic relational analysis.\textsuperscript{41} In effect, a status-based conceptualisation of vulnerability risks a ‘one size fits all’ approach in responding to vulnerability, rather than heeding the call of recent legislative and policy shifts (examined next), and relational theories (examined in the next chapter) to be more – not less - cognisant of a person’s social embeddedness and network of relationships.

\textsuperscript{37} Brown (n 25) 316.
\textsuperscript{38} An impairment or disturbance in the functioning in the mind or the brain: Mental Capacity Act 2005, s 2(1).
\textsuperscript{39} Mental Capacity Act 2005, s 3(1). The merits and pitfalls of these provisions are discussed in greater detail later in this chapter.
\textsuperscript{40} Jennifer Nedelsky, \textit{Law’s Relations: A Relational Theory of Self, Autonomy and Law} (OUP 2012) 79.
\textsuperscript{41} \textit{ibid}. 312.
More recent shifts in adult safeguarding law and policy\textsuperscript{42} betray an acknowledgment of the concerns outlined above in relation to the stigmatising effect of the status-based approach to vulnerability, and the problems in the existing legal framework around vulnerability. The Care Act 2014, as just one example of the discursive shift now becoming apparent within safeguarding, replaces the term ‘vulnerable adults’ with the term ‘adults at risk’\textsuperscript{43}. Indeed, the safeguarding policy issued by the Office of the Public Guardian (OPG) in 2015 notes that the stigmatising properties inherent the term vulnerable adult is one of the reasons for this linguistic shift: ‘The term ‘adult at risk’ is used in this policy to replace ‘vulnerable adult’. This is because the term ‘vulnerable adult’ may wrongly imply that some of the fault for the abuse lies with the victim of abuse.’\textsuperscript{44} Yet whether this linguistic shift will have any great effect in practice remains to be seen. Concern could be voiced that the legislation, which adopts a similar approach to the Scottish notion of an ‘adult at risk’\textsuperscript{45}, may not make huge strides forward in its understanding of vulnerability given that it still explicitly links the inability to protect oneself from abuse with the need for care and support.\textsuperscript{46} A full appraisal of these adult safeguarding provisions are outside the scope of this thesis, however given these criticisms of vulnerability as a legal tool as outlined here – and which are arguably ambivalently perpetuated in the Care Act 2014 - it is therefore particularly salient to continue to scrutinise and critique the notion of

\textsuperscript{42} Although as I argue in chapter 7, not mirrored in the approach to vulnerability in old age taken by the courts.

\textsuperscript{43} Section 42 of the Care Act defines an adult at risk as someone who:

(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (emphasis added).

\textsuperscript{44} Office of the Public Guardian, Safeguarding Adult (Office of the Public Guardian 2015) para. 5.2.

\textsuperscript{45} Adult Support and Protection (Scotland) Act 2007, S 3(1): “Adults at risk” are adults who—

(a) are unable to safeguard their own well-being, property, rights or other interests,
(b) are at risk of harm, and
(c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

vulnerability within adult safeguarding, which – in the context of the inherent jurisdiction - is the focus of chapter 7.

3.1.2 Responses

A further key concern for those who reject – or at least partially reject – the notion of vulnerability as it has been deployed thus far in the law under the inherent jurisdiction, is the fact that adhering to the status-based approach provides an easy option\(^47\) for those seeking to intervene. It is not difficult to see why commentators have made this argument given the wording used by Munby J in \(\textit{Re SA}\), the leading authority on this in relation to the deployment of the jurisdiction:

\[
\text{The inherent jurisdiction is not confined to those who are vulnerable adults, however that expression is understood, nor is a vulnerable adult amenable as such to the jurisdiction. The significance in this context of the concept of a vulnerable adult is pragmatic and evidential: it is simply that an adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult is not on the face of it vulnerable.}^{48}
\]

In effect, it is more likely that the court would be persuaded and willing to intervene in suspected abuse, coercion, or undue influence, where the adult in question is vulnerable under the conceptualisation of vulnerability provided earlier in the case – unable to take care of or protect him or herself against significant harm or exploitation, or is deaf, blind or dumb, or is


\(^{48}\) Above (n 15) [85] (emphasis added).
substantially handicapped by illness, injury or congenital deformity – than when a person is not deemed vulnerable under this conceptualisation. This has been attacked for the ease with which responses might be invoked if someone is deemed ‘vulnerable’ by virtue of the fact that they have an impairment or are old, compared to someone who is not considered ‘vulnerable’ on such a basis. Moreover, it has also been criticised for the fact that it may lead to a failure to engage with more difficult questions in respect of a person’s capacity, focusing attention on the impairment, and distracting attention away from structural forces that disadvantage those with impairments, a criticism that – as shall be shown later – has also been made of the diagnostic element in the capacity assessment process under the Mental Capacity Act.

In addition to criticising this notion of vulnerability on the basis that it singles out persons with impairments or older persons as being ‘easier targets’, as noted above, critics have also emphasised that such an approach also casts doubt and concerns on the types of responses that may be envisaged in such circumstances. As suggested earlier, the notion of vulnerability in its current formulation has been criticised for drawing too close an analogy with vulnerability in childhood - and therefore drawing too close an analogy with child safeguarding measures - which are inherently more paternalistic, and arguably serve a different purpose to adult safeguarding measures. Concern has therefore also emerged that the types of responses envisaged by this approach to vulnerability may be more akin to those deployed in child safeguarding measures.

---

49 ibid. [77].
50 Dunn, Clare, and Holland (n 21) 241.
54 Childhood as an inherently vulnerable stage of the life course.
safeguarding. As Sherwood-Johnson notes, responses that may ‘…[legitimate] more powers for professionals to override considerations of consent than exist for other adults…’,\(^{56}\) and which fail to listen to the voice of the person considered ‘vulnerable’.

One example of such concerns manifesting themselves in reality appears in the case of *X County Council v AA*.\(^{57}\) The case involved a young woman, DD, with profound intellectual impairments and who had previously been held to lack capacity to consent to sexual relations. DD had been part of an arranged marriage in Bangladesh to AA, and had returned, with her husband, to live in England. The issue before the judge in this particular case was whether it was possible, using the inherent jurisdiction, to grant a declaration of non-recognition of the marriage between DD and AA, even though such a remedy was not available under the Mental Capacity Act 2005. The Court held that it was possible, and proceeded to grant the declaration, notwithstanding the arguments presented by all legal representatives before the Court, including the Official Solicitor (A’s litigation friend), as well as experts in both international human rights and Islamic Law, that to do so would potentially bring shame on the family given the status of marriage - and particularly the effects that an annulment of a marriage might have - in the family’s particular cultural context. More worrying is the judge’s assertion that in invoking the inherent jurisdiction there is no need to adopt a least restrictive alternative approach\(^{58}\) – such as is provided under section 1(6) of the Mental Capacity Act 2005. The point here is not that the decision to invoke the jurisdiction in *X County Council v AA* was incorrect or that DD did not deserve any legal protection, but that the methods deployed by the Court in invoking the jurisdiction were a cause for concern - in failing to listen to AA herself, or to those around her, or to the experts and the Official Solicitor, as well as the declaration that there was

---

\(^{56}\) Sherwood-Johnson, above (n 23) 916.

\(^{57}\) Above (n 28).

\(^{58}\) ibid. [77].
no requirement of a ‘least restrictive alternative’. The decision in *X County Council v AA* seems to be a response predicated on DD’s impairments, with little credence or analysis given to other intersecting factors. It would seem, then, that the concerns enunciated in this section over the ease with which interventions can be imposed, and the types of such interventions, may be well founded.

### 3.1.3 A New Way Forward for Vulnerability?

In the next chapter, I outline the more recent theoretical debate which attempts to reconceptualise the notion of vulnerability in order to subvert some of the criticisms of its status-based roots in the law outlined above. Such a theoretical approach to certain areas of law are already beginning to emerge in the literature, however. Clough, for example, writing in the context of capacity to consent to sexual relations, argues that more recent accounts of vulnerability in the theoretical literature provide a mechanism not only to challenge the status-based conceptualisations of vulnerability, but also to challenge the responses and interventions traditionally seen as appropriate.\(^{59}\) Similarly, Carl Stychin, writing in the context of when a duty of care is owed in negligence, argues that:

> Vulnerability provides a discursive means by which to articulate demands for the legal responsibility of those in positions of privilege who otherwise can claim that they have not assumed responsibility and that they are not responsible. It shifts the focus to responsibilities that arise from ‘encounters with others’ and potentially widens and enriches our understanding of the ethical and legal duties we owe.\(^{60}\)

---

59 Clough (n 26). See also Herring and Wall (n 27).
What unites these authors in advocating for a ‘new’ vulnerability approach to their respective areas of law, is not necessarily focusing solely on the failings in vulnerability as it has historically been deployed by the law in this area - as other commentators, outlined above, have focused on - but in highlighting that the criticisms of the existing notion of vulnerability is motivated by failings in the deeper ideals that underpin the law; philosophical underpinnings to the law that stress ‘the autonomous and independent subject asserted in the liberal tradition’ as the paradigm. This paradigm is explored in greater depth in the next chapter.

According to these authors, there are two predominant ways that the recent, more nuanced theoretical understandings of vulnerability can be more productive in the legal arena in tackling this deeper theoretical problem, and which I draw upon in chapter 7. First, they stress the importance of paying far greater attention to situational forms of vulnerability, rather than simply taking the ‘easier’ option of attributing vulnerability to an inherent characteristic. For Peroni and Timmer, for example, such an approach allows a more robust notion of equality among traditionally stigmatised ‘groups’ - such as persons with HIV - to emerge in European Court of Human Rights jurisprudence. For Donnelly, this more nuanced account of vulnerability presents opportunities when the law engages with persons with dementia, and

…requires legal engagement not just with individuals but with surrounding practices, asking whether these enhance or erode autonomy capabilities. In this way, the legal lens is expanded beyond the individualist focus which still remains central in the law’s dealing with dementia.

61 ibid. 347.
63 Donnelly, ‘A Legal Overview’ (n 35) 279.
Focussing to a greater degree on situational forms of vulnerability does not ignore the effects of some impairments on certain individuals – for example the fact that dementia does cause memory loss and mood alterations\(^6^4\) – but stresses first and foremost the contextual and societal factors that exacerbate a person’s vulnerability – and, crucially, that the law may be one such exacerbating factor where it responds inappropriately. As Dunn, Clare and Holland argue, if legal interventions designed to protect the vulnerable person are justified on the basis of situational vulnerability alone, a more general assessment of situationally derived risk factors would be undertaken, and the likelihood of these factors impacting autonomous decision-making would be considered with reference to the different contexts within which the particular decision in question is made.\(^6^5\)

Second, and linked to the point above, more recent understandings of vulnerability similarly do not seek to advocate for a ‘restrained state’ - that is, they do not seek to argue that the state should not intervene thereby leaving such problems to the private domain – but that closer scrutiny should be paid to the types of interventions available: ‘The vulnerability lens…[shows] that a respect for autonomy and rights does not hinge on non-interference. On the contrary, without adequate background conditions which foster resilience and choice, autonomy and capabilities are an illusion.’\(^6^6\) As Keywood argues in relation to the decision in *A Local Authority v A*\(^6^7\) - where the Court held that failing to appreciate the broader social consequences of not using contraception was not fatal to a capacity assessment - ‘to exclude an appraisal of some form of the broader consequences as they are perceived as being relevant

\(^6^4\) See the analysis of *A London Borough v VT* [2011] EWHC 3806 (COP), and *Westminster City Council v Sykes* [2014] EWHC B9 (COP), in chapter 8 of this thesis.

\(^6^5\) Dunn, Clare and Holland, above (n 21) 246.

\(^6^6\) Clough (n 26) 387.

\(^6^7\) [2010] EWHC 1549 (Fam).
to the person does not necessarily ensure respect for autonomy’. Put simply, maximising autonomy in these cases does not mean doing nothing, or setting the bar too low – it does not require a ‘restrained state’. As the House of Lords Post-Legislative scrutiny on the Mental Capacity Act noted, no intervention can entrench a person’s vulnerability just as much as inappropriate intervention. What a situationally-focussed approach to vulnerability does require, however, is a robust state – a state that is willing to intervene, but that more importantly, greater scrutiny is given to the types of interventions imposed and considered appropriate in such instances, and scrutiny of the methods by which such interventions are deployed. As the courts have noted on multiple occasions, the law must be careful that it is directing restrictive remedies towards the appropriate party, for example – in instances of domestic or elder abuse, that the correct remedies are directed towards the ‘abuser’, rather than the ‘abused’, but it must also be sensitive to the need to provide supportive mechanisms to the person who has been abused insofar as they are willing and able to accept them.

Indeed, both Clough, and Herring and Wall have argued that the inherent jurisdiction, given its flexibility, may be a better equipped tool to respond to many of these types of circumstances. Clough suggests that it may be better equipped to deal with issues surrounding the capacity to consent to sexual relations for those with learning disabilities where someone is deemed to

---

70 A Local Authority v A (n 67) [79]: ‘The purpose, in respect of a capacitated but vulnerable adult, is to create a situation where he or she can receive outside help free of coercion, to enable him or her to weigh things up and decide freely what he or she wishes to do.’ Bodey J continues by stating that such an approach in these particular circumstances is also required under the Mental Capacity Act 2005, not just the inherent jurisdiction. See also LBL v RYJ (n 17) [62], where Macur J holds that the aim of the court in invoking the inherent jurisdiction, is ‘to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions.’
71 This aspect to vulnerability – a focus on responses, and the method by which responses are deployed – is discussed in more depth in chapter 7.
72 Clough (n 26) 392-394.
have capacity to consent to sexual relationships under the Mental Capacity Act 2005, for example, but where their autonomy may be compromised by broader societal and contextual factors such as abuse, or oppression, or a lack of education. Similarly, Herring and Wall\(^{73}\) have argued that the jurisdiction may be a more appropriate tool to use for those whose autonomy is threatened by forces that fall outside the scope of the Mental Capacity Act. The salient point of these discussions is not that the inherent jurisdiction, or even a concept of ‘vulnerability’ is necessarily a ‘bad thing’ \textit{per se}, but that reformulating the theoretical underpinnings that the notion of vulnerability has within the law actually allows the court to formulate better responses to instances where there may be wider oppressive forces at play in a person’s decision-making. This is only the case where it is premised on the more nuanced understanding of vulnerability that they advocate – and that is advocated in the next chapter. That is, a notion of vulnerability which is based on the idea of interdependence; the situated, embodied and relational person, rather than the liberal qualities of independence, individualistic functional autonomy, and the restrained state that currently underpin the law, and which, to use Clements’ terminology, ‘still betrays an able-bodied view of the world’.\(^{74}\)

3.2 Mental Capacity

This section provides an overview of the debate around the test for incapacity and the best interests framework within the law. These are discussed in greater depth in formulating the arguments that ensue in chapters 6, 7, and 8, which go on to argue that the criticisms that arise in the broader literature around mental capacity – assessed in this chapter – also arise in the context of the law as it applies specifically to older people.

\(^{73}\) Herring and Wall (n 27) 717-718.
3.2.1 The Law Before the Mental Capacity Act 2005

Before moving on to considering the debate around the Mental Capacity Act 2005, it is worth outlining briefly the legal position before this came into force. As noted above, this is covered in more depth in the chapters 7 and 8, however understanding the position before the Act came into force may shed light on some of the critiques that have come forward of the Act itself, which are considered next.

In 1990 the House of Lords held that the inherent jurisdiction could be used to authorise medical treatment on mentally incapacitated adults – in that case, the sterilisation of a young woman with learning disabilities.\(^75\) For the courts to declare that a procedure would be lawful using the jurisdiction, the procedure must be considered necessary, and to be deemed necessary it must be in her ‘best interests’. The House of Lords further held that to be in an incapacitated person’s best interests it must meet the \textit{Bolam}\(^76\) standard, imported from negligence litigation.\(^77\) In effect, to be able to declare that treatment in the best interests of an incapacitated person would be lawful, all that must be established is that the treatment was in accordance with ‘a responsible body of medical opinion skilled in that particular art’.\(^78\) Furthermore, in \textit{Re C},\(^79\) the Court clarified that for a person to be declared incapacitous, they must be unable to take in and retain treatment information, believe, and weight the information, and understand the nature, purpose, and effect of the proposed treatment,\(^80\) which may be caused by a cognitive or mental illness, or by undue influence.\(^81\) As outlined further in chapter 7 – the use of the jurisdiction for those who lacked capacity eventually expanded to decisions other than medical treatment, including residence,\(^82\)

\(^75\) Above (n 3).
\(^76\) \textit{Bolam v Friern Hospital Management Committee} [1957] 1 WLR 582.
\(^77\) Above (n 3) 560 per Lord Brandon, and 567 per Lord Goff.
\(^78\) Above (n 76) 587.
\(^79\) \textit{Re C (Adult: Refusal of Treatment)} [1994] 1 WLR 290.
\(^80\) \textit{ibid}. 295. Thorpe J held that Mr C did satisfy this test and therefore retained capacity to refuse the amputation of his leg.
\(^81\) \textit{Re T (Adult: Refusal of Medical Treatment)} [1993] Fam 95.
\(^82\) \textit{Re F} [2000] EWCA Civ 192; \textit{Re S} [2003] EWHC 1909 (Fam).
contact, marriage, and deprivation of liberty, and even – as explored earlier - in to decision-making on behalf of those who did retain capacity according to the formulation under Re C, but were otherwise vulnerable.

The approach taken by the common law, and purveyed here, has been heavily criticised. In terms of its form, in their 1991 consultation document, the Law Commission noted that the existing law relating to decision-making on behalf of mentally incapacitated adults is fragmented, complex and in many respects out of date. There is no coherent concept of their status, and there are many gaps where the law provides no effective mechanism for resolving problems.

Again, in 1995, the Law Commission’s consultation noted that the current law was characterised by ‘incoherence, inconsistency and historical accident’ and akin to a ‘string bag with holes in’.

More significantly for this thesis, however is that the common law was also criticised for its substance – the actual methods it employed for making decisions on behalf of incapacitated adults. The medicalised approach to best interests, for example, derived from F v West Berkshire and predicated on Bolam, has understandably been criticised on a number of fronts. During its various consultations on this issue throughout the 1990s, the Law Commission, noted that not only had there had been no real elucidation as to what ‘best interests’ means or

83 Re S [2002] EWHC 2278 (Fam).
84 Re SA (n 15); Re SK [2004] EWHC 3202 (Fam).
85 R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458. This approach was held to be a violation of Article 5 of the European Convention by the European Court of Human Rights: HL v UK [2004] ECHR 471, and resulted in the creation of the Deprivation of Liberty Safeguards.
86 Re SA (n 15); Re G [2004] EWHC 2222 (Fam).
88 Law Commission, Mental Incapacity (The Stationery Office 1995) para. 2.45.
89 ibid. para. 2.47.
what factors the Court must take into consideration when assessing best interests, but moreover, that it had been identified as being akin to simply ‘not acting negligently’ was unthinkable, with the Commission strenuously noting that:

[i]t should be made clear beyond any shadow of a doubt that acting in a person’s best interests amounts to something more than not treating that person in a negligent manner. Decisions taken on behalf of a person lacking capacity require a careful, focused consideration of that person as an individual.91

This criticism is echoed, and elaborated on in much of the academic literature over the use of the Bolam standard to determine best interests – it is criticised for being overly-paternalistic, and for paying little – or no – attention to the perspective of the person lacking capacity.92 As Coggon notes, it ‘might permit the doctor to do what he wants, unhindered because of the application of the notoriously troublesome Bolam test and an excessively deferential judiciary’.93 The ‘original’ best interests standard then, did not necessarily require the input either of the person lacking capacity, nor any relevant persons connected with the person lacking capacity – it simply allowed it, and rested on good practice by the doctors treating the patient.94 ‘No doubt, in practice, a decision may involve others besides the doctor. It must surely be good practice to consult relatives and others who are concerned with the care of the patient.’95 Indeed this quote belies the idea that the patient had a voice at all – the reference by Lord Goff is simply to the fact that

90 Law Commission (n 87) para. 2.22; Law Commission (n 88) para. 3.27.
91 Law Commission (n 88) para. 3.27 (emphasis added).
95 Above (n 3) 567 per Lord Goff.
it would be good practice to consult with relatives or others concerned with caring for the person – but not with the person themselves. As Donnelly rightly suggests, best interests, and particularly this early notion of best interests, has therefore ‘often been treated as if its application required no more than general good will on the part of the decision-maker.’ 96  It became a classic example of ‘doctor knows best’ 97 and a mechanism by which to silence any voice that the person with a cognitive impairment might have had. The next section of this chapter considers the ‘new’ 98 framework under the Mental Capacity Act 2005, and suggests that while it has gone some way to remedying the problems identified with the common law approach, the law in this area has continued to come under challenge both in substance and in its application along the same lines as the criticisms outlined here – particularly as it is used in relation to older persons.

3.2.2 The Mental Capacity Act 2005

The Mental Capacity Act 2005 came in to force in October 2007 and represented an attempt to create a comprehensive legal framework for making decisions in relation to property, health, and welfare on behalf of those who lack mental capacity. The Act itself is supposedly underpinned by an ethos of empowerment and involvement in both the capacity assessment, and the decision-making processes where someone is found to lack capacity. During the House of Lords debate on the (then) Mental Capacity Bill, Lord Filkin stated that ‘[t]he Bill will provide greater empowerment and better protection for vulnerable people and for those who

98 Although many commentators argue that the approach under the Mental Capacity Act 2005 is simply a codification of existing common law principles: Margaret Brazier and Emma Cave, Medicine, Patients, and the Law, (5th edn, Penguin 2011) 144. It does, however, move beyond the common law in some important respects, particularly by providing guidance as to what to consider when making best interests decisions, and a Code of Practice that elaborates on this: Department for Constitutional Affairs, The Mental Capacity Act Code of Practice (The Stationery Office 2007).
face the difficult and sensitive task of handling decisions on their behalf.99 This ethos, as well as the Act’s focus on protecting liberty and autonomy – although as argued in chapters 6, 7, and 8, notions of liberty and autonomy that are premised on an untenable and defensive liberal ideal - have been heralded as ushering in a new era in inclusive citizenship for people with cognitive impairments, particularly for persons with dementia.100

Under the Mental Capacity Act 2005, there is, first and foremost, a presumption of capacity.101 Nobody is to be deemed to lack capacity in relation to a decision because of their age or appearance or an aspect of their behaviour,102 or because they make an unwise decision,103 and before they are deemed to lack capacity, all practicable steps must have been taken to help them make the decision themselves.104 If, however, a person is unable to understand, use or weigh, or retain information, or communicate a decision105 (the functional test) because of106 a disturbance or impairment in the functioning of the mind or the brain107 (the diagnostic element) then a decision can be made on their behalf in the best interests,108 and must be the least restrictive alternative.109

99 HL Deb 21 June 2004, vol 662, col WS49. See also House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013-14 (n 69), which was heavily critical of the implementation of the empowering ethos behind the Act.
101 Mental Capacity Act 2005, s 1(2).
102 Mental Capacity Act 2005, s 3(3).
103 Mental Capacity Act 2005, s 1(4).
104 Mental Capacity Act 2005, s 1(3).
105 Mental Capacity Act 2005, s 3(1) (a)-(d).
106 PC v City of York [2013] EWCA Civ 478. According to McFarlane LJ at [52], there has to be a ‘clear causative nexus’ between the failure to fulfil the functional test, and the diagnostic element. In effect, the assessor must first consider whether the person is able to meet the functional test, then consider whether this is ‘because of’ an impairment or disturbance in the functioning of the mind or the brain.
107 Mental Capacity Act 2005, s 2(1).
108 Mental Capacity Act 2005, s 1(5).
109 Mental Capacity Act 2005, s 1(6).
The criteria governing best interests decision-making are now to be found in section 4 of the
Act, which states that a best interests decision, first and foremost, must not be made on the
basis of a person’s age, appearance, or an aspect of their behaviour which might lead to
unjustified assumptions about what is in his or her best interests.110 A best interests decision-
maker must also have regard to whether the person in question may be likely to regain capacity,
and if so when that may be.111 The person lacking capacity must be permitted and encouraged
to participate as much as possible in the decision-making process, as far as is reasonably
practicable to do.112 If the decision is in relation to the withdrawal of life sustaining treatment,
the decision-maker must not be motivated by a desire to bring about the person’s death.113 In
all decisions, the decision-maker must consider the person’s past and present wishes and
feelings, values and beliefs, and any other factors they may consider if they were able to do so,
so far as any of these are reasonably ascertainable.114 The decision-maker must also take into
consideration the views of anyone named by the person lacking capacity as someone to be
consulted on the issue in question, anyone caring for the person or with an interest in his or her
welfare, a done of any lasting power of attorney, or any deputy appointed by the Court.115
Finally, a failure to fulfill one of the requirements outlined above as far as it is reasonably

110 Mental Capacity Act 2005, s 4(1)(a)-(b).
111 Mental Capacity Act 2005, s 4(3).
112 Mental Capacity Act 2005, s 4(4). There are critics who suggest that the very process of going to the Court of
Protection, as well as the fact that the person who lacks capacity need not be joined as a part to proceedings (Re
NRA [2015] EWCOP 59), and the process of appointing litigation friends, may run counter to this provision: Alex
Ruck Keene, Neil Allen and Peter Bartlett, ‘Litigation Friends or Foes? Representation of ‘P’ before the Court of
113 Mental Capacity Act 2005, s 4(5).
114 Mental Capacity Act 2005, s 4(6). Furthermore, while their views will always be a significant factor in the best
interests decision-making process, the precise weight accorded to them will always be case and fact-specific, and
will depend on the following factors: the degree of the person’s incapacity, the strength and consistency of the
views, the impact on the person lacking capacity if they knew their wishes were not being effected, the extent to
which the wishes are rational, sensible, and responsible, and capable of being implemented, and to what extent
they can be accommodated within the Court’s assessment of best interests: ITW v Z [2009] EWHC 2525 (Fam)
[35] per Munby J.
115 Mental Capacity Act 2005, s 4(7)(a)-(d).
practicable to do so, may result in a violation of the person’s Article 8\textsuperscript{116} rights,\textsuperscript{117} or their Article 5\textsuperscript{118} rights where the issue in question is an unlawful deprivation of liberty.\textsuperscript{119}

### 3.2.3 Criticisms of the Act and its Implementation

Just as the pre-Mental Capacity Act law garnered criticism, so too has the Act attracted similar criticism in respect of its provisions and their implementation. One of the most fertile opportunities to emerge in recent years for challenging the provisions in the Act, is through the creation of the United Nations Convention on the Rights of the Persons with Disabilities (UNCRPD). As several commentators have noted,\textsuperscript{120} the UNCRPD, signed by the United Kingdom in 2007 and ratified in 2009, represents a shift from a medicalised model of disability – one that views disability as a ‘medical condition that requires fixing’\textsuperscript{121} – to a social model, where, to quote from Article 1 of the Convention, ‘interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.\textsuperscript{122} In effect, it is ‘for society to adapt to the needs of people with disabilities so that those people may maximize

---

\textsuperscript{116} European Convention on Human Rights, Art 8, the right to the protection of a person’s private and family life.
\textsuperscript{117} Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB). The Court found that the respondent NHS Trust could not claim to have been acting in the best interests of Carl Winspear, a 28-year-old man who suffered from cerebral palsy, epilepsy, spinal deformities and a number of other health conditions, when placing a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notice on his medical records following his admission to hospital, without having taken all steps to consult with his mother. Doing so had been a violation of his Article 8 rights, with the Court stating, at paragraph 58, that if ‘it is both practicable and appropriate to consult then in the absence of some other compelling reason against consultation, the decision to file the DNACPR notice on the patient’s medical records would be procedurally flawed. It would not meet the requirements of section 4(7) MCA; it would accordingly not be in accordance with the law. It would be an interference with Article 8(1) that is not justified under Article 8(2).’ See also London Borough of Hillingdon v Neary (2011) EWHC 1377 (COP) for a similar decision in relation to an unlawful deprivation of liberty.
\textsuperscript{118} European Convention on Human Rights, Art 5, the right to liberty and security.
\textsuperscript{121} Bartlett (n 120) 758.
\textsuperscript{122} United Nations Convention on the Rights of Persons with Disabilities, Article 1. There is debate to what extent the UNCRPD reflects a shift to the social model, with Kayess and French arguing that it adopts a radical social constructionist view of disability’ and may therefore risk losing sight of the effects of impairments on individuals: Kayess and French (n 120) 7.
their participation in society as a whole.'\textsuperscript{123} A full appraisal of the UNCRPD, teasing out all its potential, as well as the ambiguities and tensions that emerge from it, is beyond the scope of this thesis, and has largely been undertaken elsewhere.\textsuperscript{124} Nonetheless, it does provide an opportunity to cast a gaze upon the suitability of a functional approach to capacity assessment, and substituted decision-making regimes – both of which can be found in the Mental Capacity Act – and both of which form the legal basis for discussion in the ensuing chapters of this thesis.

Article 12 of the UNCRPD states that all persons with disabilities ‘enjoy legal capacity on an equal basis with others in all aspects of life’,\textsuperscript{125} and that persons with disabilities should be provided with support to exercise their legal capacity,\textsuperscript{126} and is a particular example of the direct challenge to diagnostic and functional criteria for capacity assessments, as well as substituted decision-making regimes. The Convention also stipulates that measures designed to protect the legal capacity of those with disabilities should ‘respect the rights, will and preferences of the person with the disability’.\textsuperscript{127} This supported decision-making paradigm has been confirmed by General Comment No.1 to the UNCRPD,\textsuperscript{128} which also asserts that where the person’s will and preferences are not discernible, measures for the protection of their legal capacity should be based on the ‘best interpretation of their will and preferences’,\textsuperscript{129} and explicitly notes that any denial of legal capacity based on either a functional assessment,\textsuperscript{130} and through the use of the

\textsuperscript{123} Bartlett (n 120) 758.


\textsuperscript{125} Article 12(2). There remains some debate as to what ‘legal capacity’ means: Gooding (n 124); Amita Dhanda, ‘Legal Capacity in the Disability Rights Convention: Stranglehold for the Past or Lodestar for the Future?’ (2007) 34 Syracuse Journal 429-462.

\textsuperscript{126} Article 12(3).

\textsuperscript{127} Article 12(4).

\textsuperscript{128} United Nations Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12: Equal Recognition Before the Law (April 2014).

\textsuperscript{129} ibid. para. 21.

\textsuperscript{130} ibid. para.15.
best interests standard is not in accordance with the UNCRPD. In effect, legal capacity is a right that should never be denied to someone through the use of a substituted decision-making process such as found within the Mental Capacity Act 2005 – regardless of a person’s cognitive impairment – and such approaches must be replaced with systems of ‘supported’ decision-making.

Naturally, some have criticised the stance of the UNCRPD and its General Comment. In a number of cases - such as when a person is in an extremely advanced state of dementia, or in a persistent vegetative state, for example – the provision of ‘support’ will not reflect the realities of the actual decision-making process. In such cases, the provision of ‘support’ – itself left undefined in the Convention - essentially does become substituted decision-making, simply because the person themselves is physically and cognitively unable to make or communicate their decision. Yet as Bach and Kerzner note in elucidating the notion of ‘support’ in such circumstances further, what such situations require is ‘representational support’ – which they argue is beneficial because

Other individuals help communicate who a person is, and to share their biography with others. These are individuals who have a knowledge of the person born out of a relationship of trust and understanding of their unique ways of communicating, and who, through shared life experience, have come to understand who the person is, what he or she values and wants and what he or she dislikes or rejects.

---

131 ibid. paras. 21, 27, and 29(b).
132 Dawson (n 124).
134 ibid.
Nevertheless, this does not mask the reality of the fact that in some circumstances, because of the severity of the cognitive impairment, the *actual decision* must be made by a third party – whether representational support exists or not – and a failure to make a decision on someone’s behalf may well shirk other legal responsibilities such as to protect persons with impairments from abuse.¹³⁵

It is also arguable that if there is no mechanism by which to assess the level of someone’s capacity – if there is no functional assessment of decision-making at all, as the UNCRPD and its General Comment argue, then this masks the realities of life with certain cognitive impairments which *do* affect a person’s functional abilities. Without some functional notion of capacity or decision-making ability, how will it be known who, and more importantly, what *types* of support – such as formal, or informal supports¹³⁶ - are needed to help someone make a decision? While the UNCRPD is notoriously silent on how to identify persons who *do* need formal provision of support such as advocacy if there is no diagnostic or functional element to mental capacity, Flynn and Arstein-Kerslake suggest the retention of an assessment process, but in order to determine what supports are required rather than one that focuses on a person’s deficiencies so as to attempt to avoid the stigmatisation of cognitive impairment.¹³⁷ This is particularly important for persons with dementia – where there is still a stigma associated with being diagnosed, and therefore potentially a reluctance to actively seek a diagnosis, and

---

¹³⁵ Such as the obligation contained within Article 16 of the UNCRPD, or broader international human rights law under the European Convention on Human Rights, Article 2 and 3. A full discussion of these obligations is outside the scope of this thesis.

¹³⁶ Formal supports, much like the notion of ‘formal care’, are supports that might be paid for, or provided on a formal or contractual basis. Informal supports, on the other hand, may be those provided by family members or friends, for example.

¹³⁷ ‘Any assessment which takes place in a support model of legal capacity should be centred on the support that is needed in decision-making to augment an individual's existing strengths, rather than the deficits of the individual’: Flynn and Arstein-Kerslake (n 53) 94. I would disagree with the idea that any assessment should be focussed solely on what supports are required, however, given that in order to assess this, an assessment must *de facto* note how a person is unable to make a decision in order to identify what types of supports are required.
consequently to seek appropriate forms of support to live with the condition. An approach predicated on the UNCRPD does nothing to highlight how or when to identify persons with dementia who may need support to make decisions. Ironically, then, for all its talk of support and equality, the UNCRPD in some ways therefore may be interpreted as further hiding those with certain cognitive impairments from the realms of formal support mechanisms.

In light of the positive shift from medicalised to social constructions of disability, however, embodied in the UNCRPD, the capacity assessment process within the Mental Capacity Act – consisting of a diagnostic and functional element – has been criticised for its adherence to a medicalised notion of the individual; it is considered stigmatising to those with cognitive impairments. As the General Comment of the UNCRPD notes – such a test is ‘discriminatorily applied to people with disabilities’, and holds people with disabilities up to a higher standard than other persons. Analyses of Court of Protection cases indicate that such a notion also emerges in the Court’s judgments. In her analysis of the deprivation of liberty safeguards, for example, Clough notes that judgments remain underpinned by an explicitly medicalised notion of disability, and Harding argues that the Court of Protection has had a tendency to pathologise and medicalise persons with dementia – an argument that is built upon in chapter 8.

---

139 United Nations Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12: Equal Recognition Before the Law (April 2014) para.15.
140 Flynn and Arstein-Kerslake (n 53) 87.
141 Clough (n 120).
The capacity assessment process contained within the Act has also been criticised on other fronts – which are examined in further detail in chapters 6 and 7 of this thesis. The functional approach to assessing capacity, arguably supports an overtly individualistic and functional notion of autonomy – explored in the next chapter - which masks the realities of abusive situations that may be – and frequently are – experienced by those with cognitive impairments, including older people. Functional accounts such as that deployed by the Act – which requires a strict causal nexus between the diagnosis of an impairment, and the failure to fulfil the functional assessment\textsuperscript{143} – necessitate an artificial separation of whether it is the impairment that is the cause of the failure to satisfy the functional test for capacity, or the abuse.

Indeed the decision in Re BKR,\textsuperscript{144} a recent case from Singapore – whose mental capacity legislation is almost identical to the Mental Capacity Act\textsuperscript{145} - highlights this criticism well. The Court in that particular case noted that it may be very difficult in such cases to differentiate between whether it is a mental impairment causing the inability to satisfy the functional criteria, or the undue influence. Yet the Singaporean Court of Appeal still held that in those circumstances, the older person will almost always be deemed to lack capacity under the terms of the Singaporean Mental Capacity Act. In effect, where the lack of capacity arises as a result of a combination of mental impairment and abuse, then the Court will have no hesitation making a best interests decision on behalf of the older person and denying their legal capacity. Such a case is indicative of the problems of artificially trying to ‘force’ cases where an older person has both a cognitive impairment and is experiencing abuse into a rigid legal framework.

\textsuperscript{143} Above (n 106).
\textsuperscript{144} Re BKR [2015] SGCA 26.
\textsuperscript{145} Alex Ruck Keene, ‘Singapore, the MCAs and Undue Influence’ (1 June 2015) available at http://www.mentalcapacitylawandpolicy.org.uk/singapore-the-mcas-and-undue-influence/ (last accessed 17 May 2016). This does not mean, of course, that the decision will be followed in this jurisdiction, but as argued further in chapter 7 of this thesis, a similar leaning is emerging in the English and Welsh courts in deciding cases where there is a confluence of elder abuse and cognitive impairments.
such as the Mental Capacity Act, rather than engaging substantively with the issues of how autonomy is threatened by the intersection of oppression, abuse, and cognitive impairments. Furthermore, it is blind to how legal interventions that deny their legal capacity may themselves be a threat to a person’s autonomy, and exacerbate their experience of vulnerability. Rather than engaging with the more troublesome and difficult questions of how the intersection of impairments, abuse, and oppression may threaten autonomy, such an approach by the courts presents a one dimensional, medicalised, and individualistic approach to autonomy, and as O’Donovan and Gilbar note, ‘[c]alling on individualistic autonomy as the primary value…whilst simultaneously overlooking the patient’s identity in relationships with others, is too narrow an approach to the complexities of human lives.’

The functional assessment of capacity has also been criticised for paying insufficient attention to even broader social contexts and oppressive situations in its application, particularly – as shown earlier in this chapter – in setting a low threshold for capacity to consent to sexual relations, and contraception. Indeed, as noted in the introduction to this thesis, and later in chapter 7, that the Act may not be sufficiently robust, or sufficiently ‘relational’, may be one of the reasons that the Court of Appeal recently held – in the case of DL v A Local Authority - that the inherent jurisdiction could still be invoked to protect those whose decisional autonomy may be threatened by abusive interpersonal relationships, yet where the person in question does not lack capacity under the terms of the Act. These criticisms are built upon throughout chapter 6, which suggests that the law in this area is grounded in a functional account of autonomy (explained further in the next chapter) that is underpinned by the liberal

147 IM v LM [2014] EWCA Civ 37. See: Clough (n 26).
148 A Local Authority v A (n 67). See also: Keywood (n 68).
149 DL v A Local Authority (n 17).
ideal of non-interference, which is unsuited to encompassing ageism as a threat to maximal autonomy for older persons. In turn, it suggests that we must turn to relational accounts of autonomy to make this connection between ageism, and autonomy.

Criticisms of functional and individualistic accounts of capacity (and therefore autonomy) that underpin legislation such as the Mental Capacity Act 2005 are explored in greater depth in the next chapter, and chapter 6. In order to satisfy these criticisms, and to account for the complexities of human lives, it is suggested that a critical scrutiny of functional accounts of capacity and autonomy through a ‘relational’ lens is required. It is important to note, however, that such accounts of relational autonomy do not deny the relevance of functional autonomy (and therefore functional capacity as contained in the Mental Capacity Act 2005) entirely – individualistic concepts are not and should not be rendered entirely defunct. What is suggested, however, is that the strand of relational autonomy literature that emphasises the importance of exploring in greater depth the effect of inter- and intra-personal relationships may lead to a more conceptually coherent account of autonomy to underpin any such legal interventions. This, in turn may lead to more focused and more appropriate responses, rather than the simple deployment of a ‘one size fits all’ best interests approach as invoked by the Singaporean Court in *Re BKR*, for example – and as chapter 7 suggests - also deployed in this jurisdiction where there are complex interplays of cognitive or physical impairment and abuse in the lives of older persons. Furthermore, it is contended not only in chapter 6, but also in chapter 7 – which explores the relationship between vulnerability and incapacity – that a substituted decision-making response such as found under the Mental Capacity Act, and has arguably found its way back in to the deployment of the inherent jurisdiction in its safeguarding role, may be inadequate because of the feelings of disempowerment that it might entrench. As Dhanda notes,
‘displacement of internal control [over decision-making] causes people to believe that the events of their lives are outside their control. This belief has strong negative effects on the person's sense of self, which impacts on subsequent behavior.’

In addition to the capacity assessment process, the best interests standard enunciated by the Mental Capacity Act – considered more in chapters 7 and 8 – has also remained the subject of fierce criticism, not least because it seemingly contravenes the principles now enunciated by the UNCRPD, outlined above. Criticisms of best interests – which are built upon in chapters 7 and 8 of this thesis – centre around two main themes: the suitability of substituted decision-making as a regime given that it denies legal capacity, and the purported objectivity of the best interests standard. The first of these criticisms has been outlined briefly in the preceding section of this chapter, therefore the remainder of this section will deal only with the second of these criticisms, in order to provide the foundation for the discussion in chapter 8 of best interests decision-making on behalf of persons with dementia in the Court of Protection.

As Buchanan and Brock, and McCubbin and Weisstub note, best interests is typically conceived of as an objective standard, yet recent developments in the law (explored in chapter 8) indicate, as O’Donovan and Gilbar note, that it also seeks to promote ‘the enhancement of the (incompetent) patient’s autonomy, by applying his or her values, wishes and ideas as much

150 Dhanda (n 125) 436.
as possible.' As Brazier and Glover argued in an early article following the Law Commission’s consultation in 1995, the approach put forward by the Commission, and which now appears in modified form under section 4

seeks to safeguard the individual's welfare and recognize the importance of recognizing subjective desires and the need to encourage any ability to decide matters for oneself, and to give guidelines about broad consultation on welfare centralisation of the views of the person lacking capacity. 

Yet despite this characterisation of best interests, the standard has come under criticism for not giving any guidance on what is being sought when making best interests decisions – there is no definition of best interests, simply a list of factors in section 4 of the Act that a best interests decision-maker must consider. Taylor, for example, argues that while the Mental Capacity Act does provide this guidance in order to pursue a decision, ‘it provides no further insight into what is actually being pursued’ when the Act speaks of ‘best interests’. This, as Ruck Keene and Auckland argue, may explain the lack of coherence in judgments emanating from the Court of Protection.

---

154 O’Donovan and Gilbar (n 146) 349.
156 It is beyond the scope of this thesis as to whether such a restricted definition is, in fact, desirable.
158 Alex Ruck Keene and Cressida Auckland, ‘More Presumptions Please? Wishes, Feelings and Best Interests Decision-Making’ (2015) 5(3) Elder Law Journal 293-301, 295. The article also criticises the lack of hierarchy within section 4 itself as a hurdle for truly centralising the voice of the person lacking capacity, and has led to proposals for reform by the Law Commission, which has suggested reforming this area so that there is a presumption in favour of the person’s wishes and feelings, unless there is ‘good reason’ to do otherwise: Law Commission, Mental Capacity and Deprivation of Liberty (Law Com CP No 222, 2015) para. 12.47. This proposal has also attracted judicial criticism. In Wye Valley NHS Trust v B, for example, Jackson J states that ‘…my respectful view is that the Law Commission proposal would not lead to greater certainty, but to a debate about whether there was or was not “good reason” for a departure from the assumption. To elevate one important factor at the expense of others would certainly not have helped the parties, nor the court, in the present case. All that is needed to protect the rights of the individual is to properly apply the Act as it stands.’ Wye Valley NHS Trust v B [2015] EWCOP 60 [17].
The best interests standard contained within the Mental Capacity Act 2005 itself has developed through case law emanating from the Court of Protection, and appellate courts – most notably the judgment of Baroness Hale in the Supreme Court case of Aintree University Hospitals NHS Trust v James,\(^{159}\) where – in an explicit rejection of the ‘reasonable person’s wishes and feelings’ approach adopted by the Court of Appeal\(^{160}\) – it was held that

> Insofar as it is possible to ascertain the patient’s wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.\(^{161}\)

This attempt to centralise the voice of the person lacking capacity within the best interests decision-making process does not, however, circumnavigate some key criticisms of substituted judgment. One of these is that there may be an inherent tension between the subjective perspective of the person lacking capacity, and the objective assessment carried out by the best interests assessors, and as Richardson points out, the subjective views must still defer to the objective assessment of best interests.\(^{162}\) This difficulty – of accommodating a person’s subjective perspective within an objective framework – has two potential implications. First, as Eldergill J notes writing extra-judicially, in objective analyses of best interests, it is possible for the courts (or perhaps best interests assessors more generally) to become too objective, which leads to the ‘perverted belief that objectivity is undermined by subjective...

---

\(^{159}\) Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 [45]. These developments are explored in greater detail in chapter 8 of this thesis.

\(^{160}\) Aintree University Hospitals NHS Trust v James [2013] EWCA Civ 65 [59]-[60]. The Court of Appeal held that if there were any doubts as to a person’s wishes or feelings, then the court should proceed on the basis that the person would act as a ‘reasonable individual’ would in the circumstances.

\(^{161}\) Above (n 159) 67 [45].

considerations.'

To put it simply, it is possible for those tasked with making best interests decisions to become too objective, and fail to situate within the best interests decision the voice of the person lacking capacity. Criticisms to this effect have been made of recent decisions involving older persons emanating from the Court of Protection. The decision in *Milton Keynes Council v RR*, for example, involved an older lady with dementia, who, as a result of safeguarding concerns, was placed in a care home away from her son and his wife, her main carers. As Series notes, the decision of the Court, however, is ‘frustratingly silent’ on the issue of RR’s wishes and feelings, and views as to her care arrangements.

Empirical research in relation to best interests decision-making for older adults indicate that this criticism also frequently occurs in practice in relation to persons with dementia. Emmett and others found, for example, that although staff professed to have a working knowledge of the provisions contained within the Act and its accompanying Code of Practice, in reality these provisions were not routinely applied properly to the decision to discharge older adults with dementia following treatment in hospital. Similarly, research conducted and published in 2015 by the Alzheimer’s Society indicates overall awareness of the Mental Capacity Act 2005 and its provisions are low, and that of 206 participants with dementia, approximately 52% felt that people made decisions on their behalf without asking them what they think sometimes

---


164 *Milton Keynes Council v RR* [2014] EWCOP B19. This case is considered in more detail in chapter 8 of this thesis.


(33%), most of the time (10%) or all the time (9%), and a large proportion were unaware of the Mental Capacity Act 2005 and the provisions contained therein.\footnote{ibid. 79.} As such, the evidence indicates that perhaps because of the stigma associated with dementia, or more specifically the perceived symptoms of dementia (memory loss and confusion, for example) those making best interests decisions have a tendency to disempower the person with dementia from the decision-making process. This mirrors broader concerns elucidated by the House of Lords Post-Legislative Scrutiny of the Act, which noted that while more broadly the empowering ethos of the Act had failed to take root at ground level, there were particular concerns over the implementation of the ‘least restrictive alternative’ principle in section 1(6) for people with dementia. It was noted, for example, that there were concerns that people with dementia were routinely being admitted from their homes into hospitals, with only half then being discharged back home.\footnote{House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013-14 (n 69) para.102.}

This lack of attention to the older person’s views is further reflected in a number of cases that have presented themselves to the courts since the Mental Capacity Act 2005 entered into force – a number of which are explored in greater detail in chapter 8. In \textit{Re MM},\footnote{\textit{Re MM} [2011] 1 FLR 712.} for example, the Court held that there had been a violation of the Article 8 rights of an older gentleman, RS, where he had been prevented from seeing his partner with dementia, MM, for ten months, after concerns about his conduct at the care home where MM resided were raised. This was based upon a mistaken belief by the local authority that following a determination that MM lacked capacity, it was automatically for the next of kin (MM’s daughters) to make best interests decisions in respect of their mother, and in spite of MM’s very clear wishes that RS be allowed to visit. Admittedly, \textit{Re MM} was an early case under the newly-implemented Mental Capacity
Act, and making mistakes regarding the provisions contained within the Act was therefore unsurprising. Yet recent research by Care England suggests that there are still some hurdles to implementing the Act in practice within care homes,¹⁷¹ and similar circumstances have occurred in relation to other older adults since. In Essex County Council v RF¹⁷², for example, the local authority had acted reprehensibly in forcibly removing a 91-year-old gentleman with dementia over whom there were financial safeguarding concerns (no further explanation being offered either by the Local Authority or the Court of Protection) from his home of 50 years and his cat, in his dressing gown without trousers or pyjama bottoms on, being told he was being taken to a hotel, and threatened with the police if he did not comply. The judge was vehement in his criticism of the manner in which the local authority acted, and awarded RF £60,000 damages for his 13-month unauthorised deprivation of liberty. Unfortunately wider case law highlights that poor compliance, and particularly a failure to listen to the person who is deemed to lack capacity, is a feature of other cases, not necessarily involving older adults.¹⁷³

The second, more abstract and potentially more dangerous criticism to be made of the best interests standard, is that in its perceived objectivity, the decision-maker’s perspective is in fact coloured by their own subjective lens – in effect, the objectivity of best interests becomes a myth, or a ‘legal fiction’¹⁷⁴ and in fact becomes characterised by the perceptions, views, and experiences of the decision-maker, and leads to incorrect capacity assessments, or inappropriate best interests decisions. As Stefan notes writing in the context of competency¹⁷⁵ assessments of women in the United States of America before the American courts: ‘We treat the perspective of

¹⁷¹ Saskia Goldman, ‘How Well is the Mental Capacity Act being used in Care Homes?’, (Community Care, 11 May 2016) available at http://www.communitycare.co.uk/2016/05/11/well-mental-capacity-act-used-care-homes/ (last accessed 13 May 2016).
¹⁷² Essex County Council v RF (n 119).
¹⁷³ See, for example: London Borough of Hillingdon v Neary (n 119); Somerset County Council v MK (n 119).
¹⁷⁴ Harmon (n 1).
¹⁷⁵ Competence is used here to reflect the difference in terminology used in different jurisdictions. While in England and Wales it is referred to as ‘capacity’, in the United States of America – the jurisdictional context of Stefan’s article - it is referred to as ‘competency’.
the person doing the seeing or judging as objective rather than subjective...yet both the setting and the identity of the expert may have a substantial impact on the outcome of the assessment. 176

This is reflected in the wider literature over how older persons are treated by those seeking to implement and enforce the Act. In their seminal report in 2012, Williams and others highlighted that whilst those with dementia were more likely than others to have their wishes considered compared to other groups of persons with cognitive impairments,177 overall they were more likely to be disadvantaged than other groups deemed to lack capacity due to a ‘concertina effect’ between being diagnosed with dementia, lacking capacity and the best interests decision being made. The concertina effect is a process

whereby the assessment of capacity and best interests decisions became compressed together in order to ensure or enforce a decision to protect the person involved. In these situations, the best interests decision had effectively already been made, and it appeared the assessment of (in)capacity was then carried out to provide the basis for that decision.178

This ‘concertina effect’ in relation to older people – particularly in issues of residence – has been noted in other domains. In CC v KK,179 a case involving the residence of an 82-year-old woman with a number of medical conditions, including Parkinson’s and vascular dementia, Baker J warned emphatically that:


179 CC v KK [2012] EWCOP 2136.
There is, I perceive, a danger that professionals, including judges, may objectively conflate a capacity assessment with a best interests analysis and conclude that the person under review should attach greater weight to the physical security and comfort of a residential home and less importance to the emotional security and comfort that the person derives from being in their own home.\textsuperscript{180}

This is particularly problematic in respect of best interests decisions, however, because it may lead to decision-makers having difficulty understanding the subjective perspective of the incompetent patient, leading to a best interests decision that does not sufficiently reflect the incapacitated person’s wishes and feelings. An example of this can be found in a recent Local Government Ombudsman report into the treatment of an older couple, Mr and Mrs N, by Cambridgeshire County Council, in moving Mr N, who suffered from dementia, to a care home fourteen miles away from his home and his wife, against both their wishes. The Ombudsman ultimately found that the Council had failed to conduct property capacity assessments and best interests decisions, failed to give either Mr or Mrs N proper information regarding the deprivation of liberty process and the opportunity to challenge decisions, or about provision of care closer to home and how it could potentially be financed. One aspect in particular of the Ombudsman’s criticism of Cambridgeshire County Council is directed at the entry on the relevant paperwork completed by the Council as stating that ‘the purpose of the [capacity] assessment is to determine whether (Mr N) is able to retain and weigh basic information to enable him to make informed decisions about the most appropriate accommodation for his safety.’\textsuperscript{181} In effect, rather than assessing Mr N’s capacity as to where to live, the issue as the

\textsuperscript{180} ibid. [65].
\textsuperscript{181} Local Government Ombudsman, \textit{Investigation into a Complaint Against Cambridgeshire County Council (Reference number 13016935)}, (20 January 2015) para. 46.
local authority saw it was whether Mr N was able to appreciate their own point of view; that the safest place for him was in a care home.

In chapter 8, by drawing on feminist and disability discourse on othering – outlined in the next chapter – the thesis explores whether persons with dementia have been ‘othered’ by certain best interests decision-making by the Court of Protection. In effect, have certain best interests decision-making undertaken by the Court of Protection fallen in to this trap of being dominated and coloured by the decision-makers own ideas of what autonomy should look like at the expense of centralising the views of the person with dementia? Chapter 8 is not therefore concerned with criticising capacity determinations or the existence of the best interests tests under the Mental Capacity Act 2005 per se – which is where the analysis in this thesis departs from the UNCRPD, which as shown above, does take issue with these two legal tools. What chapter 8 seeks to do is to examine whether there is a healthy and able-bodied ideal (again, explored and rejected in more detail in the next chapter) that underpins the Mental Capacity Act, and, if so, whether this has been used in such a way as to marginalise and hide the person with dementia from best interests decision making – that is, to reinforce their perceived ‘otherness’ by virtue of their dementia. In particular, it seeks to question whether there remains an idealistic, rational and hypothetical comparator that underpins best interests decision-making for persons with dementia who come before the Court of Protection. Moreover, by drawing on recent judgments emanating from the Court of Protection, the chapter suggests that an intersubjective approach (outlined in the next chapter), which entails a greater contextual focus on a person’s relationships - both interpersonal and intra-personal – can subvert the process of ‘othering’, and better inform the Court’s best interests decision-making for those with dementia.
3.3 Conclusion

The discussion presented in this chapter is intended to provide an overview of the existing debate in relation to vulnerability within mental disability law, as well as mental capacity law. It has been suggested throughout that there are problems, tensions, confusions, and inconsistencies within the legislative frameworks in both of these areas. It is contended throughout the rest of this thesis that viewing the law through the lens of the theories outlined in the next chapter can also demonstrate that such problems, tensions, confusions, and inconsistencies arise when the law is applied specifically to older persons who experience ageism, interpersonal abuse, and dementia. Furthermore, it has also been suggested throughout this chapter that despite these criticisms, there also remains potential within the legal frameworks - potential for these frameworks to be more robust – and crucially, to be more appropriately robust in safeguarding the decision-making of older persons. I argue, however, that in order to realise the actual potential of the law in this area, it is necessary to adopt a fundamentally different theoretical perspective. Outlining these fundamentally different theoretical perspectives is the aim of the next chapter.
CHAPTER 4: THEORETICAL BACKGROUND AND APPROACH

‘The veneration of elders may be gone, but not because it has been replaced by veneration of youth, it’s been replaced by veneration of the independent self.’

4.1 What Theories, and Why?

A number of ‘relational’ theories, derived from feminist and disability discourse have found prominence in legal commentaries in recent years. This thesis draws on three particular aspects – relational autonomy, vulnerability, and ‘othering’ - to explore whether the law, as outlined in the previous chapter, is adequately equipped to respond to the needs of older adults when making health and welfare related decisions. One of the reasons these theories have been chosen as a theoretical framework is because the focal points that are encapsulated within them – relationships and embodiment – better reflect the lived realities of old age as outlined in chapter 2. As argued in chapter 2, old age is a period of life where a person’s embodiment may become particularly obvious through the loss of certain physical functions, and a time of life when relationships take on a greater significance and may have an even greater impact on how an older person relates to herself. As such, these theories add a more nuanced, detailed, and sensitive framework by which to assess the adequacy of the law in this area – both in substance and its form - which it is suggested that traditional liberal theories fail to provide.

Conceiving of the older adult in this way - as a ‘situated embodied agent’ to use Hughes’ terminology - is important in any discussion of the law as it relates to old age for two main reasons. First, old age brings with it increasing importance assigned to existing relationships – not only does old age bring with it increased efforts to maintain continuity of relationships with

---

an individual’s environment, for example their home and loved ones, as well as their friendships, but relationships of care and dependency may also be increasingly important and increasingly required as a person ages. Frequently, an older individual will rely on relationships of care, either formal or informal, for many essential activities. Second, a theory grounded in recognising the importance of embodiment – as these relational theories are - is perhaps even more important in old age given that embodiment may be vividly experienced during that stage of the life course. Old age may bring with it frailty and certain physical or cognitive conditions that may well impact an older person’s use of her body, and bring with it a need for care, and consequently impact on other aspects of a person’s relationships.

Individualistic and liberal notions of the self which permeate traditional theoretical debates that underpin the law, are unsuited to accommodating the reality of the lived experiences for older people. Writing from a disability theory perspective, Deborah Marks suggests similar, and argues that ‘by excluding personal experience from the analysis of disability, a theoretical vacuum is left, which is filled by those who adopt an individualistic and decontextualised perspective.’ In essence, any theoretical critique of the law must use the grounded experiences...


of older people, derived, for example, from sociological debates and empirical research around old age, to inform its critique. In a similar vein, disability theorists emphasise the importance of grounding disability theory within the actual experiences of disabled people. Tom Shakespeare, for example, in arguing for disability theory to adopt a ‘critical realist’ stance, suggests that ‘[a]cademics who want to make comments about the impact of impairment might do well to base their analysis on empirical evidence about how disabled people feel about their embodiment.’

This thesis, throughout, undertakes a similar task in respect of older adults. In effect, it seeks to explain why conceptualisations of autonomy, vulnerability, and selfhood as individualistic and atomistic are inadequate, and in turn only serve to perpetuate stigma and marginalisation in old age. One of the reasons for this, that becomes particularly clear in chapter 8, as Andersen and Collins state, is that ‘[o]ppressed or marginalized groups of people are often judged by the experiences of their oppressor, rather than being understood on their own terms; this establishes a false norm through which all groups are judged…’

Chapters 6, 7, and 8 attempt to offer one solution to this problem by drawing on relational theories. More importantly, by drawing on research on the experiences of old age from other academic disciplines, it is suggested that recent, more nuanced understandings of such theories that emphasise the centrality of relationships within the lives of older people, better reflect the realities of old age.

To aid the analysis provided throughout the rest of the thesis, this chapter has two central aims. First, I explore the contours of the ethical debates on-going around the reconceptualisation of autonomy as a ‘relational’ concept, the shift from traditionally status-based vulnerability to a more nuanced understanding of vulnerability, and the discourse on ‘othering’ in conjunction

---

with the potential of an ‘intersubjective’ approach advocated for by Nagel\textsuperscript{8}, Atkins\textsuperscript{9} and Dresser\textsuperscript{10} to subvert the process of ‘othering’. Second, I outline how such theoretical debates are utilised throughout the rest of thesis to provide the normative framework for critiquing the law as it currently stands for older people.

4.2 ‘Relational’ Autonomy

In chapter 3, I sought to begin to explore how mental disability law may be premised on an unduly individualistic and healthy-bodied paradigm, which many have argued is supported by an overly liberal and defensive notion of autonomy. This is a conceptualisation of autonomy as a set of functional abilities inherent within each individual,\textsuperscript{11} and that leans towards the idea that its promotion is best served by non-interference, and which espouses the ideal of the healthy and able bodied autonomous agent.\textsuperscript{12} Although autonomy and capacity are not to be taken necessarily as synonymous, they are symbiotic, and as Donnelly rightly points out, in law, capacity (both legal and mental) is often seen as the ‘gatekeeper’\textsuperscript{13} to ‘allowing’ someone to act autonomously. The unduly individualistic account of autonomy is therefore clearly evident within mental capacity law. As outlined in the previous chapter, the Mental Capacity Act 2005 contains both a functional account of capacity\textsuperscript{14} and a requirement that the content of the decision made is irrelevant to capacity assessments.\textsuperscript{15} If the person satisfies the capacity

---

\textsuperscript{8} Thomas Nagel, ‘What is it Like to be a Bat?’ 83(4) The Philosophical Review 435-450.
\textsuperscript{11} I explore functional accounts of autonomy in more depth in chapter 6.
\textsuperscript{13} Donnelly (n 12) 90.
\textsuperscript{14} Mental Capacity Act 2005, s3(1).
\textsuperscript{15} Mental Capacity Act 2005, s 1(4).
assessment, then there is no further scrutiny of their decision, and no legal provisions available – other than the possibility of deploying the inherent jurisdiction\textsuperscript{16} to ensure their autonomy is safeguarded. In effect, within this area of law, not only has autonomy become a core principle, but the meaning assigned to autonomy is that of the individualistic defensive patient – ‘the liberal conception of patients as autonomous, self-determining rights holders has been accepted as the paradigm…’.\textsuperscript{17} In its usual deployment in medical law, mental disability law, and the philosophy that underpin these areas of law, autonomy is therefore seen as a negative liberty – upheld by a set of functional abilities that must be defended and protected from encroachment or interference either by private actors, the state, or medical practitioners,\textsuperscript{18} a concept which can only be upheld by protecting it from intrusion by others.\textsuperscript{19}

In general, critics argue, however, that such an account of autonomy is untenable – particularly in healthcare and mental capacity law – as it fails to pay sufficient attention to a person’s context and relationships.\textsuperscript{20} Autonomy as it has traditionally been deployed within law is criticised for paying little regard to wider considerations, such as the effect of oppressive socialisation on an agent’s autonomy, or the value placed by people on wider relationship-

\textsuperscript{16} Which I also criticise in chapter 7 for deploying a similar unduly individualistic philosophy in relation to older people, and has been criticised elsewhere on the same front: Michael Dunn, Isabel Clare and Anthony Holland, ‘The Empower or Protect: Constructing the ‘Vulnerable Adult’ in English Law and Public Policy’ (2008) 28 Legal Studies 234-253.

\textsuperscript{17} John Harrington, ‘Privileging the Medical Norm: Liberalism, Self-determination and Refusal of Treatment’ (1996) 16(3) Legal Studies 348-367, 363.


\textsuperscript{19} This potentially reflects liberal philosophies underpinning the law more generally, a full exploration of which is outside the scope of this thesis. Writing in the context of criminal justice for example, Norrie argues that this liberal idealisation of personhood ‘involves its conception of the individual as an abstract, universal subject endowed with rational action, autonomy and self-determination…He participates in [the state’s] law as a rational legal subject’: Alan Norrie, ‘The Limits of Justice: Finding Fault in the Criminal Law’ (1996) 59(4) Modern Law Review 540-556, 543.

centred considerations when making such decisions.\textsuperscript{21} Kong argues that autonomy, when conceptualised in the reductionist way outlined above, ‘fails to capture the full complexity of how the social and individual combine in the formation of our values and practical orientations’.\textsuperscript{22} Similarly, Whitney argues by drawing on care ethics literature, that ‘to valorize independence to the exclusion of dependency relations…is to disavow inexpungable and otherwise tacitly valued portions of our lives as communities and incarnate persons.’\textsuperscript{23}

Yet despite what appear to be strong criticisms of the conceptualisation of autonomy that underpins the law in this area,\textsuperscript{24} this thesis does not advocate for a wholesale rejection of the concept of autonomy itself. It is not argued here, as Foster suggests, that autonomy is a ‘tyrannical’\textsuperscript{25} concept, nor is it ‘philosophically and morally untenable’,\textsuperscript{26} as Gaylin has suggested. What is argued is that autonomy is important for the values it espouses, but as a theoretical concept must be reconceptualised from a functional and individualistic idea, to a relational one. One of the key reasons as to why this approach is taken, is that research indicates that autonomy as a value remains important for many older people. A transnational study published in 2001 conducted with older persons in the UK and in Italy shows that autonomy – conceived of as the ability to make one’s own decisions, independence, and retaining control over one’s life – was integral to many of the responses by the study participants.\textsuperscript{27} In studies


\textsuperscript{24} These criticisms are explored in greater depth later in this chapter, and in chapter 6.

\textsuperscript{25} Charles Foster, Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law (Hart 2009).


published by Woolhead and others,\textsuperscript{28} and Black and Dobbs,\textsuperscript{29} autonomy is seen as central to ensuring dignity for the older person. These ideas about autonomy – and the importance it holds for many older people both as an end in itself, and as means to an end of securing other values such as dignity - are also overwhelmingly reflected in other research in this area.\textsuperscript{30} It seems, then, that Ronald Dworkin’s \textit{integrity} view of the value of autonomy still rings true for older people:

The value of autonomy, on this view, lies in the scheme of responsibility it creates: autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction, and interest. It allows us to lead our own lives rather than being led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what he has made himself.\textsuperscript{31}

There is, however, an even more important aspect that becomes clear from the research cited above on the importance of autonomy for older people. While all the studies cited suggest that it is a profoundly important concept for older people, the studies also suggest that older people see autonomy as \textit{fundamentally relational}. In effect, central to the promotion and exercise of autonomy are relationships of affection, relationships of care, and – crucially for the arguments put forward in chapter 6 – positive self-relations and the preservation of self-identity. It is for these reasons that this thesis maintains that there is value in autonomy – and therefore value in philosophically interrogating autonomy in the context of old age. Moreover, it is for these

\textsuperscript{28} Gillian Woolhead and others, ‘Dignity in Older Age: What do Older People in the United Kingdom Think?’ (2004) 33 \textit{Age and Ageing} 165-170.
\textsuperscript{29} Kathy Black and Debra Dobbs, ‘Community-Dwelling Older Adults’ Perceptions of Dignity: Core Meanings, Challenges, Supports and Opportunities’ (2014) 34(8) \textit{Ageing and Society} 1292-1313.
\textsuperscript{30} See, for example: Becker (n 4); Sarah Hollcoat-Nallétembry, ‘The Meaning of “Independence” for Older People in Different Residential Settings’ (2014) 69(3) \textit{Journal of Gerontology} 419-430; Lloyd (n 3).
\textsuperscript{31} Ronald Dworkin, ‘Autonomy and the Demented Self’ (1986) 64(Supp 2) \textit{The Millbank Quarterly} 4-16, 8.
reasons that the thesis also contends that a purely functional account of autonomy belies the reality of how older people ‘do’ autonomy in practice. From this, it is therefore argued that what is required is a relational reframing of autonomy – and more specifically, a reframing that prioritises understanding relationships as ontologically prior to the completion of the functional skills that lie at the heart of traditional accounts of autonomy. In effect, the argument presented here, and in chapter 6, is not that functional accounts of autonomy are entirely redundant, but that much greater attention should be paid to the effect of relationships – and particularly broader societal relationships - on the execution of these functions.

Maintaining that there is value in autonomy is not incompatible with arguing that the current conceptualisation of autonomy that underpins the law in this area is unduly individualistic and atomistic. The ‘umbrella’ term of relational autonomy, which encapsulates the ideas proposed in the preceding paragraphs, as well as alternative ways of thinking about autonomy, has arisen out of this dissatisfaction with the apparent overly individualistic and liberal conceptions of autonomy outlined above – yet continues to maintain that autonomy is an important concept of itself. It is the reductionist, isolated and defensive account of autonomy – and indeed personhood – that relational reconceptualisations attempt to dismantle. This – as explained above - does not necessarily mean a total rejection of the concept of autonomy. Relational autonomists argue that rather that the perfectionist account of self that permeates historical philosophical discourse around autonomy, what is in fact needed is a starting point that is ‘the individual as situated in, shaped, and constrained by her sociorelational context in all its complexity; that is, its starting point is non-ideal agents in a non-ideal world, characterized by social oppression, injustice and inequality.’

web of relationships (both positive and negative), rather than the fully functioning rational individual, should be the central focus of autonomy, which recognises that ‘human beings always make decisions and take action in the context of a range of predetermining conditions, including an individual’s socialization, social class position and generation.’ Bruce Winick, discussing the stigmatising effects of labelling in mental health in 1995, before mainstream ‘relational’ theories of autonomy became prominent, argues thus;

> The concept of the self is largely socially determined, the product of a social process in which others play an essential role in individuals' acquisition of self-knowledge and in the interpretation and evaluation of life experiences. Individuals' construction of self-identity is largely dependent on the effect of reactions that are received from others. In effect, relational autonomy seeks to examine and explain the effect of such factors on the exercise of a person’s autonomy, as well as explore how such factors are also indispensable to the pursuit of autonomy.

Priaulx, writing in the context of wrongful birth and wrongful conception cases in medical negligence, puts the appeal of a relational perspective on autonomy succinctly, and emphatically:

> What a relational perspective provides is a close attention to context; it highlights those moments where the law has lost its moral compass in attempting to understand human decision making through a narrow…lens based upon values which fail to fit the context – culminating in determinations of reasonableness that twist or exclude other ways of seeing, being, trivialising other moral frameworks, which guide our

---

actions and choices. A relational perspective challenges such narrow approaches to humanity: renders visible the broad spectrum of concerns that motivate human decision making; makes understandable what law sees as contradiction and can explain those instances where individuals are caught between yes/no, black/white and choice/no choice.

In effect, the argument put forward by ‘relational’ scholars is that liberal ideals of autonomy are inherently flawed - that cognitive and emotional ability to make autonomous decisions are influenced by a wider, undefinable set of factors. This recognition of social factors that impact autonomy is crucial – without it wider forms of oppression may go unnoticed in theoretical and ethical discourse around autonomy.

There is one particular aspect of the ‘relational’ autonomy approach that is drawn upon in chapter 6 – the importance of an older person’s self-relations, or ‘self-referring attitudes,’ such as self-trust, self-esteem, self-worth or self-respect. It may seem antithetical to argue for a ‘relational’ reconceptualisation of autonomy – or one that centralises the importance of relationships - that also pays attention to a person’s self-relations, however this is not necessarily the case if the development and maintenance of self-relations is explored in greater detail. The central argument supporting the idea that self-relations are relational processes –

---


that they rise and fall based on our interactions with other people and organisations - is outlined by Joel Anderson and Axel Honneth:

Self-trust, self-respect, and self-esteem are thus neither purely beliefs about oneself nor emotional states, but are emergent properties of a dynamic process in which individuals come to experience themselves as having a certain status, be it as an object of concern, a responsible agent, a valued contributor to shared projects, or what have you. One’s relationship to oneself, then, is not a matter of a solitary ego reflecting on itself, but is the result of an ongoing intersubjective process, in which one’s attitude toward oneself emerges in one’s encounter with an other’s attitude toward oneself.39

This, and as Anderson and Honneth go on to argue, requires any society committed to promoting autonomy, to also commit to promoting and protecting relationships which also foster positive self-relations.40 Being aware of one’s self-relations, as Stoljar explains,41 is particularly important in the context of health and social care relationships, such as between doctor and patient, or carer and cared for, given the professional responsibilities incumbent on them to be aware of how broader oppressive forces may erode or undermine a person’s autonomy.

This aspect to relational discourses of autonomy - how autonomy is impacted by self-relations – is developed further in chapter 6, which explicitly explores relational conceptualisations of autonomy to highlight how ageism can be seen as a threat to maximal42 autonomy. Historically

40 ibid. 135.
41 Stoljar (n 37).
42 For an explanation of autonomy as existing on a spectrum from minimal to maximal, see chapter 6 of this thesis (n 38).
none of the predominant forms of oppression discussed in the theoretical literature (sexism,\textsuperscript{43} or disablism,\textsuperscript{44} for example) have been seen as a \textit{direct} threat to maximal autonomy in law, as cognitive disabilities or undue influence have.\textsuperscript{45} The arguments forthcoming recently, however, and as discussed above, suggest that by taking into consideration an agent’s self-perception, and how this may be impacted either positively or negatively by relationships with other persons or organisations, it can be contended that there is a link between forms of social oppression and oppressive attitudes, and an older person’s ability to act autonomously. Chapter 6 seeks to explore what this link is, and whether an argument can be made that ageism may be just as much of a threat to maximal autonomy as traditionally perceived threats, such as undue influence or cognitive impairments. If, as relational autonomy theorists posit, autonomy is impacted by much broader social forms of engagement and not just undue influence and impaired cognitive functioning, and that the development and execution of autonomy in a health or social care context ‘…depends on how [a decision] is embedded in a larger pattern of normative relations between the patient, and her health practices, both her practices of self-management and her interactions with health professionals and clinics,’\textsuperscript{46} then chapter 6 seeks to philosophically explore the link between an older person’s autonomy – and their capacity for autonomy – where they have been subjected to ageism.

\textbf{4.3 Vulnerability}

Although vulnerability has been a longstanding term within law and policy, particularly in adult safeguarding and mental disability law, (explored further in chapter 3 above, and later in

\textsuperscript{43} The process of stereotyping and discriminating against persons of a specific sex or gender.
\textsuperscript{44} The process of stereotyping on the basis of a person’s impairment or disability.
\textsuperscript{45} See, for example, key cases from the early 1990s that established this, outlined in the previous chapter, including \textit{F v West Berkshire Health Authority} [1990] 2 AC 1, which involved the proposed sterilisation of a woman with learning disabilities, and \textit{Re T} [1993] Fam 95, involving a young Jehovah’s Witness, who the Court found may have been subjected to undue influence by her family, and as a result there were doubts of her refusal of a blood transfusion. The Court subsequently declared that the transfusion would be lawful.
chapter 7), the theoretical debate on the meaning of vulnerability and the implications of this debate are only just beginning to materialise. In contrast to an approach premised solely on the existence of internal characteristics, for example, old age, frailty, or dementia – which, as outlined in the previous chapter, is found within the legal usage of the term vulnerable adult – more recently the literature has sought to explore how vulnerability can and should be understood as a multifaceted and complex concept. These accounts of vulnerability suggest that being vulnerable is not necessarily a negative fact: not only is it an inevitable feature of all human existence, but can also be construed positively, and recognising this can allow for an examination of its conceptual potential for personal development. The precise aims of the current literature on vulnerability are numerous – and interwoven. Only two of these aims are discussed in more detail in this section. First, work by Fineman in particular seeks to shift vulnerability from being a particular feature of some individuals by virtue of certain inherent characteristics, towards being both universal and particular, thereby challenging the stigma associated with both vulnerability, and the status-based characteristics that attract a demarcation of someone as being ‘vulnerable’. Second, recent literature seeks to classify types, or sources of vulnerability, and seeks to direct our attention towards the types of responses and remedies that are available or imposed when someone is considered vulnerable, and ensuring that such responses do not render a person more vulnerable.

47 Vulnerability has, however, been a feature of philosophy for many centuries, as Shiloh Whitney notes of Thomas Hobbes’ work: Whitney (n 23).
4.3.1 Universal and Particular Vulnerability

According to traditional accounts adopted by the law (outlined in the previous chapter), vulnerability is a characteristic of certain groups – for example, persons with either physical or mental impairments, or people who are old and frail. Such an approach has been present within England and Wales for a number of years. The traditional reasoning is that if a person is old, or has dementia, or another physical or mental impairment, for example, then that person is considered susceptible to harm and unable to protect themselves – they are considered vulnerable. Vulnerability is therefore considered to be a state of ‘being’ – it is a status attributed to certain people. This – as was stated in the previous chapter in the legal context of vulnerability - is referred to throughout as the ‘status-based’ approach to vulnerability.

The ‘universal vulnerability’ argument derived from more recent theoretical perspectives on vulnerability, however, suggests that rather than being a characteristic of certain groups, vulnerability is a state of being inherent within all humans and is derived in part from our corporeality. It is a feature of the ‘state of constant possibility of harm’ of all humans. In essence, because of human embodiment, and the fact that humans are all susceptible to harm, or ‘wounding’ to use Turner’s language, every human is vulnerable, not just certain groups. This is not to deny that vulnerability is experienced in a particular way by certain individuals – as Fineman herself notes:

...while human vulnerability is universal, constant and complex, it is also particular. While all human beings stand in a position of constant vulnerability, we are individually positioned differently. We have different forms of embodiment and also are differently situated within webs of economic and institutional relationships.

50 See chapter 3 of this thesis.
52 Fineman, ‘The Vulnerable Subject: Anchoring Equality in the Human Condition’ (n 49) 11.
53 Turner (n 34).
As a result, our vulnerabilities range in magnitude and potential at the individual level. Vulnerability, therefore, is both universal and particular; it is experienced uniquely by each of us.\textsuperscript{54}

The idea that vulnerability is \textit{both} universal \textit{and} particular is especially evident old age, which may well bring with it inherent sources of vulnerability such as dementia, or frailty, as well as increasing external vulnerabilities such as two that are examined in this thesis – ageism and abuse. On the face of it, however, to suggest that there \textit{are} inherent sources of vulnerability seems antithetical to the notion that vulnerability is universal. Conversely a simplistic universal vulnerability paradigm seems not to account for intuitive feelings that suggest that a person with advanced dementia living in a nursing is more vulnerable than, for example, a 30 year-old in good health living at home. As Rogers, Mackenzie, and Dodds argue:

‘[t]he ‘everyone is vulnerable’ approach dulls our responses to particular vulnerabilities, fails to account for context-specific harms, and can lead to discrimination and stereotyping of whole groups as incapable of caring for their own needs or of being self-determining’.\textsuperscript{55}

So how do we navigate through this catch-22 situation with vulnerability? On the one hand, everyone is vulnerable, yet on the other hand intuition dictates that some people do experience greater vulnerability than others because of an inherent condition. Under the universal vulnerability paradigm that emerges from Fineman’s thesis, we are not \textit{precluded} from considering these inherent factors that may generate vulnerabilities, it does not require us to hide or ignore these particular characteristics – indeed to do so would be dangerous. If, as

\textsuperscript{54} Fineman, ‘The Vulnerable Subject and the Responsive State’ (n 49) 269.
suggested earlier in this chapter, the thesis takes a broadly ‘critical realist’ stance – that is, acknowledging that certain conditions do bring with them limitations and difficulties – then it is also important to be cognisant of the fact that such inherent features may also bring increased vulnerability. That vulnerability is universal, as outlined by Turner, and Fineman, for example, is not a simple statement of fact – it is not simply a statement that ‘everyone is vulnerable’ as Rogers, Mackenzie and Dodds imply. The universal vulnerability paradigm outlined above is intended to operate as a normative legal tool – which, as is argued throughout this thesis, has traditionally been conceived of as the rational, autonomous entity rather than the vulnerable, embodied subject. One interpretation of Fineman’s conjoining of the universal vulnerable subject with particular vulnerability is therefore that it enables us to think of the human condition as in a perpetual state of vulnerability for legal purposes, but experienced differently on a particular level in reality. In the context of this thesis, it forces us to confront and to delve deeper in to what it is about that older person’s particular circumstances that contributes to their experience of vulnerability, rather than bracketing them off as simply vulnerable because of their dementia, or their political status, as Rogers, Mackenzie, and Dodds’ interpretation of Fineman implies. Fineman’s argument does not require a denial of the particular vulnerability of many older people by simply stating ‘everyone is vulnerable’, but to highlight and demonstrate the importance of exploring in greater detail how vulnerability is experienced by particular individuals and responding in a way that does not prioritise the rational, autonomous normative legal standard, but prioritises instead the vulnerable, embodied, and relational person instead.
The interpretation offered above of universal vulnerability is that far from being a literal term as critics have sometimes interpreted it, it is in fact intended as a legal and political tool, and as Herring notes, forces us to reconsider the dominant model of the self that permeates legal discourse, and entails a departure from the view of the legal self as rational, liberal and self-determining. Herring further elucidates the potential benefits of the idea of universal vulnerability as a legal tool by suggesting that if

we start with a norm of vulnerable, interdependent, caring people then the nature of legal intervention becomes different. The importance of upholding and maintaining those relationships becomes key. The law does not emphasise independence, liberty and autonomy; but rather seeks to uphold relationships and care. Much as relational autonomy seeks to displace the functional ideal by highlighting the role of relationships for autonomy, and as shown below, the notion of ‘othering’ in feminist and disability discourse seeks to challenge the healthy and able bodied standard espoused by law, recent vulnerability theory seeks to replace the dominant paradigm of the isolated, invulnerable, and resilient liberal caricature within legal and political discourse, with the ‘universal vulnerable subject’. This, as Margaret Isabel Hall notes, and as is explored in chapter 7, has the potential to fundamentally alter the legal responses that are deemed appropriate.

This goal of the theoretical vulnerability literature will not be easy – there is a historic stigma attached to the use of term ‘vulnerable’, which is perhaps derived, as Herring suggests, from this dominant legal and political ideal of invulnerability - the self-contained, and independent

---

57 Herring (n 12) 18.
58 Margaret Isabel Hall, ‘Dementia, Autonomy and Guardianship for the Old’, in C Foster, J Herring, and I Doron (eds), The Law and Ethics of Dementia (Hart 2014).
59 Herring (n 12).
actor. Noting this, and how this image can lead to the stigmatisation of vulnerability, Wolfe notes that

‘In a world that sets self-determination and dependency at odds and lauds self-determination while belittling dependency as a form of weakness or shortcoming, it is possible to be alienated from the fundamental human reality of interdependent welfare or to develop a willful desire to disavow it’. 60

Hall summarises this point neatly in respect of old age, and suggests that the fear of vulnerability as a normative tool is rooted in its traditional use to denote status based characteristics. She argues that the

[r]esistance to the idea of vulnerability as key to a conceptually coherent category of “law and aging” is strong, and rooted in the idea that vulnerability = weakness and resistance to the presumption that age = loss of capacity. The fear is that legal theory focusing on personal vulnerability increases social vulnerability, the more significant source of harm, to the extent that it reinforces ageist presumptions of weakness and incapacity.61

Divorcing vulnerability from status – which the more recent accounts of vulnerability seek to achieve - actively strives to challenge the traditional stigma and marginalisation associated with being vulnerable, and, as Whitney argues, the challenge then becomes seeing vulnerability not simply as an opportunity to be ‘wounded’ as Turner has suggested of the term, but as a source of potential;

…the challenge of the dependency critique is to rethink personhood in a manner

that not only acknowledges corporeal vulnerability, but that also affirms its role in our lives as the opportunity to deepen our relationships, instead of understanding it only as the opportunity to experience wounding and death.  

Indeed research conducted with older persons themselves as well as nurses caring for older persons, also identify with the term vulnerability in the sense it is used here. It was acknowledged by participants in these studies that vulnerability was associated first and foremost with ‘being human’ – it was considered a feature of all humans – and in particular, that both older persons in care homes, and the nurses caring for them, felt vulnerable. Importantly, however, for the participants in the study conducted with older persons, old age did bring an inherently increased feeling of vulnerability – particularly with increased frailty, perceived threats to their dignity, and through feelings of de-personalisation and exclusion that came with being an older person in society. The studies also found that while vulnerability was seen as a burden, it was also seen by the participants as a potential resource – particularly for the nurses - it was seen as an opportunity for nurturing and developing. Although it is impossible to draw any firm conclusions on the nature of vulnerability in old age from these few studies, they do indicate that the more nuanced concept of vulnerability presented in the theoretical debate and outlined here, may have some purchase in reality in the lives of older people, and those caring for older people.

---

62 Whitney (n 23) 559.
4.3.2 Sources of Vulnerability

If vulnerability may be properly characterised as both universal and particular, as suggested in the preceding section, and as it is deployed throughout this thesis, then a second aim of the more recent literature on vulnerability is to seek to clarify types, sources, or, to use Mackenzie, Rogers, and Dodds’ terminology, to develop a ‘taxonomy’ of vulnerability. In essence, is it possible to broadly identify and categorise sources of vulnerability without reverting to the status-based approach?

Mackenzie, Rogers, and Dodds, in one of the leading books in this area, propose three sources of vulnerability: inherent, situational, and pathogenic. Inherent vulnerability, they argue is a source of vulnerability that exists within individuals, and ‘arise from our corporeality, our neediness, our dependence on others, and our affective and social natures’ – this is intended to displace the traditional status-based vulnerability. Situational vulnerability, on the other hand, is a vulnerability that depends specifically on a person’s context, and may be exacerbated by ‘personal, social, political, economic, or environmental situations of individuals or social groups.’ The authors themselves note that neither of these two categories of vulnerability is mutually exclusive, and that inherent vulnerabilities can reflect, to a large extent, the environment around individuals, and as a result, the distinction between inherent and situational vulnerability – beyond what has been outlined in the previous chapter - is not taken forward in this thesis.

---

66 ibid. 7.
67 ibid. 7.
68 ibid. 8.
A final source of vulnerability that the authors note, however, and which is applied later in this thesis, is pathogenic vulnerability. This is described as being ‘when a response intended to ameliorate vulnerability has the paradoxical effect of exacerbating existing vulnerabilities or generating new ones.’ 69 This aspect of the more recent philosophical literature on vulnerability seeks to direct attention towards the content of the responses and remedies imposed that address a person’s vulnerability. It seeks to ensure that responses to perceived sources of vulnerability do not entrench that person’s experience of vulnerability even more. Munby J summarises this idea well in *Local Authority X v MM and KM*, 70 a case involving decisions as to the capacity of a woman with paranoid schizophrenia, a moderate learning disability, poor cognitive functioning, and a history of being sexually abused, to consent to sexual relations. In holding that she did not lack capacity, Munby J states that

…the court must be careful to ensure that in rescuing a vulnerable adult from one type of abuse it does not expose her to the risk of treatment at the hands of the state which, however well intentioned, can itself end up being abusive of her dignity, her happiness and indeed of her human rights. 71

As Stychin argues, 72 the importance of this aspect of vulnerability discourse is to shift attention towards relationships of power, not only between individual persons, but also between individual persons and the courts or the state. This shift in attention enables an assessment of the adequacy of existing legal remedies and responses to experiences of vulnerability, and how such responses are implemented, so as to ensure they do not aggravate a person’s experience

---

69 *ibid.* 9. They also suggest that vulnerability ‘generated by a variety of sources, including morally dysfunctional or abusive interpersonal and social relationships and sociopolitical oppression or injustice…’ may be pathogenic, however this idea resonates more with situational vulnerability, and as such, this dimension to the taxonomy they propose is not explored in this thesis.

70 *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam).

71 *ibid.* [118].

of vulnerability or create additional power imbalances between the state and the person experiencing vulnerability. If they do, as the House of Lords has recently stated that the implementation of the Mental Capacity Act does on occasions,\textsuperscript{73} then it is imperative to re-imagine and reconfigure alternative responses to such vulnerability, as Margaret Isabel Hall suggests.\textsuperscript{74} Stripping back these responses and re-imagining an alternative framework as Hall proposes, does not mean not responding to perceived sources of vulnerability – to do so would be to entrench the ideal of the liberal subject and the restrained state even further. As Fineman argues - ‘[the] liberal subject…is indispensable to the prevailing complementary ideologies of personal responsibility and the noninterventionist or restrained state.’\textsuperscript{75} It does, however, require greater consideration and scrutiny of the types of responses imposed and that the state sees as appropriate. To take a simple example - if someone has dementia, and lives with their exhausted husband who cares for them and who can no longer cope, should the first port of call be to place the person with dementia into a care home, where they may become agitated, and may sever the relationship between the person and their husband, or should it be to assess to what extent greater respite care or support should be provided for the husband in the first instance?\textsuperscript{76} This aspect of the vulnerability discourse suggests the latter – to do so pays greater attention to and shows greater respect for a person’s relationships, but uses imagination and diversity in implementing responses to both the person with dementia’s experience of vulnerability, as well as the husband’s, while avoiding a response that may exacerbate the vulnerability of both.

\textsuperscript{74} Hall (n 58).
\textsuperscript{75} Martha Fineman, ‘Equality, Autonomy and the Vulnerable Subject in Law and Politics’ (n 56) 17 (emphasis added).
\textsuperscript{76} There are legal implications of this approach that are discussed briefly in chapters 7 and 8, given that the Court of Appeal has recently noted that the Court of Protection ‘...has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party...than the adult if he had capacity would be able to obtain himself’: \textit{Re MN} [2015] EWCA Civ 411 [80].
Chapter 7 uses this critique of existing notions of vulnerability, as well as its conceptual potential proposed by Fineman among others, to highlight how recent judgments by the courts in three key cases involving older adults in abusive relationships – *DL v A Local Authority*[^77], *London Borough of Redbridge v G*[^78], and *NCC v PB and TB*[^79] have adopted a confused approach to what it means to be a vulnerable older adult, particularly when the older person is subjected to abusive interpersonal relationships. It is argued that the courts remain committed to a status-based approach to vulnerability based on their cognitive impairments such as dementia (in *London Borough of Redbridge v G*) or physical impairments associated with old age and mental illness (in *NCC v PB and TB*). Moreover, chapter 7 critiques this approach inherent in the courts’ recent judgments on the basis of the types of responses it envisages in such instances. In legal terms, it suggests that the courts may be adopting the ‘best interests’ framework which has been much criticised (see chapter 3), but that such responses may add to the older person’s experience of vulnerability where it compromises their valued relationships, or does not put additional supportive mechanisms in place to help them cope with the removal of such abusive relationships.

The broader ideas emerging from this section, however, also feature to some extent throughout the rest of the thesis in its examination of the vulnerability that arises out of relationships in health and social care characterised by ageism on the part of the care provider – as well as considering how legal responses and remedies to such ageism may have the potential to ameliorate this vulnerability, or entrench it even further. Likewise, in its exploration of how the Court of Protection makes best interests decisions on behalf of a person with dementia who lacks capacity under the Mental Capacity Act 2005, it is argued that the Court deploys a process

that has, on occasions, ‘othered’ the person with dementia. To use the language of vulnerability, this could also be seen as a way in which legal responses and methods exacerbate a person with dementia’s experience of vulnerability. Throughout the thesis, then, is a shift in focus from perceived internal sources of vulnerability, such as old age and dementia, towards examining how vulnerability is experienced as a result of a complex interplay of factors both inherent to the older person, and external to the person – such as ageism, abuse, and interaction with legal provisions under the inherent jurisdiction and the Mental Capacity Act.

4.4 ‘Othering’ and Dementia

In the ethico-legal literature, dementia has traditionally been discussed in relation to what is known as the ‘personhood problem’, or the ‘someone else’ problem. 80 This debate seeks to analyse whether the person with dementia can be considered the same person they were before they had dementia, and what moral, ethical, and legal implications this has for the validity of their advance decisions or directives. In essence, if they are not considered the same person, then should their advance directives have only minimal moral force? Given the extensive literature on this debate, 81 this thesis assumes a different theoretical framework by which to assess the adequacy of the law in engaging with persons with dementia where they may lack mental capacity, and I argue that the theoretical approach drawn on in this section, and later in chapter 8, here better reflects the lived realities of having dementia.

---

4.4.1 ‘Othering’

‘Othering’ is a process long discussed in feminist and disability theory discourse – as De Beauvoir noted in her seminal work, The Second Sex, written in 1949, ‘the category of Other is as primordial as consciousness itself. In the most primitive societies, the most ancient mythologies, one finds the expression of duality – that of the Self and Other.’

As with relational autonomy and vulnerability, outlined above, one of the central aims of De Beauvoir, among many others, is to uncover, draw attention to, and challenge power imbalances that arise as a result of dominant ideologies contained within such dualities. This section of the thesis does not aim to undertake a review of all literature on ‘othering’ – to do so would be an impossible feat. What this section aims to do is to focus on the broad themes that emerge from predominantly feminist and disability discourse on ‘othering’, and how such processes have presented themselves in the context of dementia. In effect, this section broadly addresses a question that is explored further in chapter 8 – what are the central components of ‘othering’?

It is important to note that this is only one theoretical lens by which it is possible to consider the way in which people with dementia are treated. Disability theorists have long since rejected medicalised notions of disability, favouring instead a more social model of disability, and arguing that there is no inherent difference experienced by a person with impairments, but it is as a result of their encounters with society that they are ‘disabled’; ‘personal experiences of

---

82 Simone de Beauvoir, The Second Sex (H M Parshley tr, Vintage 1997) 16 (emphasis in original).
83 It would also cross over in to psychoanalytical theory works by key authors such as Jacques Lacan, among others. These authors argued that because of the sexed nature of masculinity and femininity (or ‘phallogocentrism’ as Lacan terms it), patriarchy – or the masculine as the dominant gender – is psychologically enforced on females upon birth, and self-perpetuates within women throughout the life cycle: Jacques Lacan, ‘The Meaning of the Phallus’ (1958) in J Mitchell and J Rose (eds), Feminine Sexuality: Jacques Lacan and the Ecole Freudienne, (Macmillan 1982). In effect, man is born with a penis and is therefore considered ‘normal’ or even ‘superior’ on the basis of having penis, while a woman is born without a penis and is therefore considered ‘other’, or subnormal – females are constructed in opposition to males and are therefore afforded the qualities men deem they ought to have, or that women cannot even ‘exist’ without the masculine ideal: Toril Moi, Sexual/Textual Politics (Methuen 1985) 163.
84 I use the term ‘more’ here to reflect the fact that many advocate for a middle ground – not ignoring the effect of impairments, but also acknowledging that societal barriers exist. See, for example: Shakespeare (n 6).
being denied opportunities are not to be explained by our bodily limitations (our impairments) [the medical model of disability] but by the disabling social, environmental, and attitudinal barriers which are a daily part of our lives.\(^{85}\) There have, in turn, been increasing calls to apply this social model of disability to dementia\(^{86}\) especially following the shift embodied within the UNCRPD outlined in the previous chapter. Those who advocate the social model of disability in relation to dementia suggest that it is not the inherent limitations of persons with dementia that stand in their way, but it is society’s disablement of persons with dementia that does this. While there are similarities between this approach, and the ‘othering’ analysis presented here – the details of applying a strictly social model critique to dementia have been discussed elsewhere and are outside the scope of this thesis.\(^{87}\) Moreover, a purely social model approach to dementia risks obfuscating the fact that dementia does entail changes to cognitive and emotional functioning which must be recognised, and reflected in the legal approach. It is the subject of chapter 8 as to how the Court of Protection may be able to do this in a more sensitive manner within the context of best interests decision-making.

At the heart of ‘othering’, is the idea of a comparator – as with the theories outlined in the preceding sections, ‘othering’ takes place because societies and institutions (such as legal institutions) construct a prevailing standard which is taken to be the normative framework by which everyone else is judged – this is De Beauvoir’s ‘Self’ in the duality between ‘Self’ and ‘Other’. According to some feminist philosophers, it is the masculine standard – that of the ‘atomistic and individualistic’\(^{88}\) male. In disability theory, it is the ‘integrated and fully

---


\(^{87}\) ibid.

\(^{88}\) Ngaire Naffine, Law and the Sexes: Explorations in Feminist Jurisprudence, (Allen & Unwin 1990) 145. See also De Beauvoir (n 82).
functioning body’. This idea of a comparator is not confined to the realms of philosophy, however. Such criticisms have also been made of the standards deployed by law and the legal system, some of which have been outlined earlier in this chapter. Feminist legal scholars such as Catherine MacKinnon, Ngaire Naffine, and Carol Smart have argued that the values that the law espouses also inherently reflect masculine values. Smart in particular argues that ideals of objectivity and neutrality which are celebrated in law are actually masculine values which have come to be taken as universal values. Thus...this analysis suggests that when a man and woman stand before the law, it is not that law fails to apply objective criteria when faced with the feminine subject, but precisely that it does apply objective criteria and these criteria are masculine. To insist on equality, neutrality and objectivity is thus, ironically, to insist on being judged by the values of masculinity.

According to Naffine, the political and legal norm is that of the ‘able bodied, autonomous, rational, educated, monied, competitive and essentially self-interested’ male, extrapolated from its contextual space. Fiona Campbell argues similarly in respect of the healthy body, and suggests that such standards are characterised by ableism – ‘a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect species-typical and therefore essential and fully human’. It is these standards that dictates who the ‘Self’ is, and how everybody else is to be judged - anybody who fails to meet this standard is considered ‘Other’.

---

91 Naffine (n 88).
93 Ibid. 32.
94 Naffine (n 88) 52.
There is, however, an additional feature to ‘othering’ which is at the centre of what makes it so problematic – how the comparator outlined above has been deployed by society generally, and more specifically by law, to highlight and victimise deviance from this standard. In effect, the perceived failure of those who eventually become classed as ‘Other’ to reach the standard defined by law as the idealistic paradigm. For some, such as Shildrick, this failure is seen to be for reasons linked to corporeality or embodiment – ‘the indeterminacy of body boundaries challenges that most fundamental dichotomy between self and other, unsettling ontological certainty and threatening to undermine the basis on which the knowing self establishes control’. Exploring how this process takes shape in more detail, Keywood notes that:

Female corporeality has been conceptualised in philosophical discourse as leaky, eruptive and volatile, inextricably associated with the bodily secretions of female reproduction…and in need of confinement to the private sphere…The female body is differentially constituted as a signifier of volatility and fluidity, in need of containment by the regulatory forces which stabilise and determine the limits of identity in Western culture.

Essentially, what this suggests is that ‘a marked difference in embodiment are seen a priori as deviations from a singular model, rather than equally valid alternatives’.

For others, rather than embodied differences, it is perceived psychological difference, such as irrationality, emotion and ‘madness’ that create otherness. ‘Othering’ does not simply revolve around the identification of a difference because of gender or an impairment – but the associated

96 Margrit Shildrick, *Leaky Bodies and Boundaries: Feminism, Postmodernism and Boundaries* (Routledge 1997) 34.
98 Shildrick (n 89) 50.
100 See distinction here between ‘sex’ and ‘gender’ – sex is biological and gender is socially constructed.
unjustified victimisation,¹⁰¹ stigma and blame that goes hand in hand with this difference, and that purportedly justifies correction, or – to adopt Keywood’s terminology - ‘containment’ or silencing of those considered ‘Other’. This, in turn, reaffirms the initial masculine or able-bodied paradigmatic standard as both valued and valuable, and reinforces existing power imbalances. As Weicht notes in his discussion of dependency in old age,

…the identity of being the other, i.e. the dependent person, is essentialized.

The dichotomy created between the dependent older person and the independent active, agentic individual enables a reaffirmation of all that is most valued. The Other is used, by way of comparison…to define what a reasonable life is; the Other is used to define one’s own independence.¹⁰²

In chapter 8, I use the idea of ‘othering’ outlined in this section to analyse the processes undertaken by the Court of Protection when making best interests decisions on behalf of the person with dementia who is deemed to lack capacity under the provisions of the Mental Capacity Act 2005. In doing so, I draw on empirical and theoretical research – detailed below - highlighting this process of ‘othering’ taking place in various spheres. It is well established in research that persons with dementia experience changes in social identity and how society interacts with them once they are diagnosed with the condition, and as the condition progresses. These changes in interaction are predominantly negative. Research indicates that older people frequently identify as having been treated negatively by others as a result of having dementia, reporting that other individuals saw them and their diagnosis as something to be feared, or

¹⁰¹ MacKinnon (n 90).
would consider them ‘odd’ and ‘foolish’,\textsuperscript{103} or experiencing a ‘social death’,\textsuperscript{104} as well as noting that negative stereotypes and language associated with dementia also have an adverse effect on persons living with dementia.\textsuperscript{105} Jennings, for example, argues that having dementia means having ‘…a kind of agency that seems devoid of meaning and lacking in humanness, not because it really is, but only because we do not know how to interpret it’.\textsuperscript{106}

Furthermore, and in the same way that Keywood has noted the courts’ tendency to adopt a medicalised and pathologised approach to dealing with cases involving women with anorexia nervosa,\textsuperscript{107} empirical research – some of which has been considered earlier in this section, and in the previous chapter - indicates that there is a tradition of depersonalising or medicalising the person with dementia, into an almost non-human entity, or to construct them as the passive receptor of care and decision-making by third parties.\textsuperscript{108} This is a phenomenon that Tom Kitwood describes as a process of ‘malignant social psychology’ and occurs as a result of dialectical process between people with dementia, and society,\textsuperscript{109} as well as a feeling on behalf of the person with dementia that they are somehow responsible for their memory loss,\textsuperscript{110} and

\begin{flushleft}

\textsuperscript{104} Tula Brannelly, ‘Sustaining Citizenship: People with Dementia and the Phenomenon of Social Death’ (2011) 18(5) Nursing Ethics 662-671; Elizabeth Peel, ‘“The Living Death of Alzheimer’s” versus “Take a Walk to Keep Dementia at Bay”: Representations of Dementia in Print Media and Carer Discourse’ (2014) 36(6) Sociology of Health and Illness 885-901.


\textsuperscript{107} Tom Kitwood, Dementia Reconsidered: The Person Comes First (OUP 1997).

\end{flushleft}
the negative emotional impacts this consequently has on the person and their close relations.\footnote{Sara Powers and others, ‘I wish they would remember that I forget:’ The Effects of Memory Loss on the Lives of Individuals with Mild-to-Moderate Dementia’ (2015) Dementia (Online First) DOI: 10.1177/1471301214553236.}

As Stirling argues in her discussion of how persons with dementia are dealt with in a medical treatment context:

\...

...the rights safeguarded by this system are the rights of the discursively generated ‘patient’ and not necessarily the rights or desires of the unified subject. There is a split between the ailing, silenced body as it is constituted by the institution, and the socially sanctioned, articulate body.\footnote{Jeanette Stirling, ‘Dementia, Discourse, Difference and Denial: “Who Did I Become?”’ (1995) 2 Law Text Culture 147-159, 155.}

In effect, to adopt Kitwood and Bredin’s analysis,\footnote{Tom Kitwood and Kathleen Bredin, ‘Towards a Theory of Dementia Care: Personhood and Well-being’ (1992) 12 Ageing & Society 269-287.} once a diagnosis of dementia is established, it is very easy for that person to become the person \textit{with dementia}, rather than the \textit{person} with dementia. The dementia takes precedence over other aspects of their being and renders them ‘Other’ from the fully functioning and healthy paradigm outlined above. It is contended in chapter 8, that this, on occasions, characterises the approach taken by Court of Protection in its best interests decision-making process, yet can potentially be circumvented by adopting an intersubjective approach.

\textbf{4.4.2 An ‘Intersubjective’ Approach}

At the centre of an intersubjective approach, is what Nagel calls the ‘subjective character of experience’\footnote{Nagel (n 8) 436.} which he defines to be ‘something that it is like to \textit{be} that organism – something it is like \textit{for} that organism.’\footnote{\textit{ibid.} 436.} He then goes on to suggest how it is possible (or not) to understand another’s subjective character experience by drawing on the analogy of what it must be like to be a bat. It is possible, for example, for us as humans to try and imagine what
it would be like for us to be a bat\textsuperscript{116} yet this is problematic as it does not get to the bottom of what it is like for a \textit{bat} to be a bat. He then argues that we may wish to describe how a bat perceives the world – through the use of sonar for example.\textsuperscript{117} Yet again, however, he suggests that this is an incomplete account of the subjective character experience - while it may be possible to describe how a bat functions, to do so still does not account for how a bat experiences these functions. In effect, as Atkins elucidates, ‘perceptions are attached to a specific individual perspective; every experience embodies a first-person point of view.’\textsuperscript{118} Yet as Dresser argues, this does not necessarily mean that we cannot attempt to ascertain another’s subjective character of experience: ‘By combining our subjective imaginations with the objective knowledge achievable through scientific, clinical, and everyday observation, Nagel thinks that we can advance our understanding of the mental lives of other organisms.’\textsuperscript{119}

Although Nagel’s account itself does not explicitly use the term ‘intersubjective’ – subsequent interpretations of his essay have. As Atkins suggests, for humans, how we experience the world is not bodily alone –

we gain a sense of self and a concrete understanding of our bodily states intersubjectively. That means that what it is like to be in any particular state is always informed by a familial, social and historical context…Identity is undeniably discursive, but even so, the individuality, the specificity, of each person’s perceptual and cognitive faculties endows each subject with a certain unique “take” on experiences which are nonetheless socially and historically situated.\textsuperscript{120}

\textsuperscript{116} \textit{ibid.} 439.
\textsuperscript{117} \textit{ibid.} 439-440.
\textsuperscript{118} Atkins (n 9) 73.
\textsuperscript{119} Dresser (n 10) 674.
\textsuperscript{120} Atkins (n 9) 73 (citation omitted).
In effect, our take on experiences is always informed by our relationships to our surroundings, ourselves, and other individuals, and for Atkins, being able to elucidate this ‘take’ on experiences in this way — through an examination of, and informed by relationships and embodiment - is central to respecting a person’s autonomy in medical ethics:

If we accept that the subjective character of experience is irreducible and that it is grounded in the particularity of our points of view, then we are bound to realize that our respect for each other’s differences and autonomy embodies a respect for the particularity of each other’s points of view. Respect for autonomy is at the same time recognition of the irreducible differences that separate us as subjects.

Furthermore, and as Atkins goes on to argue, such an approach may, crucially, account for a person’s behaviour that leads other persons to perceive them as ‘Other’. As Nys and Nys point out, it aids in moving beyond a medicalised and reductionist account of psychiatric illness — such as that argued above is prevalent within othering: ‘Insofar as the subjective dimension (the experience of illness) is important in psychiatry, it is crucial to remind the psychiatrist that this dimension is lost on the objective reductionist model of the disease.’

121 Mackenzie disagrees with this aspect of Atkins’ argument, and suggests that instead of demonstrating respect for a person’s autonomy, it in fact shows respect for a person’s humanity. Yet this point is circular. If autonomy is part of humanity, then if the subjective character of experience shows respect for autonomy as Atkins suggests, then by default it is also respecting a person’s humanity. Furthermore, Mackenzie does not demonstrate how she understands ‘humanity’ and therefore how this is different from autonomy: Catriona Mackenzie, ‘Relational Autonomy, Normative Authority and Perfectionism’ (2008) 39(4) Journal of Social Philosophy 512-533, 516.

122 Atkins (n 9) 75.

123 This can be demonstrated by a brief survey of the history of medicine: certain states of illness no longer exist because behaviours which were once considered symptomatic of a pathology are no longer so regarded. A well-known example is the case of so-called “female hysteria” of the nineteenth century — a supposed gynaco-cerebral condition that can be linked directly to a certain way of regarding women and their behaviours rather than to any merely organic disturbance.’ Atkins (n 9) 73 (citation omitted).

To summarise an intersubjective approach, then, what is required is first and foremost a recognition that every person has their own subjective character of experience – a first hand experience of what it is like to be them – which is particularly important when a person has a cognitive impairment. Furthermore, an intersubjective approach does not suggest that it is completely impossible to understand another’s subjective character of experience and that any attempt to do so should be abandoned in favour of a purely objective account of that person’s experiences. An intersubjective approach advances the idea that in order to better understand a person’s own subjective character of experience, far greater attention to situational factors and a person’s social context, as well as an understanding of the cognitive impairment on the person affected, is required.

In order to argue that an intersubjective approach is well placed to counter ‘othering’, however, it is not enough to simply reiterate the benefits of such an approach or what it entails. It is necessary to map the potential of an intersubjective approach directly on to the problematic aspects of ‘othering’, as well as indicate why such an approach is particularly important in the context of dementia. As noted above, at the heart of an intersubjective approach is a recognition that every person has their own subjective character of experience – that is, we all have a distinct experience of what it is like to be us. More important, however, is what is to be done with recognising that this subjective character of experience exists. An intersubjective approach requires that rather than imposing our own ideas of what it might be like to be a person with dementia, for example, that greater effort is made to enunciate what it is like to be that particular person with dementia. In effect, a person is not marginalised, or portrayed as ‘deviant’ because of a cognitive or physical impairment – such as dementia - but that greater effort is paid to try and understand what it is like to be that particular person with that

125 Nagel (n 8) 444-447.
impairment; a recognition that the subtleties of dementia may mean it affects every person differently, for example. As Dresser notes of the American judiciary and how it should engage with incompetent\textsuperscript{126} patients through the use of those who are closely connected to persons with dementia:

By listening more closely to [those] who have written on their experiences being with and caring for patients with dementia, we can take substantial steps toward improving our perceptions of the patients' experiential worlds. By combining the caregivers' observations with the literary and scientific accounts of dementia, I believe that we can achieve adequate evidentiary ground for judgments on the nature of life from the patient's point of view. Of course, certainty is unattainable; but certainty is not a goal attainable in any of our medical decisionmaking. Nor is it attainable in any of our legal decisionmaking regarding the mental states of human beings.\textsuperscript{127}

In effect, such an approach allows for a fundamental shift in how a person’s differences are interpreted. Rather than acting as a tool that serves to reinforce their exclusion, they become a tool used to better understand their lived experience – but in order to do this, it requires a shift away from the idealistic paradigm that underpins ‘othering’. As Shildrick argues forcefully,

\[\text{[p]erhaps if there were more recognition that there is no single acceptable mode of embodiment, and that all bodies are unstable and vulnerable, then rather than}\]

\textsuperscript{126} See Chapter 3 of this thesis (n 175).

\textsuperscript{127} Dresser (n 10) 690. It is arguable that in this quote Dresser slips in to the suggestion that the person with dementia themselves do not have voices in the decision-making process given that she argues that courts should listen more closely to the experiences of \textit{carers or relations}. Yet this remains a relevant point – and as shown in the previous chapter, one that is legally required by section 4(7) of the Mental Capacity Act. Furthermore, this thesis – and particularly chapter 8 – argues that such an approach can also be adopted of the persons with dementia themselves. In effect, not only can courts go some way to adopting an intersubjective approach by listening to carers, as Dresser insinuates, but that it is also possible – and indeed necessary - to understand the subjective character of experience of the person with dementia, by listening to the person themselves as well.
being labelled as deficient, the bodies that are further from normative standards would be revalued as simply different.\\textsuperscript{128}

The benefits of an intersubjective approach – and its central features as outlined above, are particularly important for persons with dementia. Much research – outlined shortly - indicates that being diagnosed with dementia brings with it a continued struggle to make sense of their identities, and a critical objective following a diagnosis of the condition is maintaining their self-identity – their sense of self, and preserving identities that are important to them.\\textsuperscript{129} Yet – and this reflects Atkins’ idea that our subjective character of experiences is always informed by our relational contexts - the research also indicates that one way that older persons with dementia do continue to preserve their sense of self is through their relationships. Relationships serve a crucial purpose in acting as sources of happiness and continued fulfilment, and relationships of care with intimates, spouses, and children, are of utmost importance as they operate as essential mechanisms of support for completion of day to day activities.\\textsuperscript{130}

Moreover – and again, this lends itself as support to the assertion under an intersubjective approach that we should be cognisant of the fact that dementia does entail changes in cognitive

\\textsuperscript{128} Margrit Shildrick, ‘Critical Disability Studies: Rethinking the Conventions for the Age of Postmodernity’ in N Watson, A Roulstone and C Thomas (eds), Routledge Handbook of Disability Studies (Routledge 2012) 40.


functioning - a further central theme of research conducted with persons with dementia is that they demonstrate a desire for others to recognise that the condition does entail changes. Dementia does bring with it changes to cognition, emotions, and memory, and research indicates that participants with dementia do want these symptoms to be acknowledged – but crucially, acknowledged in the right way. Just as persons with dementia indicate the need to adapt to their own changing capabilities, and the need to adopt mechanisms through which they maintain their self-identity to take account of such changes, they also demonstrate a desire for other individuals to also be aware of changes that come with dementia – rather than simply ignoring or being fearful of such changes, or ostracising them based on these changes. Indeed in one recent study, a participant exclaimed ‘I wish they would remember that I forget!’ It certainly appears that the central themes of an intersubjective approach - maintaining identity, the importance of relationships, and awareness of how a cognitive impairment affects an older person – are also heavily represented in qualitative research involving older people with dementia, which lends robust support to the argument presented in this chapter – and later in chapter 8 - that such an approach is better equipped for making best interests decisions on behalf of persons with dementia.

The benefits of an intersubjective approach – and particularly how it is used to counter othering are explored further in chapter 8. In that chapter, such an intersubjective approach is applied in the context of best interests decision-making under the Mental Capacity Act 2005 for persons with dementia. Mr Justice Peter Jackson, a High Court and Court of Protection judge, writes extra-judicially that ‘[t]o have to answer [the question of what is in an incapacitated person’s best interests] it on their behalf calls for a high degree of consideration and the imagination to

131 Powers (n 111). See also: Pearce, Clare and Pistrang (n 129); Charlotte Clarke and Cathy Bailey, ‘Narrative Citizenship, resilience and Inclusion with Dementia: On the Inside or on the Outside of Physical and Social Places’ (2016) 15(3) Dementia 434-452.
move outside the limits of one’s own experience.'132 If this is indeed the case – and I argue in chapter 8 that it is - then given the potential benefits of an intersubjective approach, it may be particularly fruitful to assess the possibilities of such an approach in the context of best interests decision-making. As suggested in the previous chapter – and argued to a fuller extent later in chapter 8 – the best interests model has occasionally been interpreted in such a way as to ‘other’ the person lacking capacity from the decision-making process, notwithstanding the shift away from such practices that has occurred in the best interests standard over the last 25 years.133 It is suggested in chapter 8, however, that because the features of an intersubjective approach counter the features of ‘othering’ – as outlined here - it perhaps provides a more fruitful avenue for Court of Protection judges to apply the best interests standard in such a way that is more respectful of the person with dementia’s own subjective character of experience informed by their relational contexts, as well as a deeper understanding of what it is like to live with dementia for the person who comes before the court and lacks capacity.

4.5 Conclusion

There are two aims to drawing on the theories outlined in this chapter, and that are used to critique the law in the chapters that follow. First, to highlight that there is an unduly individualistic theory that underpins mental disability law. The theories outlined in this chapter have the potential to uncover the liberal underpinning of the law in this area, and to demonstrate the failings of such a philosophy in relation to older people. Yet – second - this chapter has also sought to demonstrate that there is potential inherent within these relational theories to provide a more suitable – and importantly, a more realistic - framework within which the law

133 Explored in greater detail in the last chapter, and in chapter 8 of this thesis.
can safeguard decision-making for older adults who face ageism, abuse, or dementia. It is to this that the thesis now turns in more depth.
5.1 Ageism and Autonomy: Explorations Through a Relational Lens

Ageism within the context of care has attracted increasing attention in recent years. Similarly, autonomy has developed into a prominent concept within health care law and ethics. This chapter explores the way in which ageism, understood as a set of negative attitudes about old age or older people, may impact on an older person’s autonomy in making health or welfare-related decisions. In particular, by appealing to feminist constructions of autonomy as relational, I will argue that the key to establishing this link is the concept of self-relations such as self-trust, self-worth and self-esteem. This chapter aims to demonstrate how these may be impacted by the internalisation of negative attitudes associated with old age and care. In light of this, any legal or policy response must be sensitive to and flexible enough to deal with the way in which ageism impacts autonomy.

5.2 The Good, the Bad, and the ‘Vulnerable Older Adult’

Recent declarations by the Court of Appeal indicate that the inherent jurisdiction has survived the implementation of the Mental Capacity Act 2005 for adults considered ‘vulnerable’ and whose decision-making is threatened by reasons other than mental impairment – such occasions may include instances of elder abuse. In this chapter I argue, however, that the post-Mental Capacity Act courts have adopted a confused and outmoded status-based conceptualisation of the vulnerable older adult, in particular where decision-making is threatened by abusive interpersonal relationships experienced by an older individual. This has particular implications in terms of the types of remedies imposed by the courts on older adults in such circumstances. I suggest that by being more cognisant of recent more nuanced understandings of vulnerability, the courts may be better suited to identifying, and responding to perceived sources of vulnerability in a way that is more empowering for the older adult.
5.3 ‘This Man with Dementia’\textsuperscript{1} – ‘Othering’ the Person with Dementia in the Court of Protection

In recent years, dementia has been subjected to an increasing ethical, legal and political gaze. This chapter analyses how the Court of Protection considers the perspective of the person with dementia when making best interests decisions on their behalf under the Mental Capacity Act 2005. The chapter draws upon feminist and disability literature to highlight how the Court has, on occasions, ‘othered’ the person with dementia during the process of making best interests decisions. This is despite law and policy increasingly emphasising that the views of the person who lacks capacity should be central to any best interests decision, as well as emphasising the importance of de-stigmatisation of cognitive impairments, such as dementia. Finally, using examples from recent cases, I argue that by adopting an intersubjective approach, and by recognising and exploring the complexity of the relationships that the person with dementia has, the Court can go some way to avoiding the process of ‘othering’.

\textsuperscript{1} SCC v LM [2012] EWHC 1137 (COP) [84].
CHAPTER 6: AGEISM AND AUTONOMY: EXPLORATIONS THROUGH A RELATIONAL LENS

6.1 Introduction

Ageism, or the ‘process of systematic stereotyping of and discrimination against people because they are old’\(^2\) within health and social care has begun to attract significant attention. Concerns over its presence have been advanced in both academic and non-academic literature.\(^3\) With projections estimating a rapid increase in the number of older people over the coming years; 15.5 million over the age of 65 in the United Kingdom by 2020, and 6 million over the age of 80 by 2030,\(^4\) as well as increasing levels of of chronic long term health conditions,\(^5\) and increasing fiscal constraints on healthcare systems, there are concerns that ageism will intensify.\(^6\)

At the same time, autonomy has developed a prominent role within both health and social care. The conceptualisation of autonomy fostered in this area of law and the underpinning ethics, however, has been criticised for being overly individualistic in that it pays limited attention to

---

1 This chapter is a development of the following article: Laura Pritchard-Jones, ‘Ageism and Autonomy in Health Care: Explorations through a Relational Lens’ (2014) Health Care Analysis (Online First) DOI: 10.1007/s10728-014-0288-1.
an individual’s broader social context and inherent interdependence. Consequently, the range of recognised ‘threats’ to autonomy such as lacking mental capacity by virtue of cognitive impairments, or undue influence are also interpreted in a narrow, individualistic, and binary way.

In this chapter, I appeal to aspects of relational autonomy to argue that ageism, understood as a set of negative attitudes about old age or an older person because of their age, may equally fail to promote an agent’s autonomy way when making health or welfare related decisions, because of the effect such ageism has on an individual’s self-relations, or ‘self-referring attitudes’, such as her feelings of self-worth, self-esteem, and self-trust. While there is increasing literature on old age and relational autonomy, as well as on the advantages of relational autonomy in other contexts, the dynamics of how ageist attitudes interact with

---

relational perspectives on autonomy remain unexplored in the literature. It is this lacuna I hope to go some way towards filling in this chapter. This understanding is of increasing importance not only given the concerns highlighted above about ageism in the care context, but also because of evolving debates around whether there ought to be a specific international human rights convention for the protection of older people, for example.\textsuperscript{15} Autonomy plays an important role within human rights principles, and it is therefore essential that we have a model of autonomy that truly reflects the threat posed to decision-making by ageism if specific human rights legislation to protect older people is under consideration. The issue being explored in this chapter, then, is an ethical one, but one that exists within a legal framework, and that clearly may have legal ramifications.

In order to examine the issue raised here I will begin by providing a brief overview of what is claimed to be the prevailing individualistic account of autonomy within this area of law, and its underpinning philosophy. By drawing on critiques of this account, I will assert that while this conceptualisation does recognise some external threats to autonomy – such as undue influence, for example – it is ill-equipped to account for how ageism threatens an older person’s autonomy. What is needed to draw this link – the link between ageism and autonomy - is a relational account of autonomy that takes into consideration a person’s self-relations, which may be threatened because of the effect an internalisation of such ageist attitudes. I will conclude by providing some thoughts on how the argument presented in this chapter may be translated into practice in the legal arena, specifically in light of the critiques of relational autonomy.

6.2 Individual Versus Relational Autonomy

Broadly conceived, two predominant ways of thinking about autonomy have emerged in the literature; the individualistic and the relational.\textsuperscript{16} The first focuses largely on an agent’s internal functional capacity for decision-making and direct cognitive or third party threats to these abilities, and asserts that the content of the decision made is irrelevant. As long as the agent is able to fulfil these procedural requirements she will be considered autonomous and no intervention to assist or to protect can be justified.\textsuperscript{17} An operational example of such a functional account of autonomy can be found in many capacity assessment tests. Under the Mental Capacity Act 2005, for example, an individual must be able to understand and retain information relevant to the decision in question, use the information to help her reach the decision, and finally, be able to communicate her decision.\textsuperscript{18} The Act also permits unwise decisions to be made if these criteria are fulfilled.\textsuperscript{19}

This procedural, functional, and act-specific account of autonomy, frequently enunciated through capacity assessments, dichotomises autonomy in that it asks whether an agent is able to satisfy certain procedural or functional requirements. If yes, then the agent is autonomous (has capacity); if not, then she is deemed non-autonomous (not to have capacity). As Donnelly argues, capacity as a legal term, has therefore come to be seen as the ‘gatekeeper’ to

\textsuperscript{16} There is considerable variation in the terms used to describe the two versions of autonomy. Alternatives for the individualistic include: procedural, internalist, liberal, and content-neutral. Alternatives for the relational include: externalist, socio-relational. This chapter is not concerned with the subtle differences between each of these theories, and the terms individualistic, functional, or procedural autonomy are used to broadly reflect the former, and relational to reflect the latter.

\textsuperscript{17} One oft-cited philosophical definition of such an account is possession of a ‘second-order capacity to reflect critically upon one’s first order preferences and desires, and the ability either to identify with these or to change them in light of higher order preferences and values.’ Gerald Dworkin, \textit{The Theory and Practice of Autonomy} (OUP 1998) 108.

\textsuperscript{18} Mental Capacity Act 2005, s 3(1)(a)-(d). This is only if there is an impairment or disturbance in the functioning in the mind or the brain – a diagnostic element: Mental Capacity Act 2005, s 2(1).

\textsuperscript{19} Mental Capacity Act 2005, s 1(4).
autonomy.\textsuperscript{20} If a person is deemed to have capacity (of which there is a presumption under the Mental Capacity Act 2005)\textsuperscript{21} then that person is deemed autonomous, or more specifically, the decision they are purporting to make is assumed to be autonomous. There is little or no subsequent (or even prior) examination of the nature of the assumed autonomy. In light of this, both autonomy and capacity are considered binary constructs – either a person is capacitous (and therefore autonomous) or they are not. This point will be considered further later. In philosophy, while it is true that most procedural accounts of autonomy therefore require ‘critical reflection, authenticity, and content neutrality’,\textsuperscript{22} there is often very little reflection on how these characteristics are to be established or what ‘critical reflection, authenticity, and content neutrality’ actually look like. They simply ask whether the person possesses the necessary cognitive functions – which are assumed to be inherent within all individuals - and if so, the decision made is to be considered an autonomous one even if it is also considered to be ‘unwise’.

As several critics have argued, however, behind this account of autonomy lies a mythical (masculine)\textsuperscript{23} agent; the self-sufficient, self-determining individual who encounters no physical or psychological encroachment on his person from other individuals, and for whom

\textsuperscript{21} Mental Capacity Act 2005, s 1(2): ‘A person must be assumed to have capacity unless it is established that he lacks it’.
\textsuperscript{23} Although this chapter is not concerned with the feminist criticisms of the autonomous agent as being ‘male’ \textit{per se}, it is worth noting that a number of feminists have been critical of the atomistic conception of autonomy given its propensity for being orientated towards the masculine conception of the self. Naffine for example, argues that ‘[t]he autonomy of the individual...was explicitly reserved for the male’: Ngaire Naffine, \textit{Law and the Sexes: Explorations in Feminist Jurisprudence} (Allen & Unwin 1990) 105. Similarly, Gilligan argues that ‘the capacity for autonomous thinking, clear decision-making, and responsible actions—are those associated with masculinity and considered undesirable as attributes of the feminine self’: Carol Gilligan, \textit{In a Different Voice} (Harvard University Press 1993) 17. See also: Lorraine Code, \textit{What Can She Know? Feminist Theory and the Construction of Knowledge} (Cornell University Press 1991); Catharine MacKinnon, ‘Feminism, Marxism, Method, and the State: Towards Feminist Jurisprudence’ (1983) 8(4) Signs 635-658.
dependency, for example, is undesirable;\textsuperscript{24} an individual who is readily able to extract her or his thought process from the influences of others so as to perform the functional skills required for autonomy. As Harrington suggests, ‘the liberal conception of patients as autonomous, self-determining rights holders has been accepted as the paradigm.’\textsuperscript{25}

Despite these strong criticisms, autonomy retains its position as an important principle in both law and ethics because it upholds certain ideas that are deemed valuable.\textsuperscript{26} It epitomises the notion that we may live a life that is true to ourselves true to our own authentic choices, and avows an inherent respect for our subjective experiences, our embodiment, and our individuality.\textsuperscript{27} Indeed, for older people, research suggests that autonomy (in some format) is a particularly important concept; it denotes a retention of \textit{some} independence at a time when there may be increasing frailty, dependency, engagement with health and social care services, and negative stereotyping of their capabilities.\textsuperscript{28} The criticisms directed towards autonomy outlined above are of its interpretation and performance as unduly individualistic - the suggestion that we make decisions in a perfunctorily procedural manner; not necessarily in the

\textsuperscript{24} Martha Fineman, one of the leading critics of autonomy on this count, argues that ‘[the] liberal subject...is indispensable to the prevailing complementary ideologies of personal responsibility and the noninterventionist or restrained state...The image of the human being encapsulated in the liberal subject is reductive and fails to reflect the complicated nature of the human condition’: Martha Fineman, ‘Equality, Autonomy and the Vulnerable Subject in Law and Politics’ in M Fineman and A Grear (eds), \textit{Vulnerability: Reflections on a New Ethical Foundation for Law and Politics} (Ashgate 2013) 17. See also: Jennifer Nedelsky, \textit{Law’s Relations: A Relational Theory of Self, Autonomy and the Law} (OUP 2011); Fineman (n 7); Catriona Mackenzie, ‘The Importance of Relational Autonomy and Capabilities for an Ethics of ‘Vulnerability’ in C Mackenzie, W Rogers, and S Dodds (eds), \textit{Vulnerability: New Essays in Ethics and Feminist Philosophy} (OUP 2014).


\textsuperscript{27} These ideas may seem individualistic in themselves, and therefore paradoxical to the argument that autonomy should be understood relationally, however there is a clear distinction to be made between saying that the values that autonomy upholds are individualistic, and that autonomy itself – or the skills required for its maximisation - are individualistic. Simply because the values may be interpreted in an individualistic manner does not necessarily mean that their gatekeeper (autonomy) should also be.

values that autonomy upholds *per se*\(^{29}\) or the value autonomy has for older people. As we shall see, however, an individualistic conceptualisation of autonomy may not adequately reflect the everyday lived experiences (both positive and negative) of older people.

In contrast to the individualistic construction, the concept of relational autonomy attempts to ‘incorporate our experience of embeddedness in relations, *both the inherent, underlying reality of such embeddedness, and the oppressiveness of its current social forms.*\(^{30}\) On the one hand, it is causally relational because it is *affected by* relationships with others on both a macro and micro level: it does not exist within a vacuum subject only to the will and constraints present *within* an individual as the procedural account of autonomy would imply. Even the overly individualistic and purely functional conception of autonomy recognises this – that autonomy may be compromised where there are individually coercive relationships operating in relation to specific decision-making. One legal example of this is *Re T*,\(^{31}\) a case concerning the validity of the refusal of a blood transfusion by a young, pregnant Jehovah’s Witness. Lord Donaldson held that in instances where undue influence may be present, the real question is ‘does the patient really mean what he says or is he merely saying it…because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?’\(^{32}\) Lord Donaldson’s use of the term ‘no longer think and decide for himself” is a resounding reinforcement of the impact that undue influence may have on the functional account of autonomy, and one which prioritised non-interference.

---

\(29\) There is, of course, a body of literature that argues that autonomy is a ‘thoroughly noxious’ concept: Sarah Hoagland, *Lesbian Ethics: Towards New Value* (Institute of Lesbian Studies 1988), however this seemingly ignores the values autonomy upholds, which is a primary focus of this chapter and of relational autonomists in general. The assumption here is that autonomy itself is an important concept because of the values it embodies, but the procedural account is unduly atomistic, and a relational model should be understood as the more appropriate conceptualisation.

\(30\) Nedelsky (n7) 10 (emphasis added).

\(31\) *Re T* (n9).

\(32\) *ibid.* 113.
Relational autonomy, however, and particularly the conceptualisation of relational autonomy advocated here, is more expansive in that it is able to situate a person within her broader social context – in essence, it requires a deeper interrogation of the factors that ‘go into’ autonomy. Such a relational reconceptualisation is able to recognise that autonomy may also be threatened where there is stigma attached to being a member of a societal group, and that this may in turn impact on the way an individual makes certain decisions because of the disproportionate impact such stigmas have on a person’s self-relations. As Oshana notes, this is not to suggest that individualistic functional accounts have no relational elements whatsoever – Re T, outlined above, is testament to this. Nor is it to suggest that such accounts of autonomy are defunct. Relational accounts of autonomy suggest that is is not simply a question of how actions threaten autonomy (such as undue influence outlined in Re T above), but is also a question of how broader and subtler oppressive forces such as attitudes and beliefs about individuals and groups may also threaten maximal autonomy and the authenticity of a decision. In this sense, relational autonomy is concerned with how autonomy interacts with an individual’s relationships on all levels; micro, macro, and indeed her relationship with herself.

A relational conceptualisation goes even further, however, and recognises that relationships may also strengthen an individual’s ability to act with maximal autonomy. It may be seen as

---

33 Decisions made under such conditions may attract what Stoljar terms the feminist intuition, ‘which claims that preferences influenced by oppressive norms of femininity cannot be autonomous’: Natalie Stoljar, ‘Autonomy and the Feminist Intuition’ in C Mackenzie and N Stoljar (eds), Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self (OUP 2000) 95. Oshana explains this by arguing that being autonomous under the procedural conceptualisations of autonomy does not lack any socio-relationality, but that the agent’s ‘psychological condition...is alone important for her autonomy’: Marina Oshana, ‘Personal Autonomy and Society’ (1998) 29(1) Journal of Social Philosophy 81-102, 85.  
34 Oshana (n 33).  
35 It is worth noting here, however, that Marina Oshana presents a ‘perfectionist’ account of autonomy, that is, someone who willingly and voluntarily surrenders their autonomy, such as the deferential wife, cannot be considered autonomous in doing so. The argument presented in this chapter should be distanced from this perspective for two reasons. Firstly, because this perfectionist relational account fails to realise the idea that autonomy is a more flexible, non-binary concept: see below (n 38). Secondly, Oshana’s account does not rely on the idea of self-identification as a central tenet of autonomy, which this chapter does.
constitutively relational in the sense that interdependence and positive relationships with others are an essential element to autonomy in the first place. In other words, individuals are simply not able to act in a maximally autonomous way without relationships or a social context within which to operate.\textsuperscript{36} Indeed, and as Oshana argues, ‘the objective social criteria according to which we judge someone as autonomous…are independent of the individual’s internal state’;\textsuperscript{37} in order to be considered autonomous, we must be considered by others to have the requisite properties to act autonomously. In light of this, then, maximal autonomy requires positive relationships of recognition on both a micro (individual) and macro (societal) level. Drawing on a relational account of autonomy allows us to retain the value implicit in the concept but also recognise that autonomy is far more flexible and malleable than the binary way it has traditionally been understood – especially within mental disability law. A more expansive relational conceptualisation, and in particular one that is concerned with an individual’s relationships on all levels - including self-relations - both presupposes and reinforces the idea that the ability to act autonomously is not black and white; it is more intuitively understood as existing on a spectrum from minimal to maximal. This, in turn, more accurately reflects the idea that oppressive attitudes and socialisation such as ageism have differing degrees of impact on different individuals, and therefore on their ability to act autonomously, as well as better reflecting the idea that self-relations are not simply binaries either. As an individual, I do not look at myself in either a ‘positive’ or a ‘negative’ light. I may look at different aspects of my being, my personality, or appearance with different degrees of positivity and negativity. A relational conceptualisation allows us to focus on the precise ways in which the subtle attitudes such as ageism may impact on the way an individual views herself, and therefore her autonomy,


\textsuperscript{37} Oshana (n33) 85.
rather than simply asking a simple yes or no question as to whether a person is able to fulfil certain functional criteria.\(^{38}\)

Finally, and of particular importance in old age, relational autonomy does not focus solely on the decision-making *process*. Relational autonomy, particularly Fineman’s account\(^ {39}\) which emphasises interdependence, forces us to recognise that while many older people retain the ability to make autonomous decisions on the procedural account, some may find it difficult to execute these choices without dependence on others. For many older people,\(^ {40}\) autonomy could therefore be understood as a twofold process; decision-making, and the execution of their decisions. If simply making decisions is all that is required of the procedural account, without any means of executing them, then the decision and its contents are rendered meaningless; autonomy risks becoming an empty concept, bereft of value for many older people who depend on others on a daily basis to give effect to their choices.\(^ {41}\)

\(^{38}\) This idea in particular has been used in different contexts by different authors. For example, Schwartz argues that the notion of ‘perfect’ autonomy does not exist, but rather that we should recognise its existence on a spectrum from minimal to maximal autonomy: Andrew Schwartz, ‘Autonomy and Oppression: Beyond the Substantive and Content-Neutral Debate’ (2007) 39 *Journal of Value Inquiry* 443-457. Similarly, Donnelly, drawing on the work of Joseph Raz, advances the idea that autonomy is an ‘achievement’, moving beyond this dichotomisation of autonomy found in traditional health care law and ethics. She suggests that our ability to act autonomously is, in fact, continuously evolving towards a state of achievement, rather than being fixed: Donnelly (n 20) 41.

\(^{39}\) Fineman (n 7).

\(^{40}\) This idea is not just applicable to older people, but applies to any one of any age. The idea that autonomy is a two-fold process as presented here is, however, easier to see when illustrated in the context of old age where individuals may exhibit greater dependency, and situational or pathogenic vulnerabilities, that is, those vulnerabilities that are context specific (situational) or those that are ‘generated by...morally dysfunctional or abusive interpersonal and social relationships and socio-political oppression or injustice’ (pathogenic): Catriona Mackenzie, Wendy Rogers and Susan Dodds, ‘Introduction: What is Vulnerability and Why does it Matter for Moral Theory?’ in C Mackenzie, W Rogers, and S Dodds (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (OUP 2014) 9.

\(^{41}\) Although this aspect to relational autonomy will not be discussed in any depth in this chapter, an example of this can be found in the *McDonald* case. In *R (McDonald) v Royal Borough of Kensington & Chelsea* [2011] UKSC 33, the applicant sought judicial review of the decision of her local authority to remove the provision of night time care to help her access the toilet. This service was replaced with incontinence pads. Ultimately the Supreme Court held, with Lady Hale dissenting, that the removal of assistance to use the toilet was lawful, and did not violate the applicant’s Article 8 rights. On the analysis presented here, the provision of night time care would be indicative of enabling a maximally autonomous decision under the circumstances (the circumstances being that Elaine McDonald was not able to use the toilet without such assistance). Removal of the night time assistance reduced her ability to act in a maximally autonomous way. On the spectrum of autonomy presented in this chapter, night time carers would represent a step towards maximal autonomy, incontinence pads would be on the spectrum somewhere below this. Of course this case also highlights how difficult courts would find it if they had to uphold only maximal autonomy, especially in light of increasing fiscal constraints on social care provision:
6.3 Ageism in Care and its Impact on Self-Relations

If ‘ageism’ refers to a set of attitudes towards an individual (or group of individuals) solely based on age then logically it denotes attitudes towards someone of any age, but importantly, it must be because of their age. Qualitative research suggests that the main features of the prevailing stereotype of the older person, as the focus of this chapter, are as being less capable and of lower status, or, as Butler enunciates, ‘senile, rigid in thought and manner, old-fashioned in morality and skills...’. It is interesting to note for the purposes of this chapter, then, that the prevailing ageist and negative stereotype of the older person is as someone who lacks the ability to act autonomously; who is entirely dependent on others. At the core of this representation, as with any stereotype, is a lack of individual recognition - preferring to consider older people, and the older population as a homogenous group. This highlights the first of two key distinctions that emerge from the literature on ageism; the contrast between ‘macro’ and micro’ level ageism. These terms denote the level on which ageism may operate; ‘macro’ referring to ageism found on a broad organisational or societal level such as in the media or popular culture, whereas ‘micro’ level ageism denotes ageist attitudes held by individuals. Macro ageism may frequently buttress micro level ageism, but more invidiously, it may be hidden under the guise of other objectives, such as health care rationing policies.

---


43 Butler (n 2) 35.

44 Thornton (n 42).


46 Recent proposals by the National Institute for Clinical Excellence (NICE), for example, suggest taking into consideration a treatment’s ‘wider societal benefit’, such as the patient’s capacity to return to work, as well as unpaid activities such as child-care, volunteering and domestic work: Department of Health, Methodology for Estimating ‘Wider Societal Benefits’ as the Net Production Impact of Treatments (2014) available at https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-guidance/NICE-technology-appraisals/DH-
Although ‘macro’ level ageism will not be discussed in detail here, it is important to be aware that individual or micro-level ageism may be caused and buttressed by macro level ageism.47

The second, more critical distinction that emerges from the literature is between attitudes, and behaviours or actions. The difference here is between ageism as an attitude, or ‘a feeling or belief”48 about older people, as opposed to age discrimination, ‘which involves behaviour or treatment.'49 These two concepts are not mutually exclusive; age discrimination may, and often will, happen as a result of ageism – underlying attitudes or values that denigrate the status or value of older people. As has been established earlier, however, the focus of this chapter is on the way ageism, that is, the attitudes underpinning actions such as age discrimination, impacts on the autonomy of an older person. If a doctor withholds information about a particular treatment from an older patient because of the patient’s age, and because he or she does not think it is a worthwhile treatment for someone ‘old’, the link between the action of withholding of information and how the patient’s autonomy is compromised is easy to see; the patient does not have access to information that enables the exercise of maximal autonomy.50 Similarly, if

48 Herring (n 3) 12.
49 ibid.
50 This is not a purely hypothetical example. Evidence of such practices have been highlighted in the following reports: Department of Health, Ageism and Age Discrimination in Primary and Community Care in the United Kingdom (n 3); Department of Health, Ageism and Age Discrimination in Social Care in the United Kingdom (n
an older person residing in a care home is subjected to physical or verbal abuse by someone who knows that, because of their age, they are unable to defend themselves, and threatened with ‘repercussions’ if they tell, it is not difficult to see how this action – the abuse - may directly threaten their autonomy. The threat of repercussions is akin to what the law characterises as undue influence, as explored above in discussing Re T. The way ageist attitudes affect autonomy, however, is an interesting link to attempt to draw, and more difficult to pinpoint than how the actions threaten autonomy. As yet, however, the link between how ageism threatens autonomy has remained unexplored in the ethics literature. This chapter, as stated at the outset however, seeks to demonstrate how autonomy may be threatened by the impact negative attitudes about old age and older persons have on an individual’s self-relations. In order to do this, it will be helpful to consider two brief examples:

Elizabeth, 83, lives in a nursing home. Although she generally does not mind living there, there is one carer who is rough when attending to her, calling her a ‘whingeing old bag’ and when asked by Elizabeth to be less rough, replied by saying, ‘Shut up, you have to take this sort of treatment at your age, you’re not really a human anymore, you’re just an animal.’

Elizabeth does not report the incidents because she believes that the treatment is to be expected now she lives in a nursing home. To Elizabeth the conduct is perfectly normal; she is less worthy of respect because she is ‘old’ and lives in a care home. The attitude that because of her age this sort of behaviour is acceptable has been normalised.

---

3); Department of Health, *Ageism and Age Discrimination in Secondary Health Care in the United Kingdom*, (n 3); Joint Committee on Human Rights (n 3).

51 Again, this example is not entirely hypothetical - similar facts were found in the following Nursing and Midwifery Council fitness to practice hearings: Nursing and Midwifery Council, Case 83A0008E, 27 March 2008; Nursing and Midwifery Council, Case 09E0079C, 14 February 2013.
Cassie, 70, is diagnosed with early stage breast cancer. She expresses concern for the total mastectomy that her doctor recommends, and indicates that her preference would be for a lumpectomy instead. Upon hearing her thoughts, her doctor laughs at her and asks ‘Why worry about keeping your breasts at your age?’ Cassie relents, and believes her doctor will think she is silly for wanting to keep her breasts at her age if she were to pursue her preferred treatment. \(^{52}\)

In both of these scenarios, that there is clear wrongdoing is unquestionable. For Elizabeth, it is the physical and verbal abuse received at the hands of her carer. For Cassie, it is the disrespect evinced by the doctor’s words. The analysis in this chapter, however, seeks to highlight how the attitudes behind either the carer or the doctor’s actions, may threaten Elizabeth and Cassie’s autonomy. Can a relational conceptualisation of autonomy point us in the direction of how to account for the ways in which the attitudes that underpin the wrongdoing in these scenarios may also constitute a threat to Elizabeth and Cassie’s autonomy? More specifically, can the concept of self-relations – as outlined earlier - shed any light on this matter?

The perspective derived from relational autonomy is that self-relations instil a confidence in ourselves to act with authority; they enable us to validly consider ourselves as authors of our own lives, and makers of our own decisions. If, then, we are not able to view ourselves as a ‘...competent deliberator...it is hard to see how one can take oneself seriously in one’s practical reasoning about what to do’. \(^{53}\) This argument sits ill-at ease with individualistic accounts of autonomy criticised above, which simply require a set of functional procedural conditions to

\(^{52}\) This example is derived in part from one presented by Clough and Brazier (n 46) 3. This is also a good example of the ‘macro’ and ‘micro’ level ageism distinction highlighted above; the doctor’s ageist attitude may well have been informed by broader assumptions about older people, particularly older women, as ‘asexual’: Joel Gwynne, ‘‘Mrs Robinson Seeks Benjamin’: Cougars, Popular Memoirs and the Quest for Fulfilment in Midlife and Beyond’ in I Whelehan and J Gwynne (eds), Ageing, Popular Culture and Contemporary Feminism (Palgrave Macmillan, 2014) 47.

be fulfilled before an agent can be considered autonomous, with no further scrutiny of broader oppressive factors that feed into the decision-making process. The two ideas (self-relations and procedural or individualistic autonomy), however, are not wholly incompatible or irreconcilable. In order to be able to reflect critically on a particular choice or decision, relational autonomists who assert the importance of positive self-relations might suggest that we must also possess a self-confidence that we have the ability to reach a minimum level of critical reflection in the first place, or that a decision made in light of a lowered sense of self-worth may not be maximally autonomous. If a procedural account of autonomy requires us to rely on our critical reflection and on our capacity for critical reflection, then relational autonomy posits that this dual reliance is only possible if we have an element of self-trust in ourselves to do this.\(^{54}\) Simply going through the procedural motions would render autonomy a vacuous concept. Without some element of positive self-relations, we may very well be acting autonomously on the procedural account, but the decisions would not necessarily mean anything to us.

If negative self-relations also affect our ability to view ourselves as someone worthy of respect and therefore deny our personal authority with which to act with conviction when making decisions, then this, furthermore, is counterintuitive given the very reason we value autonomy in the first place. If, as argued earlier, the value of autonomy is in its ability to enable us to live a life that is authentically ours, then not having trust or confidence in our ability to make decisions that serve that purpose clearly goes against this very value. Negative self-relations seemingly preclude us from being able to realise the very reason we attribute worth to the concept of autonomy in the first place. It is these aspects of self-relations that may be damaged by ageism, through an internalisation of the attitudes, such as weakness, worthlessness or

---

inferiority, which may underpin such actions,\textsuperscript{55} as demonstrated in the two examples. The older person, such as Elizabeth or Cassie in the examples above, may no longer have the reflective or evaluative abilities required to act with a maximal degree of autonomy, because she has internalised the ideas and assumptions based on her old age and this in turn precludes her from viewing herself as a competent agent,\textsuperscript{56} or someone worthy of being considered a competent or valuable agent in her own right by others. To be clear, the analysis provided here does not necessarily suggest that on every occasion where there are ageist attitudes will there be a threat to maximal autonomy.\textsuperscript{57} The important factor here is that there will almost always be a threat to maximal autonomy when the ideas espoused by the ageist attitudes have been internalised, or normalised, by the older person and this has, in turn, affected her decisions.

So, to return to the examples provided above, in Elizabeth’s scenario the attitudes espoused by the carer have threatened Elizabeth’s autonomy because of what it has instilled or reinforced in her; a lowered sense of self-worth in that she now believes she is less deserving of a respectful attitude because of her advanced age and the consequences of her old age (living in a nursing home). In turn, this has taken away her ability to see herself as a competent, worthwhile agent, and critically reflect over the decision to report the abuse or not. Indeed, Elizabeth seemingly does not even recognise that there is even an ‘option’ to report because to her, the conduct is perfectly acceptable. Similarly, Cassie now has a lowered sense of self-worth and self-confidence as a result of having internalised the attitudes expressed by her doctor; she views her physicality, and more specifically her female embodiment, as less

\textsuperscript{55} This argument has been made previously in relation to victims of domestic violence. See, for example: Schwartz (n 38) 453-4.

\textsuperscript{56} She may very well retain the potential to become a maximally autonomous agent if her cognitive functioning remains maximally operative: Paul Benson, ‘Free Agency and Self-Worth’ (1994) 91(12)\textit{Journal of Philosophy} 650-668, 658. The argument presented here is not concerned with the way that oppression may hinder our cognitive development.

\textsuperscript{57} Although this may well be the case. For example, if an older person is discriminated against because of an age based rationing policy then this may still have an impact on that particular person’s autonomy because of her age, but it is not akin to saying that her autonomy is curtailed because the way she views herself has changed.
important now because she is older, and lacks the confidence to pursue her preferred treatment because she fears her doctor will think her silly because of her age. The internalisation of the ageist attitudes held and espoused by her doctor has influenced her decision into one that she may have otherwise made differently. Objectively, she may display what appears to be rational, un-coerced self-determination, but an appeal to the model of relational autonomy presented in this chapter allows us to recognise that her negative self-relations preclude her from making a maximally autonomous decision over her choice of treatment. This is, of course, only one analysis of Cassie’s situation. There may, and almost certainly will be, additional factors in her decision-making, part of which is discussed below in a contrasting scenario. However, the possibility that ageism may operate in a way that is perhaps more subtle than in, for example, the first scenario, should alert us to explore more intricately the different facets of what autonomous decision-making in care means for older people, as Donnelly advocates.

Consider an alternative example, whereby instead of maintaining silence because she feels she is older and worthless, Elizabeth recognises that the actions of her carer are wrong, and that she does not deserve such treatment solely because she lives in a nursing home. However, she chooses not to report the behaviour because overall, she likes the nursing home and doesn’t want to be seen as a troublemaker, especially as hearing of this mistreatment would deeply

---

58 This is to take coercion in the legal sense such as in Re T (n 9) where there is direct coercion by one party over another’s decision.

59 These points are of particular contemporary relevance given the increasing debate over the legalization of assisted suicide, and more specifically, the fact that the universal prohibition on assisted suicide is designed to protect those who may seek help ending their lives simply due to lowered self-worth, for example: R (Nicklinson & Anor) v Ministry of Justice [2014] UKSC 38 [311]-[315].

60 Donnelly (n 20).

61 Charpentier and Soulières’ recent study indicates that the desire to not be seen as a troublemaker is very much present when deciding what course of action to take by older people in residential homes: ‘I’m not doing anything to jeopardize my stay here. I like it here. So it’s best to keep quiet.’ (Mr. P., age 82 [translation]); ‘If we complain too much we get a reputation as old troublemakers! Grumpy old complainers! It’s easy to put negative labels on us. My philosophy is that if you want to be liked you have to be likeable. I do my best not to upset anyone.’ (Ms. M., age 96 [translation]); Michèle Charpentier and Maryse Soulières, ‘Elder Abuse and Neglect in Institutional Settings: The Resident’s Perspective’ (2013) 25 Journal of Elder Abuse and Neglect 339-354, 350. A similar story (that of Betty) is presented by Les Bright. ‘Unhappiness and depression gave way to fear, itself accompanied by a decision to do or say nothing that would inflame the situation further’: Les Bright, ‘The Abuse of Older People
upset her son, with whom she has a close relationship. Similarly, let us imagine that Cassie, nevertheless offended by the doctor’s words, continues to pursue a lumpectomy as she does not want to undergo highly invasive treatment, which would mean taking too much time away from caring for her husband who suffers from dementia. On these facts, the decision to keep quiet, or the decision over which treatment to undergo is not made because the ways in which Elizabeth or Cassie self-relate have necessarily changed. There is no indication in these examples that the attitudes that underpin either the carer or the doctor’s behaviour have impacted on either Elizabeth or Cassie’s self-relations or self-identification so as to alter the decision made. This does not, of course, make the actions condonable, nor does it mean that their decisions are maximally autonomous. In all instances there is an objective element to the circumstances; some form of wrongdoing has, in fact, occurred, irrespective of whether or not it is recognised as such by Elizabeth or Cassie.

The key difference between the two sets of scenarios, however, is the presence of subjective recognition by the individual; whether the act is subjectively recognised as improper by the person who experiences it. In the most recent example, Elizabeth subjectively recognises the impropriety of the actions but makes a conscious decision not to act on it, albeit in pursuit of the desire for a quiet life and not to upset her son; and in these circumstances to force her to report may constitute a greater threat to her autonomy than to respect her choice not to. In the first example, however, no action can be taken (by Elizabeth) because she does not recognise the wrongness of the act, or the explicit ageism that lies behind it. Focussing on this highlights the fact that the failure to ‘see’ ageism is central to its internalisation. Indeed, recent studies


82 We could, of course, argue that there is an acceptance in this example of the subjugated role, or that autonomy is compromised because Elizabeth doesn’t want to upset her son, however neither of these threats are necessarily to do with the attitudes underpinning the actions in the first place.
have indicated a significant difference in the rates of mistreatment or neglect reported by staff compared to those reported by care receivers, or have explicitly demonstrated a lack of recognition by older people of conduct that is improper. This discrepancy may suggest that in practice, there has been, to some extent, an internalisation of the idea that such conduct is acceptable, or ‘normal’, for older people, particularly those who encounter such treatment within the health and social care system. More worryingly, this also implies that such conduct may consequently be significantly underreported. While the arguments presented thus far in this chapter have therefore been largely theoretical, it is for these reasons that it is necessary to highlight some possible practical dimensions to translating such a theory into practice.

6.4 The Problems of Relational Autonomy: Putting it into Practice

As noted above, the argument presented in this chapter in terms of conceptualising the link between ageism and autonomy is largely theoretical. Nevertheless, this raises the question of how such an argument can be translated into practice. Can ageism be recognised in law or policy as the threat to autonomy that it is, and if so, how? Clearly this task will not be easy, not least because, as mentioned earlier, the law operates so as to dichotomise autonomy through the legal concept of capacity; either an agent has capacity and is therefore autonomous in the eyes of the law, or not. In this section, however, I hope to highlight some of the practical dimensions of adopting a relational approach, which necessitates more flexibility than simply dealing with these under the rubric of mental capacity law.

---

63 A study conducted in the Czech Republic by Bužgová and Ivanová reported that only 11% of care receivers noted some form of abuse, while even less (5 %) witnessed an act of mistreatment directed towards themselves or another older person in the institution. On the other hand, 27.8 % of staff surveyed noted that they themselves had psychologically abused a patient, and 42.1 % had observed another staff member psychologically and verbally abusing patients: Radka Bužgová and Katerina Ivanová, ‘Violation of Ethical Principles in Institutional Care for Older People’ (2011) 18 Nursing Ethics 64-78.

64 Bužgová and Ivanová (n 63); Charpentier and Soulières (n 61).

65 Interestingly, research from other domains suggests that normalisation may also operate as a coping mechanism: Elizabeth McDermott, Katrina Roen and Jonathan Scourfield, ‘Avoiding Shame: Young LGBT People, Homophobia and Self-Destructive Behaviours’ (2008) 10(8) Culture, Health & Sexuality 815-829.
Before undertaking this task, however, it is worth noting that relationality – and specifically relational autonomy - has been criticised primarily on the basis of its potential for increased paternalistic responses, such as mandatory reporting of abuse, or increased surrogate decision-making. John Christman for example, argues forcefully that a relational approach could be dangerous not only because it risks marginalising the voices of those who are already oppressed, but also because of the potential for relational autonomy to allow forcible state intervention when someone does not meet the relational model of autonomy he critiques (which will inevitably, he argues, always be the case). He summarises by suggesting that ‘[i]t is one thing to publically criticize modes of social practice that denigrate their participants, but it is another to define autonomy in a way to claim that those participants are not fully functioning agents at all.’

Although Christman’s criticisms have intuitive force, there are a number of key points to make here. Firstly, Christman’s critique is predominantly directed towards Oshana’s account of relational autonomy, which itself rests on the assumption that autonomy, like capacity, is a binary construct - a notion that I have explicitly rejected above. The arguments in this chapter rest on the construction of autonomy and autonomy capabilities more flexibly; that autonomy - and the capabilities that maximise it - exist on a spectrum. The account that places self-identification as a core feature of autonomy, such as presented here, by its very definition

---

67 Christman argues that '[t]o label such persons as non-autonomous because they do not stand in the proper social relations to their alleged “superiors” means that deliberations about the meaning of equality and legitimate authority is circumscribed to exclude voices who are otherwise...competent and authentic in ways that the procedural account of autonomy require’: Christman (n 66) 157.
68 Christman (n 66) 158.
69 Oshana (n 33).
70 Above (n 38).
cannot rest on an either/or construction of autonomy because – as explained earlier - the way an individual self-identifies in light of external relationships is not an either/or concept. Not only does Christman’s critique predicate itself on the binary construction of autonomy then, but so does Oshana’s account of relational autonomy that his criticisms are aimed at. Indeed Christman himself recognises that other relational autonomy theorists promote the existence of autonomy on a spectrum, and he quotes Nedelsky to this effect.71 Christman’s concerns, then, are perhaps best read as a critique of Oshana’s perfectionist72 account of relational autonomy rather than a wholesale rejection of all relational accounts.

Furthermore, if the predominant concern with relational theories is that responses may be inadequate, insufficient or overly paternalistic, this does not necessarily mean that we should simply adopt the individualistic and functional account of autonomy so as to avoid difficult questions about whether the responses are working or are best suited to a given task. As feminist scholars have argued in relation to law’s responses to gender inequality,73 it may be that the law itself in its current format is insufficiently equipped to deal with more nuanced and relevant theories. Indeed, it is arguable that such overly paternalistic responses would be a misreading of the argument presented in this chapter. Adopting such responses where autonomy is compromised by the internalisation of ageist attitudes may only serve to diminish the older person’s self-relations even further. Taking decision making out of their hands compounds the idea that she is less capable by removing control over the decision to a third party.74 Such a response only asks whether the person’s autonomy is compromised or not.

71 ‘While traditional accounts of authenticity refer only to the isolated agent reflecting on his or her own desires, relational accounts “think of autonomy in terms of the forms of human interactions in which it will develop and flourish”’ (emphasis added): Christman (n 66) 148, quoting Nedelsky (n 7) 16.
72 See above (n 35).
73 See, for example: Naffine (n 23).
when in fact a legal response should be addressing *why* autonomy is compromised on those particular set of facts. By exploring the threats to autonomy in more detail, be they ageism-related or not, the courts (if we are to seek a legal response) are better able to respond in a way that emphasises the task of promoting maximal autonomy. As Friedman argues in relation to domestic violence, the best response may very well be to bolster the agent’s self-relations so that not only is she able to recognise instances of such mistreatment,75 but also, and perhaps more importantly in light of the arguments put forward here, she is able to recognise the negative attitudes that underpin such acts.

One method of achieving this sort of outcome in England and Wales, however, may be by utilising the High Court’s inherent jurisdiction.76 The decision of the Court of Appeal in *DL*77 confirmed that the inherent jurisdiction has survived the implementation of the Mental Capacity Act as a ‘safety net’78 to protect those who may not lack capacity under the Mental Capacity Act’s provisions, yet nevertheless remain vulnerable because of other factors. Although rightly avoiding the impossible task of providing an exhaustive list of when an adult may be considered ‘vulnerable’, the Court in *DL* explicitly recognised that instances of ‘elder abuse’ may meet this criterion and therefore be sufficient to invoke the jurisdiction.79 A full

---

76 It is questionable whether such a response can be effected by the law. This would, of course, depend on the type of interference suffered warranting legal intervention, which is why I am tentatively advancing this suggestion. Whether the law (in the form of the inherent jurisdiction or the Mental Capacity Act 2005) should intervene in turn raises questions as to when the law ought to intervene. Clearly it would be impossible, and undesirable, to suggest that the court involves itself wherever it suspects ageism, particularly as ageism and its effects may well be very subtle and unidentifiable. In light of this, it is also important to explore alternative responses, such as the importance of human rights principles, the role of regulatory bodies, and the role professional education for health care workers can have in combatting ageism, which is generally outside the scope of this chapter, but may provide fertile ground for further research.
77 [2012] EWCA Civ 253. This case raised the legal issue of whether the inherent jurisdiction of the High Court remained to protect ‘vulnerable adults’ who do not fall within the remit of the Mental Capacity Act 2005. The case concerned an elderly couple who had been subjected to mistreatment by their son, DL, but nevertheless who retained capacity under the Mental Capacity Act. The Court of Appeal held unanimously that the inherent jurisdiction had survived notwithstanding the implementation of the Mental Capacity Act. 78 ibid. [61], citing Lord Donaldson’s terminology in *F v West Berkshire Health Authority* [1990] 2 AC 1.
79 Above (n 76) [64].
analysis of the remit of the jurisdiction post-Mental Capacity Act is beyond the scope of this chapter, and has been discussed elsewhere. However, if, in theory at least, its primary function remains to ‘[facilitate] unencumbered decision-making…free of external pressure’, under the arguments presented here the inherent jurisdiction, buttressed by other policy measures such as state appointed advocates, or a system of supported decision-making as found in other jurisdictions, may be better suited to understanding and encompassing ageism and promoting maximal autonomy for older people.

While this may be the case in some, particularly serious instances of ageism that result in abuse – perhaps as was the case in DL itself - the jurisdiction is not a desirable or practical solution for every instance of such ageism. It would, for example, still require the establishment of a threshold over which the courts will be prepared to intervene. It would also require greater sensitivity to the types of interventions offered by the inherent jurisdiction rather than a one-size-fits-all approach – explored further in the next chapter. More appropriate responses to ageism will therefore also have to be extra-judicial, and require training and education initiatives, as well as the development of a human rights agenda emphasising the equality of older people as rights holders.

81 In reality it is impossible to conceive of a decision that is made completely free from external pressures and therefore the most that can be hoped from any legal intervention is a removal of external pressures that may render the decision unauthentic.
82 LBL v RYJ [2010] EWHC 2665 (COP) [62].
83 Such advocates can be appointed in certain circumstances to those who lack capacity under the Mental Capacity Act ss. 35–41, however it may be that one response is to expand the role of such advocates to be included within the inherent jurisdiction. For a general overview of the benefits of a state appointed advocate system for people with disabilities, see: Eilionoir Flynn, ‘Making Human Rights Meaningful for People with Disabilities: Advocacy, Access to Justice and Equality Before the Law’ (2013) 17(4) The International Journal of Human Rights 491–510.
In addition, the argument presented in this chapter also suggest that it is important that responses are better able to promote positive relationships – a key feature of accounts of autonomy that take self-relations as central to its maximisation. It is welcome to see that the Court of Protection in the case of London Borough of Redbridge v G\textsuperscript{85} has recently highlighted the role of positive relationships within older peoples’ lives. The case – discussed in more depth in the next chapter - concerned a 94-year old lady, G, who had been subjected to coercion at the hands of her live-in carer, C, and it fell to the Court of Protection to determine whether G lacked capacity under the Mental Capacity Act, or if not, whether it would be possible to invoke the inherent jurisdiction to protect her from C’s influence. There are criticisms to be made of the judgments handed down by Russell J in this case, notably the fact that G was found to have dementia and therefore lacked capacity under the Mental Capacity Act, when in reality the clear cause of her ambivalent decision-making was most likely C’s influence, combined with the mild dementia – such criticisms are explored in more depth in the next chapter. However, one feature of the judgments does bear thinking about further, and is a welcome acknowledgment of how positive relationships can build positive self-relations. For nearly 80 years G had been a member of the same church, and at points Russell J even refers to G’s relationship with the church and her fellow churchgoers as being her ‘church family’.\textsuperscript{86} The emphasis that Russell J places on G’s positive relationships with members of her church, as well as the orders given that every effort is to be made to try and reintegrate G into her church community, are timely; they indicate a welcome acknowledgement by the Court of how relationships may operate to promote a person’s wellbeing and sense of self.

\textsuperscript{86} [2014] EWCOP 17 [84].
In light of the decision in *Aintree University Hospitals NHS Foundation Trust v James*,\(^87\) where it was held that decision-makers, in determining what course of action would be in a patient’s best interests under the Mental Capacity Act 2005, must take into consideration a person’s welfare in ‘the widest sense, not just medical but social and psychological’,\(^88\) there is no reason why a similar approach may not be adopted by the courts in relation to other older adults, such as those whose autonomy may be threatened by the internalisation of ageist attitudes.\(^89\) Notably, Russell J’s decision in *London Borough of Redbridge v G* demonstrates an acknowledgment of the importance of (re)developing positive relationships to promote a person’s wellbeing. Surely a recognition therefore that this in turn enhances their autonomy, and that autonomy is therefore not a binary concept would be the next logical step in this process? Along with accentuating the need to minimise ageism, the arguments presented in this chapter also indicate that positive social networks should also be emphasised further in any response, whether it is a judicial, social or policy response, to ageism-encumbered decision making. It is promising to note that from *Aintree* and *London Borough of Redbridge v G*, the courts are perhaps gradually beginning to understand the importance of such relationships when making decisions, and particularly care-related decisions.

### 6.5 Concluding Remarks

By using a relational lens, the arguments presented in this chapter have sought to illustrate how ageism, understood as a set of attitudes about older people or an individual older person, may be internalised and threaten autonomy. There will, of course, be additional factors involved in

---

\(^87\) *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.  
\(^88\) *ibid.* [39].  
\(^89\) By using *Aintree* as an analogous case here, I am not advocating the use of the Mental Capacity Act in such cases. There are, of course, those where the older person may well lack capacity under the Act’s provisions, however the use of *Aintree* is simply to highlight that holistic and relational approaches to an individual’s welfare have begun to be recognised by even the highest appellate court in other contexts, and therefore there is no impediment, at least in theory, as to why this type of approach could not be taken elsewhere.
any decision-making process for older people. The aim here has not been to disentangle all these factors. It is to specifically draw attention to how ageist attitudes, as just one of these factors, may threaten an older person’s autonomy. In order to be cognisant of this what we must ask is not ‘how can ageist attitudes in health and social care be understood in light of the existing individualistic model of autonomy’? The answer to this is that these accounts of autonomy are not adequately suited to this task. What we should be asking is, ‘how can autonomy be (re)-constructed so as to address the effect of ageist attitudes within health and social care?’ This, in turn, potentially has broader ramifications; we should not try to fit the issues that older people face into existing legal and ethical frameworks, but we should be developing new ones to account for and deal with these issues.

7.1 Introduction

The mistreatment of older adults, sometimes termed ‘elder abuse’, has been defined as ‘a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person’. It encompasses a broad spectrum of types of abuse, such as psychological, physical, financial and sexual. Recent studies place the prevalence of such abuse in the domestic sphere as between 2.5-4%. The impact such abuse has on an older individual, and particularly an older adult’s decision-making ability, is becoming an increasing concern for policy-makers and academics alike, with emphasis being placed on how such abuse may engender a fear of reprisals in its victims, as well as affecting their self-esteem and self-worth. Before 1 April 2015, identifying and responding to the domestic abuse of older persons was a matter left to local authorities, under the No Secrets guidance published in 2000. This minimal approach to safeguarding has been heavily criticised; in 2008, for example, the Commission for Social Care Inspection reported that the existing legal framework for adult protection is ‘neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years.’

---

1 This chapter is a development of the following article: Laura Pritchard-Jones, ‘The Good, the Bad and the ‘Vulnerable Older Adult’’ (2016) 38(1) Journal of Social Welfare and Family Law 51-72.
consequence, calls were made for a comprehensive statutory safeguarding scheme, which the Care Act 2014 now aims (but arguably fails) to achieve by placing an obligation on local authorities to make enquiries where an adult, who, by virtue of his or her ‘needs’, is considered at risk.

At the same time, it is now beyond doubt that the High Court’s inherent jurisdiction has survived the implementation of the Mental Capacity Act, and exists alongside the Act to protect those whose decision-making is threatened by reasons other than an ‘impairment of, or disturbance in the functioning of the mind, or brain,’ or to authorise a detention of those who do not come either within the deprivation of liberty safeguards under the Mental Capacity Act 2005, or the Mental Health Act 1983. According to Munby J:

... the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.

---


8 Care Act 2014, s 42. The Serious Crime Act 2015 has also recently been enacted, which criminalises coercive or controlling behaviour in intimate or family relationships (Serious Crime Act 2015, s 76). It remains to be seen to what extent this provision will also support the obligations incumbent on local authorities by virtue of the Care Act.


10 Mental Capacity Act, s 2(1).


12 Re SA (Vulnerable Adult with Capacity: Marriage) [2005] EWHC 2942 (Fam) [77].
Central to the more recent interpretations of the inherent jurisdiction, then, is this notion of the ‘vulnerable adult’ and despite the long history of this term in law and policy – outlined below - it is only recently that the theoretical literature has begun to grapple with what it means to be ‘vulnerable’, and question its predominant construction in this context. The recent arguments put forward are that vulnerability is both universal and particular, a feature that is inherent in all persons by virtue of our embodiment albeit experienced differently by each individual, rather than a term to denote certain sub-groups of the population such as the elderly or those with physical or cognitive impairments.

If existing safeguarding law and policy fails to make sufficient attempt at providing a comprehensive statutory framework for tackling such abuse, and its effect on decision-making, as commentators have noted, then it may well be that local authorities and the courts increasingly resort to the inherent jurisdiction to safeguard those older adults who experience abusive interpersonal relationships that affect their decision-making, and who do not fall within the scope of the Mental Capacity Act. Indeed, the Court of Appeal has recently noted as such: ‘[t]here is, in my view, a sound and strong public policy justification for [the retention of the inherent jurisdiction alongside the Mental Capacity Act]. The existence of ‘elder abuse’ ... is sadly all too easy to contemplate.’ In light of this it is important for the court invoking the inherent jurisdiction to have a clear and consistent approach as to who it considers a ‘vulnerable older adult’. This chapter builds upon literature applying the ‘new’ vulnerability analysis in

---


15 DL v A Local Authority (n 9) [63].
other domains,16 as well as existing critiques of the inherent jurisdiction,17 by exploring recent case law involving older adults, and in particular by focusing on three key cases;18 **DL v A Local Authority**,19 **London Borough of Redbridge v G**,20 and **NCC v PB.**21 By focusing on these cases I argue that the courts are using an outmoded and confused concept of vulnerability in relation to older adults, and that this, given the ‘theoretically limitless’22 remedies available under the jurisdiction, is problematic in terms of the responses it envisages for instances of such abuse. By adopting a more nuanced and consistent account of vulnerability, the courts may be better suited to identifying the complex nature of decision-making for older adults23 who experience abuse, and will therefore be able to respond more appropriately in such instances.

7.2 The Legal Context of the ‘Vulnerable’ Adult

7.2.1 The Historical Background

In 1990 the House of Lords, asserting the inherent jurisdiction, held that treatment on a

---


18 The facts of these cases are explained in more detail later in this chapter. It is worth noting at the outset that only DL was in fact decided using the jurisdiction. **London Borough of Redbridge v G** and **PB** were decided under the Mental Capacity Act, but, nevertheless, **PB** contained lengthy discussion of the jurisdiction before its ultimate rejection, and **London Borough of Redbridge v G** provided interesting comments on vulnerability. This point, and the difficulty it presents in blurring the legal boundaries of ‘capacity’ and ‘vulnerability’, will also be discussed further in this chapter.

19 [2011] EWHC 1022 (Fam); **DL v A Local Authority** (n 9).


22 **Re B (Secure Accommodation: Inherent Jurisdiction) (No. 1)** [2013] EWHC 4654 (Fam) [20].

23 Whilst the aim of the chapter is to examine the construction of the ‘vulnerable older adult’ in these cases, and examine the broader legal implications of this for the development of the inherent jurisdiction more generally, the arguments presented may apply to other ‘groups’ traditionally considered vulnerable, and how these particular cases interplay with other inherent jurisdiction cases will form a key feature of the analysis.
mentally incapacitated adult would be lawful as long as it was necessary, and it was to be deemed necessary if it was in her best interests.\textsuperscript{24} Subsequently, there followed a number of cases authorising (or authorising the withdrawal of) medical treatment under the inherent jurisdiction for individuals who were considered unable to give valid consent by reason of mental incapacity\textsuperscript{25} or because of coercion or undue influence.\textsuperscript{26} That the use of the jurisdiction was confined only to medical treatment seemed beyond doubt in 1995 by Hale J (as she then was) in \textit{Cambridgeshire County Council v R.}\textsuperscript{27} In this case, the local authority sought declarations in respect of the family of a 21-year-old woman in its care that, \textit{inter alia}, it would be lawful to prevent her family contacting her. Hale J held that the declaratory jurisdiction could only be invoked to protect a legal right, and not to limit an individual’s freedom of association.\textsuperscript{28}

Since then, however, the scope of the jurisdiction has been extended further by the courts in two marked directions. First, following \textit{Re F},\textsuperscript{29} where the Court of Appeal upheld declarations sought by the local authority to restrict the contact of an abused young woman who had a low intellectual age with her natural family, the jurisdiction has been extended to cover decisions

\textsuperscript{24} \textit{F v West Berkshire Health Authority} [1990] 2 AC 1
\textsuperscript{25} \textit{Airedale NHS Trust v Bland} (1993) AC 789; \textit{Re MB (Medical Treatment)} (1997) 2 FLR 426; \textit{Re Y (Mental Patient: Bone Marrow Donation)} [1997] Fam 110.
\textsuperscript{26} \textit{Re T (Adult: Refusal of Treatment)} [1993] Fam 95.
\textsuperscript{27} \textit{Cambridgeshire County Council v R (An Adult)} [1995] 1 FLR 50.
\textsuperscript{28} Hale J explains a legal right in the context of this particular case by stating that, ‘It is access, or freedom of association, rather than harassment, or freedom from association, which is protected under English law’ (emphasis in original): \textit{ibid.} 52. She goes on to say that ‘[i]t is clear ... from the troubling circumstances of this case that there exists no wholly appropriate legal mechanism for examining whether or not W should be free to make her own decisions in the vital matter of her relationship with her family ... it is a sad state of affairs that the law is unable to provide suitable protection in such a situation’: \textit{ibid.} 56.
\textsuperscript{29} \textit{Re F} [2000] EWCA Civ 192.
other than medical treatment, such as deprivations of liberty, contact, residence, marriage, and publication restraint.

Moreover – and particularly important now that the Mental Capacity Act 2005 provides the legislative framework for decision-making for those who are deemed to lack capacity ‘because of an impairment of, or a disturbance in the functioning of, the mind or brain’ – the scope of the jurisdiction has seemingly affirmed the early decision of the Court of Appeal in Re T, and has been extended to adults who are deemed unable to make decisions for reasons other than mental impairment; more recently called ‘vulnerable adults’. In Re G for example, the Court was asked to determine whether the jurisdiction could be used to make residence and contact orders for a 29-year-old woman, G, who had a history of mental illness and had previously been subjected to a guardianship order under section 7 of the Mental Health Act 1983. The Court held, notwithstanding the fact that at the time of the hearing G had regained mental capacity as to her contact and residence, that the inherent jurisdiction could still be used to grant the declarations sought – a failure to do so would mean that G’s condition would almost certainly deteriorate and she would lack capacity again. Similarly, in Re SA the question for the Family Division was whether the jurisdiction could be invoked to protect an 18-year-old who suffered from profound communication difficulties from an unsuitable arranged marriage in Pakistan, notwithstanding the fact that she had capacity to marry. In finding that it could be

---

30 R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458. This was subsequently ruled unlawful by the European Court of Human Rights in HL v UK [2004] ECHR 471, which led to the Deprivation of Liberty Safeguards being inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007. More recently, however, see An NHS Trust v Dr A [2013] EWHC 2442 (COP), which suggests that the jurisdiction can be used to plug the gaps in the existing framework, and its interface with the Mental Health Act 1983.

31 Re G [2004] EWHC 2222 (Fam); Re S [2002] EWHC 2278 (Fam).

32 Re S [2003] EWHC 1909 (Fam).

33 Re SK [2004] EWHC 3202 (Fam); Re SA (n 12).

34 Local Authority v Health Authority [2004] All ER 480.

35 Re T (n 26).

36 Re G [2004] EWHC 2222 (Fam).

37 Re SA (n 12).
invoked in these circumstances, Munby J held that:

A vulnerable adult who does not suffer from any kind of mental incapacity may nonetheless be entitled to the protection of the inherent jurisdiction if he is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors.\(^{38}\)

### 7.2.2 Who is the ‘Vulnerable’ Adult?

So whom does the law have in mind when it speaks of ‘vulnerable’? Central to the conceptualisation of vulnerability adopted by the courts in these cases is the notion of an inherent characteristic meeting a risk of harm. According to Munby J in *Re SA*, an adult is deemed to be vulnerable if he or she is ‘unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity.’\(^{39}\) In light of this, Munby J goes on to say that ‘SA is plainly a vulnerable adult. She is substantially handicapped by her disabilities. And, particularly because she is deaf and dumb, she may well be unable to take care of herself and protect herself against significant harm or exploitation’.\(^{40}\) The approach adopted by Munby J in *Re SA* has been cited with approval by subsequent courts grappling with cases involving older adults,\(^ {41}\) and is one that is not uncommon more generally

---

\(^{38}\) *Re SA* (n 12) [79].

\(^{39}\) *ibid.* [82]. This approach was endorsed by the Court of Appeal in *DL*. It is also important to note the broad brush approach that Munby J takes to this idea of vulnerability, though. Despite this definition, he also states that it is difficult to delineate the group he considers vulnerable (at [77]), and that the definition he has given is ‘descriptive, not definitive; indicative rather than prescriptive’ (at [82]). The particular wording used by Munby J also mirrors the statutory approach under section 29(1) of the National Assistance Act 1948, although the Act does not use the term ‘vulnerability’ explicitly, section 29(1) states that ‘[a] local authority shall have power to make arrangements for promoting the welfare of persons...who are blind, deaf or dumb, and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.’ I would like to thank Kirsty Keywood for bringing this point to my attention.

\(^{40}\) *Re SA* (n 12) [120].

\(^{41}\) *City of Sunderland v PS and CA* [2007] EWHC 623 (Fam); *DL v A Local Authority* (n 9).
in the case law. In *LBL v RYJ*,\(^{42}\) for example, which involved capacity determinations in respect of a young woman who had suffered brain damage at birth and had significant learning difficulties, the Court cites a report prepared by the educational psychologist which states that '[the individual] has an extremely low IQ, [is] unlikely to be capable of leading a fully independent adult life and in this respect will need help, support and care for the foreseeable future. *Her limitations make her vulnerable.*'\(^{43}\)

Similarly, in *Local Authority X v MM and KM*,\(^{44}\) the issue was whether MM, who suffered from paranoid schizophrenia and a moderate learning disability, had decision-making capacity with regard to, *inter alia*, residence, contact and marriage. In his decision, Munby J again ties vulnerability to being at risk of abuse and states that ‘the appropriate role of the law here is to protect the vulnerable, who as such may become easy targets for abuse or who may find themselves in exploitative contexts’.\(^{45}\) In doing so, he refers to the case of *Dudgeon v UK*.\(^{46}\) Albeit a case that involved the criminalisation of homosexuality, the European Court of Human Rights in *Dudgeon* offers an illustrative account of vulnerability as deriving from an inherent characteristic, which is cited with approval by Munby J:

> There can be no denial that some degree of regulation ... can be justified as ‘necessary in a democratic society’... to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence.\(^{47}\)

---

\(^{42}\) *LBL v RYJ* [2010] EWHC 2665 (COP).
\(^{43}\) *ibid.* [38] (emphasis added).
\(^{44}\) *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam).
\(^{45}\) *ibid.* [130].
\(^{46}\) *Dudgeon v UK* (1981) 4 EHRR 149.
\(^{47}\) *ibid.* [49], adopting the language of the Wolfenden Report; Committee on Homosexual Offences and Prostitution, *Report of the Committee on Homosexual Offences and Prostitution* (The Stationery Office 1957) cited by Munby J in *Local Authority X v MM and KM* (n 44) [128].
Moreover, Munby J’s approach in *Local Authority X v MM and KM* automatically ties being ‘elderly’ in with being ‘vulnerable’ – in paragraph 120 alone he links being ‘elderly’ with being ‘vulnerable’ together three times.

This approach to vulnerability – the presence of an inherent characteristic within an individual such as old age or a cognitive impairment, which is deemed to bring with it a risk of harm – is also one that arises in other legal contexts involving older adults. In *Watts v UK*,\(^\text{48}\) for example, which involved a challenge by a 106-year-old woman to the proposed closure of her care home, the European Court of Human Rights stated that:

> [T]he presence of cognitive impairments ... makes the individual particularly vulnerable, for no matter how much work is done to explain the situation and to help them come to terms with the situation, all that work may be lost because of the failure to register and to remember ... these vulnerability factors increase the risk of adverse reactions to the relocation stress ... \(^\text{49}\)

Likewise, in *LLBC v TG*,\(^\text{50}\) a case concerning the residence of TG, a 78-year-old gentleman with dementia, vulnerability is linked to the fact that TG is ‘elderly’ and ‘infirm’.\(^\text{51}\)

This idea that a vulnerable adult is someone who is unable to protect herself because of an inherent characteristic, such as age or cognitive impairment, is also one that appears in adult safeguarding policy more generally. *No Secrets*,\(^\text{52}\) the safeguarding policy framework superseded in 2015 by the Care Act 2014, defined a vulnerable adult as:

> [S]omeone who is or may be in need of community care services by reason

---


\(^{49}\) *ibid*. SE5 [53]. The language used by the Court is adopted from the Jolley Report: David Jolley, *Court Report: Lancashire Care Association*, CO/2278/2002.

\(^{50}\) *LLBC v TG*, *JG and KR* [2007] EWHC 2640 (Fam).

\(^{51}\) *ibid.* [40].

\(^{52}\) Department of Health (n 5).
of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.  

Similarly, section 42 of the Care Act 2014 now places a statutory obligation on local authorities to make enquiries where it has reasonable cause to suspect that an adult is in need of care and support, is experiencing or is at risk of experiencing abuse or neglect, and the needs that the individual has render him or her unable to protect him- or herself from the abuse or neglect.  

Both the approach taken to vulnerability by the inherent jurisdiction cases (and the broader cases) then, as well as the policy and statutory provisions surveyed here, present vulnerability as being at risk because of an inherent characteristic. More recently under the Care Act 2014, because of something that renders them ‘in need’ of care and support – an impairment, so to speak, which leaves them unable to protect themselves from abuse. In effect, vulnerability depends first and foremost on the existence of an inherent characteristic, which then renders an adult at risk of harm.

53 Ibid. para. 2.3 (emphasis added). This approach itself was adopted from Who Decides, the green paper on decision-making for mentally incapacitated adults, which ultimately led to the enactment of the Mental Capacity Act 2005: Lord Chancellor’s Department, Who Decides: Making Decisions on Behalf of Mentally Incapacitated Adults (The Stationery Office 1997).

54 Care Act 2014, s 42(1)(a)-(c). What exactly the Act means by ‘enquiries’, however, is left unexplained; the guidance for implementation simply refers to ‘whatever enquiries [the local authority] thinks necessary to decide what if any action needs to be taken and by whom’, and explains that ‘enquiry’ could mean any number of things from an informal chat with the individual in question, right through to a ‘much more formal multi-agency plan or course of action’: Department of Health, Care and Support Statutory Guidance (The Stationery Office 2014) paras. 14.57-14.64. Second, the Act repeals section 47 of the National Assistance Act 1948, which provided local authorities with a power of removal of a vulnerable adult, but does not replace this with any other provisions such as a power of entry. In this respect the Care Act arguably falls short in comparison with the provisions in both the Scottish (Adult Support and Protection (Scotland) Act 2007) and Welsh (Social Services and Well-being (Wales) Act 2014) legislation: Gary Fitzgerald and Alex Ruck Keene, Action on Elder Abuse Briefing Paper on the Need for a New Power of Access in Defined Circumstances (2014) available at: http://londonadass.org.uk/wp-content/uploads/2014/12/PowersofEntryanalysisoftheLaw.pdf (last accessed 28 May 2016).

55 The approach to vulnerability based on the presence of internal characteristics is not one that is peculiar to social welfare law and policy, though. For example, the current offences of wilful neglect or ill-treatment found in section 44 of the Mental Capacity Act and section 127 of the Mental Health Act 1983 are ones that apply when a person lacks capacity, or the perpetrator reasonably believed that person lacked capacity (i.e. because of an impairment of, or a disturbance in the functioning of, the mind or brain according to section 2(1)), or when an individual is being treated for a mental health disorder. This remains the legal position until sections 20 and 21 of the Criminal Justice and Courts Act 2015 enter in to force, which provide for general offences of wilful neglect or ill-treatment by health care workers or health care providers. For a critique of the scope of the current offences, as well as their utility, see Amel Alghrani and others, ‘Healthcare Scandals in the NHS: Crime and Punishment’
7.2.3 (Re)-Conceptualising Vulnerability

This idea of ‘vulnerability’ (or ‘adult at risk’) promulgated both by the courts and safeguarding law and policy more generally, then, is two-dimensional – the meeting of an inherent characteristic, such as disability or age, with a risk of being subjected to some form of harm. In essence, an individual must be vulnerable because of something (an internal characteristic), to something (risk of abuse or neglect). The problems with this approach to vulnerability, particularly for older people, are multiple. If part of what renders an older person vulnerable is his or her age, or the impairments that are associated with advanced age such as frailty, or an illness like dementia, as has been alluded to in Watts v UK, LLBC v TH, JG and KR and Local Authority X v MM and KM, and cited with approval in DL, then it seems to follow that simply belonging to a group with that particular characteristic (i.e. old age, frailty or dementia) indicates that the individual is ‘vulnerable’. While an older person, or a person with dementia, may well experience a level of vulnerability that a younger person, or a person without dementia does not experience, the approach outlined above fails to make reference to exactly what it is about old age or dementia, for example, that impacts on the ways in which an older adult experiences vulnerability.56

56 The use of the phrase ‘experience vulnerability’ as opposed to ‘being vulnerable’ is important. On the account of vulnerability presented here, it is important to distinguish between the two. More recent vulnerability theory, which emphasises the role of external factors, align more to an understanding of vulnerability as being experienced, however an account of vulnerability that looks at an internal characteristic gives the impression that vulnerable is something an individual can ‘be’ – a status. It is the former understanding of vulnerability that this chapter adheres to and as such the term ‘experience vulnerability’ is deliberately used here.
For example, an older woman with late-stage dementia who resides with her abusive husband in a rural area with limited access to medical treatment and facilities, and who is cared for by a series of different carers provided by a private care agency, will experience vulnerability in a different way to an older man with early stage dementia but who lives with his lovingly devoted wife who cares for him well, and with many high-quality medical facilities nearby. In the first scenario, the woman’s experience of vulnerability may be compounded because of the different intersecting layers: her gender, the abuse she suffers from her husband, the discontinuity of care, her geographic location and lack of facilities. The dementia of itself does not necessarily render her vulnerable without exploring the other – predominantly external factors. In other words, the current two-dimensional approach criticised above fails to recognise the multiple sources of an older individual’s particular experience of vulnerability, and may therefore place the older person at risk of an inadequate response to ‘perceived’ internal sources of vulnerability. In essence, it is arguable that internal characteristics themselves do not generate the heightened experience of vulnerability; it is inadequate support mechanisms that generate this.

Furthermore, the approach currently promulgated by law and policy is grounded in, and reinforces the essentialising and stigmatising properties of both vulnerability and old age. Tying vulnerability to an internal characteristic such as old age, or a cognitive impairment such as dementia, for example, which are themselves loaded with negative connotations, reinforces

57 See, for example: Peroni and Timmer (n 16).
the idea that being vulnerable (or being at risk) is a ‘bad thing’, a weakness, a fault or something to be feared, as old age, and features or conditions associated with old age have come to be seen. This approach was perhaps most obviously adopted in a recent judgment by Newton J, who stated that, ‘the Court of Protection is concerned with the weak and the vulnerable.’

In essence, vulnerability equates to weakness.

At the same time, the association between ‘traditional’ vulnerability and old age, also mutually reinforces the stereotypical view of old age itself, as well as the need for care and support in old age, as something to be feared, something ‘bad’, or as a negative state of being. This outmoded approach to vulnerability, as Luna argues, is a ‘simplistic answer to a complicated problem’; it belies the universal nature of what it is to be vulnerable, that is, vulnerability exists in each individual, not just those with certain characteristics. If vulnerability is being at risk of a particular harm or threat, then it exists in every individual by virtue of our embodiment and corporeality, which renders us susceptible to any physical and emotional harm.

It exists because of our interdependence – our relationships with others, and even because of the ways in which the society we inhabit may be structured – for example, certain power imbalances may render us susceptible to being harmed. It is this particular feature of vulnerability, the idea that in order to be vulnerable you must be susceptible to something, that Fineman argues in fact makes the concept a universal one – one that inheres in all of us, not just certain individuals based on a certain characteristic.

---

62 Fineman, ‘The Vulnerable Subject: Anchoring Equality in the Human Condition’ (n 13).
The idea that vulnerability is universal, or a quality associated with human corporeality, is not purely theoretical or abstract. Recent research suggests that this alternative conceptualisation of vulnerability in fact has some practical weight – that in relation to older people, vulnerability is characterised by those tasked with caring for older people as simply ‘being human’, and furthermore is not only experienced by the older person as previous constructions of vulnerability would indicate, but is also experienced by caregivers for older adults.63 Furthermore, research also suggests that many of those tasked with caring for older adults envisage vulnerability as a positive state of being - a state that gives rise to opportunities for personal development and a recognition of care needs.64

7.3 Vulnerability and the Older Adult

7.3.1 The Cases

The most recent cases that give an indication of the courts’ current approach to the vulnerable older adult (and vulnerability more generally) are the three cases that form the analysis for this chapter; A Local Authority v DL, London Borough of Redbridge v G and NCC v PB. DL concerned the treatment of an elderly couple (ML aged 90 and GRL aged 80) by their son, DL, with whom they lived. There had been concerns by the Local Authority since 2005 of physical assaults, verbal threats and controlling behaviour by DL, which included controlling the visits by care professionals to his mother, ML, as well as concerns of financial abuse.65 It was agreed by the Local Authority that neither ML nor her husband, GRL, lacked capacity as to residence and contact with their son under the Mental Capacity Act (although by the time proceedings reached the High Court it was agreed that GRL did lack capacity),66 and proceedings were

64 Bettina Steinbock-Hult and Anneli Sarvimäki (n 63).
65 A Local Authority v DL (n 19) [6].
66 ibid. [2].
therefore commenced under the inherent jurisdiction. The issue for the Court to determine was a legal one: had the inherent jurisdiction survived the implementation of the Mental Capacity Act 2005? In a unanimous decision the Court of Appeal held that it had.

Since DL, two cases in particular involving older adults have arisen where applications were lodged, in part, under the inherent jurisdiction on the basis of the older adult’s vulnerability. *London Borough of Redbridge v G* concerned a lady of 94, G, who lived with C, and C’s husband, F, to whom she had been introduced through membership of her local church. There had been concerns over G’s welfare for a number of years following allegations that C was acting in an overbearing and verbally abusive manner, as well as allegations of possible financial abuse, resulting in five safeguarding referrals between March 2011 and May 2013. The issues that fell to the Court of Protection to be determined were multiple, over a series of judgments, and included, *inter alia*, whether G had capacity as to litigation, her financial affairs, contact with C and F, and contact with the press. Following a determination by Russell J that she lacked capacity as to these issues, 67 it was subsequently held that it would be in her best interests to place restrictions on her contact with both C and F and the press 68 and orders were granted requiring C and F to move out of G’s property.

*NCC v PB and TB* concerned an application, again lodged under both the Mental Capacity Act and the inherent jurisdiction (in the event that PB was deemed not to lack capacity under the Mental Capacity Act), concerning, *inter alia*, the residence 69 of PB, a 79-year-old woman, who had been married to TB for a number of years. There were concerns over PB’s lifestyle with TB, which included unsanitary living conditions, being abandoned on ‘road trips’ and abusive

---

69 There was also a question over PB’s refusal of an endoscopy, however this was not ultimately an issue to be decided by the Court as PB voluntarily underwent the procedure (*NCC v PB and TB* (n 21) at [124]).
behaviour by TB towards PB. The issue to be determined by the Court was whether she lacked
capacity to decide where to live under the Mental Capacity Act or whether her decision-making
was fatally impaired because of the nature of her relationship with TB, thereby invoking the
inherent jurisdiction. Parker J, sitting in the Court of Protection, found that she lacked capacity
under the Mental Capacity Act, and authorised her residence in a care home based on this
finding. Nevertheless, the Court in \textit{NCC v PB} did provide some interesting \textit{obiter} comments
on the notion of vulnerability in the context of the inherent jurisdiction.

Both \textit{London Borough of Redbridge v G} and \textit{PB} then, concerned individuals with what was
deemed to be an impairment or disturbance in the functioning or the mind or brain: G was
deemed to have dementia, whilst PB was deemed to have residual schizophrenia or schizo-
affection disorder, a diagnosis on which the two experts could not agree.\textsuperscript{70} This led the Court
of Protection in both cases to hold that they were not capable of satisfying the remainder of the
functional test for capacity.\textsuperscript{71}

\subsection*{7.3.2 Outdated Vulnerability}

At first glance, the outcome of these cases may seem intuitively appealing. The facts of the
cases are highly emotive, and the decisions represent a desire to safeguard older adults from
what appear to be abusive relationships, where there are unequal power relations at play.
Indeed, and as shall be shown later, recent accounts of vulnerability do not necessarily require
the courts to take a back-seat or non-interventionist stance. However, the heavy reliance on
outdated and status-based conceptualisations of vulnerability by the courts in these cases

\textsuperscript{70} \textit{NCC v PB and TB} (n 21) [59].
\textsuperscript{71} Mental Capacity Act 2005, s 3 – unable to use, weight, retain relevant information or communicate their
decision.
indicates that the judiciary has not made huge strides forwards in their understanding of the vulnerable older adult.

The use of the term vulnerability as a descriptor in these cases illustrates this point well. ‘Vulnerability’ in London Borough of Redbridge v G, for example, is frequently deployed as a descriptor alongside ‘old’, ‘frail’, ‘elderly’ and ‘incapacitous’. In the capacity judgment, Russell J describes G as an ‘old, vulnerable lady’.\(^{72}\) In discussing the reporting restrictions, Russell J states that ‘I have done so to protect the privacy of G who is old, frail and vulnerable.’\(^{73}\) In a later hearing, Cobb J holds that ‘there is ... a legitimate public interest in the reporting of proceedings in the Court of Protection concerning our vulnerable, elderly and incapacitous. There is a separate legitimate public interest in the court protecting the vulnerable, elderly, and the incapacitous from public invasion into their lives.’\(^{74}\) This, again, mirrors similar descriptive approaches taken by earlier decisions involving older adults, outlined above.\(^{75}\) The association of vulnerability with old age, and certain corporeal or cognitive impairments associated with old age such as frailty or incapacity (this point will be returned to in a short while), indicates that the courts are deploying the term as a concept that attaches to those who demonstrate such characteristics. In effect, a return to the status or characteristic-based vulnerability criticised above – and in chapter 3 of this thesis.

This approach to vulnerability is perhaps most starkly (and worryingly) illustrated in PB where, in discussing whether she could have invoked the inherent jurisdiction if PB had not lacked capacity under the Mental Capacity Act, Parker J states that:

\(^{72}\) London Borough of Redbridge v G [2014] EWCOP 17 [12].  
\(^{75}\) See in particular the judgment of Munby J in Local Authority X v MM and KM (n 44) at [120]: ‘The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with.’
‘Unsoundness of mind’ is not the same as ‘incapacity’. PB has a diagnosed psychiatric condition which compromises her decision making. If it is not established that she lacks capacity this would be on the narrowest interpretation of MCA 2005 (‘because of’) and would not impinge upon her diagnosis or her vulnerability, which results from her psychiatric condition.⁷⁶ Although obiter, given that PB was deemed to lack capacity under the Mental Capacity Act, Parker J’s approach here is firmly rooted in the idea that vulnerability stems from PB’s psychiatric condition and is again reminiscent of the status based approach to vulnerability. Parker J’s assertion indicates that the jurisdiction retains a role in respect of those who do suffer from psychiatric conditions but where their impairment does not mean they lack capacity under s.2(1) of the Mental Capacity Act.⁷⁷ This, combined with the approach in London Borough of Redbridge v G, where vulnerability status was linked to G’s age and physical or cognitive characteristics, indicates that the courts in these cases continue to view vulnerability as resulting from an inherent characteristic, such as age, or - as Parker J specifically states - a psychiatric condition.

Tying vulnerability to an individual’s inherent characteristic, such as dementia in London Borough of Redbridge v G, or her schizo-affective disorder in PB, presents the court with an easier task than having to engage with the messy reality of the various intertwined factors that contribute to their experience of being vulnerable at an individual level, such as PB’s attitudes towards marriage and her husband, or the fact that G’s reluctance to have C and F removed as her carers may be because she believes her home will be taken from her and she will be placed

⁷⁶ NCC v PB and TB (n 21) [119] (emphasis added).
⁷⁷ If this is the case, then we could question whether it is accurate from an administrative point of view, as counsel for DL did on appeal (DL v A Local Authority (n 9) [36]–[39]), but which was rejected by the Lord Justices (DL v A Local Authority (n 9) [57]–[63]).
in a care home.\textsuperscript{78} For the courts, it is far easier to attribute vulnerability to something concrete, or medical, such as their age or their psychiatric condition, than it is to try and navigate through a more complex set of circumstances that these two adults and themselves in – it is Luna’s\textsuperscript{79} simplistic answer to a complicated problem in a very practical setting. The Court of Appeal itself in \textit{DL} even acknowledges that it is easier to identify internal characteristics that generate vulnerabilities, with MacFarlane LJ stating that ‘it is not easy to define and delineate this group of vulnerable adults, as, in contrast, it is when the yardstick of vulnerability relates to an impairment or disturbance in the functioning of the mind or brain.’\textsuperscript{80}

In addition to this, another feature of these particular cases that demonstrate their steadfastness to a status-based approach to vulnerability is in the way they characterise the relationship between ‘vulnerability’ and ‘incapacity’. As noted earlier, prior to the implementation of the Mental Capacity Act, the inherent jurisdiction had developed to protect those whose decision-making was impaired because of mental incapacity. Following \textit{Re G} and Munby J’s decision in \textit{Re SA}, however, it is obvious that mental incapacity is not the only basis on which to invoke the jurisdiction, or upon which a person can be vulnerable. According to Munby J in \textit{Re SA}:

\begin{quote}
[I]t can be seen that the inherent jurisdiction is no longer correctly to be understood as confined to cases where a vulnerable adult is disabled by mental incapacity from making his own decision about the matter in hand ... [t]he jurisdiction, in my judgment, extends to a wider class of vulnerable adults.\textsuperscript{81}
\end{quote}

\textsuperscript{78} \textit{London Borough of Redbridge v G} [2014] EWCOP 485 [33].
\textsuperscript{79} Luna (n 60).
\textsuperscript{80} \textit{DL v A Local Authority} (n 9) [64]. This functional approach has also been heavily criticised by the Committee on the Rights of Persons with Disabilities as ‘it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right’: United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) Article 12, and UNCRPD General Comment No 1 ‘Equal recognition before the law (Art. 12)’ (11 April 2014) CRPD/C/GC/1 para. 15.
\textsuperscript{81} \textit{Re SA} (n 12) [76] (emphasis added).
Munby J’s approach, quoted here, is explicitly endorsed by both the High Court and the Court of Appeal in DL.82

Although ‘the confluence of mental impairment and undue influence is not all that unusual’,83 as the Singaporean Court of Appeal recently noted in a similar case, in the cases discussed here however, the judiciary has a tendency to exhibit semantic confusion as to the distinction between experiencing vulnerability, particularly when experiencing abusive relationships in old age, and being incapacitated (or lacking capacity). In the very first paragraph of the capacity judgment in London Borough of Redbridge v G, Russell J phrases the issue to be determined as whether G’s lack of capacity ‘is because of mental impairment within the meaning of the MCA sections 2 and 3 or if not whether she is a vulnerable adult deprived of capacity by constraint, coercion or undue influence ...’.84 This idea of lacking or being deprived of mental capacity because of undue influence reappears during Russell J’s summary of the expert psychiatric and social worker evidence: ‘[b]oth [the social worker] and Dr. Barker ... share the view that G’s capacity to reach decisions is undermined by the influence and presence of C and F.’85 Russell J, however, is not alone in adopting this confused approach. A similar confusion is present in the arguments made by the Local Authority in DL:

[Counsel’s] submissions have therefore been to delineate the extent of the jurisdiction so that it only covers those cases where it is necessary for the court to act because a person’s capacity to make decisions for themselves has been overborne by circumstances other than those covered by the MCA 2005.86

82 A Local Authority v DL (n 19) [19]; DL v A Local Authority (n 9) [53]. It is precisely because vulnerability differs from mental incapacity that the courts in both Re G and Re SA felt the need to make the declarations it did; neither G nor SA lacked mental capacity, but both were at risk of harm. In G’s case it was the risk of losing her capacity again should she have unrestricted contact with her father, and for SA it was the risk of harm if she was forced to enter in to a marriage.
83 Re BKR [2015] SGCA 26 [88].
85 ibid.
86 A Local Authority v DL (n 19) [50] (emphasis added).
This argument is also one accepted by the Lord Justices in DL, with MacFarlane LJ stating that ‘[n]othing in the MCA 2005 makes express provision with respect to individuals who may lack capacity for a reason other than an impairment of, or disturbance in the functioning of, the mind or brain’.  

This approach is also implicit in PB. In her summary of the expert evidence regarding PB’s capacity, Parker J states ‘... Dr. Barker is not certain about the extent to which PB’s decisions may be based on her beliefs about marriage, and to what extent TB’s influence leads her to be incapacitous all the time.’ To suggest that a vulnerable person can retain capacity under the Mental Capacity Act but can nevertheless be ‘incapacitated’ (and, furthermore, incapacitated ‘all the time’) because of his or her vulnerability is disingenuous for a number of reasons. First, from a legal standpoint it risks bringing in the best interests standard found under the Mental Capacity Act, with none of the safeguards contained therein into the court’s remit of responses in these cases (discussed in more detail below).  

As Ruck Keene notes of the decision in PB, ‘how is such an approach to be distinguished from taking a decision on behalf of such an adult?’ It is, furthermore, worrying from an ethical standpoint. Using the term ‘incapacitated’, even in its non-legal sense, shifts the ultimate reason, or even the ‘blame’, for not being able to make an autonomous decision back to the individual who has been abused –

---

87 DL v A Local Authority (n 9) [58] (emphasis added). This is despite earlier references to vulnerability that MacFarlane LJ makes, which align vulnerability to autonomy, rather than capacity: ‘the jurisdiction...is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity ...’: DL v A Local Authority (n 9) [54]. This latter conceptualisation of vulnerability as pertaining to autonomy may be more in line with recent theoretical accounts.  

88 NCC v PB and TB (n 21) [63] (emphasis added).  

89 For example, the decision made must be carried out in the least restrictive way – Mental Capacity Act, s 1(6); or the list of relevant factors to be considered when making the decision – Mental Capacity Act 2005, s 4(6), and that capacity is act and decision-specific, not global (which is what Parker J insinuates by stating ‘incapacitous all the time’).  

90 The legal consequences of this approach were argued forcefully by counsel for DL (DL v A Local Authority (n 9) [36]–[41]), although this argument was not accepted by the Lord Justices. See also: Barbara Hewson, ‘“Neither Midwives nor Rainmakers” – Why DL is Wrong’ (2013) Public Law 451-459.  

as shown in chapter 3, something which recent safeguarding policy more generally has explicitly tried to move away from.\textsuperscript{92} Saying that an individual may be ‘incapacitated’ because of external forces such as coercion or undue influence indicates that it is a failure on their behalf that they are unable to make the decision – a defect within that individual’s abilities to resist external pressure, so to speak, and, as we shall see later, risks inviting inappropriate responses directed towards the individual who has been abused rather than the abuser. In a more recent decision, \textit{Re DM},\textsuperscript{93} Hayden J in fact stresses the separateness of the two concepts; ‘I emphasise that “vulnerable” is not to be conflated with the concept of incapacitous’,\textsuperscript{94} and later, is keen to keep separate the remedies available under the Mental Capacity Act 2005, from the remedies available under the inherent jurisdiction for those who are vulnerable.\textsuperscript{95}

How, then, does the characterisation of the relationship between capacity (or incapacity) and vulnerability presented in \textit{DL, London Borough of Redbridge v G} and \textit{PB} support the argument presented here, namely that the courts still view vulnerability in relation to older people as being derived from an inherent characteristic? As noted earlier, in light of the Mental Capacity Act, ‘lacking capacity’ in one sense is now to be understood legally as stemming from a disturbance in the functioning of the mind or brain according to section 2(1) of the Act. Clear examples of such things as will be considered sufficient to fulfil this criterion are given in the Code of Practice to the Act, and include medical conditions such as dementia.\textsuperscript{96} It is clear, then, that lacking capacity in its most common legal usage is now linked to a medical condition or cognitive impairment, something that, as noted earlier, recent vulnerability literature seeks to move away from. Characterising vulnerability as being incapacitated, as the courts do here, is

\textsuperscript{92} See chapter 3 of this thesis, section 3.1.1, and 3.1.2.
\textsuperscript{93} \textit{Re DM} [2014] EWHC 3119 (Fam).
\textsuperscript{94} \textit{Ibid.} [5].
\textsuperscript{95} \textit{Ibid.} [10].
reminiscent of the Mental Capacity Act approach, and risks linking an individual’s vulnerability to an internal, often medical characteristic (i.e. his or her dementia, for example) – or reflects a ‘defect’ or an impairment in an older individual’s ability to resist external undue influence. Indeed, such an approach was clearly articulated in the recent Singaporean case of *Re BKR*,\(^{97}\) involving the capacity of an older woman to make decisions over her property and affairs, and who was alleged to have both a mental impairment and have been subjected to undue influence. The Singaporean Court of Appeal held that only where there was no material question of the mental impairment causing the incapacity that the court would have no jurisdiction under the Singaporean Mental Capacity Act.\(^{98}\) In other words, wherever there is any suspicion that the mental impairment was just one of the causes of the incapacity then the issue will be determined under the Act. As I shall argue in the next section, this approach may invite inappropriate responses by the courts to perceived vulnerability.

### 7.3.3 Inappropriate Remedies for Older Adults

In order to assess the implications for older people if the courts are committed to retaining a status-based approach to vulnerability, it is important to contextualise the courts’ responses within the critiques and approaches to legal remedies derived from the theoretical literature. Recent theoretical stances on vulnerability do not assert that interventions or responses by the state or other individuals are unwanted; they in fact seek to move away from a non-interventionist stance.\(^{99}\) Indeed, the recent House of Lords post-legislative scrutiny report on the Mental Capacity Act notes on several occasions that a lack of response can entrench the experience of vulnerability just as much as improper responses.\(^{100}\)

---

\(^{97}\) *Re BKR* (n 83).

\(^{98}\) *Ibid.* [124].


vulnerability literature does seek to achieve, however, is to highlight the role that others, and, particularly for Fineman\textsuperscript{101} the role that the state plays in reducing the effects of external sources of vulnerability for older people. Mackenzie\textsuperscript{102} and Kohn,\textsuperscript{103} however, go further than Fineman, and draw attention to the fact that in being responsive, the state can in itself constitute an additional source of vulnerability or further entrench an older person’s experiences of vulnerability. It has the potential for creating what Mackenzie terms a ‘pathogenic’\textsuperscript{104} source of vulnerability. This refers to the idea that socio-political or legal responses to the perceived ‘vulnerability’ of older adults may exacerbate them, or add an additional layer of vulnerability to an individual’s experience. It is this feature of vulnerability that Clough notes is especially important, ‘as it invites a deeper analysis of the impact of laws and policies – their ability to achieve their stated aims and, more importantly, to foster resilience in those rendered vulnerable’.\textsuperscript{105}

In the context of this chapter, these two aspects of the more recent vulnerability literature (the responsive state, and being circumspect of pathogenic vulnerability) are especially important - they indicate a need to consider the types of remedies imposed in these particular cases, and an analysis of whether such responses constitute pathogenic sources of vulnerability in themselves. In other words, do they entrench the older person’s vulnerability more than no response or an alternative response? This is especially pertinent to explore, in light of other recent inherent jurisdiction decisions which envisage its task as being ‘facilitative’ rather than

\textsuperscript{101} Fineman, ‘The Vulnerable Subject: Anchoring Equality in the Human Condition’ (n 13); M Fineman, ““Elderly” as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility” (2012) 20 The Elder Law Journal 71-112.
\textsuperscript{104} Mackenzie (n 102) 39.
\textsuperscript{105} Clough (n 16) 373.
‘dictatorial’, an approach that may perhaps be more in line with recent conceptualisations of how best to respond to vulnerability in older adults and mitigating ‘pathogenic’ vulnerability.

First, as argued earlier, the courts’ current approach attributes an older adult’s vulnerability to an inherent characteristic, and suggests that the inherent jurisdiction retains a role for those who suffer from psychiatric conditions but where the condition does not mean they lack capacity under the Mental Capacity Act. A review of the statistics concerning the presence of psychiatric conditions in old age reveals why the implications of this position may be extensive for older adults. It is well recorded that the number of older adults with cognitive or mental impairments is increasing in England and Wales; the number of adults with dementia in the UK currently stands at around 800,000 and is expected to rise to over 1 million in 2025, and nearly 2 million in 2050. Furthermore, it is predicted that in those over the age of 85, one in five will be diagnosed with dementia. Although perhaps the most commonly thought of, dementia is not the only psychiatric condition that affects older adults. Recent studies indicate that severe depression, anxiety disorders and lifetime alcohol disorders are also common in those over the age of 65. As a result of this we can expect increased legal activity as to their decision-making over the coming years, and as has been noted recently in Deprivation of Liberty Safeguard applications. While the majority of this activity may well,

106 In particular, I discuss the difference between the approach of the courts in the cases that form the focus of this chapter, in comparison with the approach in LBL v RJJ and A Local Authority v A [2010] EWHC 1549 (Fam). It is also important to note, however, that the arguments put forward here do not advocate for a non-interventionist approach, i.e. a reinforcement of the public-private divide. What this chapter seeks to highlight is that intrusion may be welcome, but vulnerability theory has the potential for illustrating more appropriate types of remedies.
107 See also An NHS Trust v Dr A (n 11).
at present, be dealt with under the Mental Capacity Act, the approach of the courts in these
cases indicates that even if those with cognitive impairments are not necessarily found to lack
capacity under the Mental Capacity Act, they still remain ‘vulnerable’ based on the presence
of a cognitive impairment and could be subject to orders under the inherent jurisdiction
regardless of the fact that they legally still have capacity. From a purely statistical perspective,
attributing vulnerability for the purposes of the inherent jurisdiction to an internal characteristic
such as a psychiatric condition has potentially significant implications for older adults – and
may mean that, if they are at risk of harm, their decision-making may be more readily and
easily scrutinised by the courts, a position already advanced by Munby J.112

Secondly, in the case of *A Local Authority v A*113 - which involved the decision-making ability
as to contraception of a woman with serious learning difficulties who was also in a seemingly
overbearing marriage - as well as in the case of *LBL v RYJ*,114 the courts held that the purpose
of the inherent jurisdiction was ‘to facilitate the process of unencumbered decision-making’,115
and to ‘create a situation where ... she can receive outside help free of coercion to enable ... her
to weigh things up and decide freely what ... she wishes to do’.116 However, the result of the
reasoning by Parker J, outlined above, is to the effect of stating that a residence order could
still have been placed on PB by virtue of the fact that she had a psychiatric condition, even if
she had not lacked capacity under the Mental Capacity Act.117

---

112 ‘[A]n adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom
the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade
the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult
is not on the face of it vulnerable’ (*Re SA* (n 12) at [83]).
113 *A Local Authority v Dr A* (n 11).
114 *LBL v RYJ* (n 42).
115 ibid. [62].
116 ibid. [79].
117 And, furthermore, would still have been compliant with Article 5 of the European Convention on Human
Rights. Her reference to ‘unsound mind’ is in light of the requirements of Article 5(1)(e) of the European
Convention, which stipulates that a person may be deprived of their liberty in accordance with a procedure
In my view the inherent jurisdiction does extend to orders for residence at a particular place...Assuming that it would not constitute an unlawful deprivation of liberty in my view I would be entitled to make an order for placement against her will pursuant to the inherent jurisdiction. There are serious risks to PB if she is not properly cared for or if she is not protected against TB.\footnote{NCC v PB and TB (n 21) [121]-[122].}

Given the confusion the courts have between vulnerability and incapacity demonstrated above, this approach (stating that a decision made in PB’s best interests under the Mental Capacity Act could also be authorised by invoking the inherent jurisdiction) is perhaps unsurprising. Ethically, however, it is problematic as a remedy imposed on PB does little to highlight and respond to the external features that may compromise her decision-making – preferring to respond to a threat that is based on her perceived inherent vulnerability, i.e. her cognitive impairment and her physical impairments. This is, again, not only at odds with remedies provided in cases such as DL, where injunctions were granted against the son (as opposed to the parents), but even London Borough of Redbridge v G, where injunctions were granted against C and F, not G. It is even incompatible with previous cases such as A Local Authority v A, where undertakings were directed towards enabling Mrs A to make a decision as to contraception away from the influence of her husband. Authorising PB’s detention in a care home based on her ‘inherent’ vulnerability may in fact render her susceptible to other (pathogenic) sources of vulnerability. Given the value she places on her marriage, she may feel disempowered or exposed based on not being able to reside with her husband, or in her own prescribed by law if they are of unsound mind. We can question how wide the court in PB envisages the term ‘unsoundness of mind’ and whether this would, then, extend beyond those who have psychiatric conditions to also include those who have been subjected to coercion or undue influence. An analysis of how broad ‘unsoundness of mind’ may be framed is beyond the scope of this chapter, however it is worth noting that the Winterwerp criteria require someone of unsound mind to be suffering from a ‘true medical disorder’ established by ‘objective medical expertise’: Winterwerp v The Netherlands [1979] 2 EHRR 387 [39].
home – an aspect of moving to care homes that is frequently reported by older people in empirical research, or she may even develop negative relationships with staff in the care home - even more likely given her original reluctance to live there.

Finally, and as touched upon earlier, the approach taken by Parker J may also be seen as envisaging a ‘best interests’ approach for the inherent jurisdiction. Apart from being paternalistic, a criticism often levied at any ‘best interests’ standard, this type of approach is problematic both legally, and theoretically, in light of the aims of the recent vulnerability literature, particularly for older people. If A Local Authority v A and LBL v RYJ are correct, then ‘the goal of the jurisdiction is to safeguard decision-making, rather than to safeguard well-being per se’. If this is indeed the case, then the proper remit of the jurisdiction is to facilitate and promote maximally autonomous decision-making for older adults. A ‘best interests approach’ does not necessarily sit comfortably with the aims of vulnerability theory for older people, which emphasise the need to recognise effective ways in which empowerment and self-


121 Although outside the scope of this chapter, it is important to note that without any provision of review for PB’s detention, this approach subverts the current procedural requirements that exist under the Deprivation of Liberty Safeguards and may also therefore be unlawful under the European Court of Human Rights ruling in HL v UK (n 30). Had this case been decided under the inherent jurisdiction, however, and Parker J had put in place measures for the court to review her detention (as happened in An NHS Trust v Dr A), then this approach, being more stringent procedurally than the review mechanisms found in the Deprivation of Liberty Safeguards, may in fact be more human rights compliant. I would like to thank Beverley Clough for drawing my attention to this last point.

development can be promoted among older persons, as opposed to simply taking decision-making out of their hands. A more nuanced vulnerability approach for older individuals focuses our attention on the ‘conditions necessary for developing and maintaining [a specific set of] capacities’ not simply applying a substituted decision-making approach.

The decision in PB, however, arguably fails to recognise this in a way that is empowering for PB herself, by stating that whilst the inherent jurisdiction ‘exists to protect, liberate and enhance personal autonomy ... [t]o be maintained in optimum health, safe, warm, free from physical indignity and cared for is in itself an enhancement of autonomy’. While it may be argued that this is correct from an objective standpoint, the way someone should want to make a decision objectively is irrelevant, the relevant issue framed by more nuanced accounts of vulnerability is how PB herself wants to make a decision, and calls for a legal response that supports this decision-making process (this is an argument developed further in the next chapter). In particular, the approach demonstrated by the courts explicitly derides the value she places on her marriage and her ability to reside with her husband, which she values notwithstanding his controlling behaviour, and arguable lack of understanding of her medical needs. At paragraph 63, cited earlier, for example, Parker suggests that she is uncertain as ‘to what extent TB’s influence leads her to be incapacitous all the time’ and at other points indicates that she needs ‘protection’ from her husband because she is at risk.

In the context of the inherent jurisdiction, a responsive vulnerability theory requires a

---

123 Fineman, “‘Elderly” as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility’ (n 101); Margaret Isabel Hall, “‘Old Age’ (Or, Do We Need a Critical Theory of Law and Aging?)’ (2014) 35 Windsor Review of Legal and Social Issues 1-13.
125 NCC v PB and TB (n 21) [113].
126 ibid. [63] (emphasis added).
127 ibid. [71].
consideration of the subjective experiences of the older adult – it does not necessarily seek to escape value judgments or interference, but recommends that legal responses make such judgments from the subjective point of view of the older adult at the heart of the proceedings, rather than from an objective stance. This point becomes particularly salient when we reflect upon the multiplicity and diversity of factors that older people take into consideration when making decisions about their care. Comparing these three cases highlights this particular point well. In PB, PB is an individual who clearly values her interdependence and marriage to her husband over and above many other factors. In contrast, G, in London Borough of Redbridge v G, values her independence – as well as her interdependence from the relationship with her fellow churchgoers. In DL it was uncertain, even doubtful, that any of the three parties concerned wanted the litigation. ML at the very least did not want proceedings brought in respect of her relationship with her son, and whilst it was not so certain that this was the case for her husband, GRL, it was uncertain how much he would want to go against his wife’s wishes.

7.4 Implementing Responsive Vulnerability Theory

So what types of remedies would a responsive vulnerability analysis have envisaged? How could the courts have reacted more appropriately in the cases critiqued in this chapter? To put this question bluntly, how could the courts have responded to the situations encountered by GRL and ML, G, and PB, in a more ‘vulnerability-friendly’ manner? One suggestion that emerges from this analysis would be to simply remove the requirement under section 2(1) of the Mental Capacity Act that incapacity must be because of an impairment or disturbance in

the functioning of the mind or the brain. This would have the benefit of retaining the safeguards contained in the Act itself for such cases, and the aspects of the Act that the House of Lords’ post-legislative scrutiny were in favour of, but removing the association between incapacity and impairment, thereby making the Act itself applicable to situations where an individual’s decision-making is threatened by elder abuse. This would mean that cases such as these could be decided under the Act, but without the artificiality of having to establish the causal nexus between the diagnostic element and the functional element of lacking capacity – thereby potentially encompassing DL-type facts.

Even at first glance, however, there are potentially a number of problems with this suggestion. First, removing this requirement from the Act does not itself automatically render the Act relevant to instances of elder abuse – the question remains ‘at what point does the state intervene in such cases’? Removing this aspect of the Act simply requires us to establish an alternative threshold over and above which the state will consider it necessary to intervene; and leaves adults without legal protection where that threshold is not met. As such, if this is a viable option, then more work must be done on how to establish what would then be the necessary boundaries of the Mental Capacity Act, or even whether such boundaries are legally realisable. Neither does such an approach conquer the problems that are encountered when faced with ‘best interests’ decision-making – it would continue to take decision-making out of an older person’s hands and place it in the hands of a third party – an approach rejected by the recent vulnerability literature. Moreover, neither does such an approach adequately address the concerns raised earlier regarding the ethical implications of conflating external threats to decision-making such as abuse, with perceived internal ‘failures’, such as impaired functional capabilities.

I would like to thank Paul Skowron for this point.
Finally, given that the Supreme Court has held that the Mental Capacity Act ‘is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further ... the court has no greater powers than the patient would have if he were of full capacity’, an alternative suggestion would be to retain the inherent jurisdiction for cases such as those analysed here, but make greater use of the breadth of remedies available under the jurisdiction. In *London Borough of Redbridge v G*, it is welcoming to note the local authority’s assurances of home care for G, given her fears about moving to a care home, and the Court’s emphasis on re-integrating G with her church community, as well as the removal of C and F from G’s home. However, given the clearly detrimental effect both C’s conduct and the legal proceedings had on G, and the court’s rejection of her consistently expressed wishes for C and F to remain in her home, perhaps the Court could also have explicitly considered the possibility of offering ongoing emotional support and advice, such as counselling, to the extent that G would have been willing and able to accept such offers, and to the extent that these are not already provided within the care package available to G. Similarly, in *PB*, rather than simply authorising her residence in a care home with limited supervised contact with her husband, the Court could potentially have explored alternative options such as providing secure community living arrangements and an appropriate care package, as well as less restricted contact with TB.

In light of the recent decision in *Re MN* however, where the Court of Appeal held that the Court of Protection ‘... has no more power, just because it is acting on behalf of an adult who

---

130 *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67 [18].
131 *London Borough of Redbridge v G* [2014] EWCOP 17 [43].
133 *NCC v PB and TB* (n 21) [123].
134 *Re MN* [2015] EWCA Civ 411.
lacks capacity, to obtain resources or facilities from a third party ... than the adult if he had
capacity would be able to obtain himself’

135 it may be that the courts are progressively moving
in the opposite direction, at least where an individual lacks capacity under the Mental Capacity
Act. It remains to be seen whether the courts would take this line if faced with a similar case
under the inherent jurisdiction, and if it did, then this would also indicate that the jurisdiction’s
remedies are not ‘theoretically limitless’, after all.

7.5 Conclusion

‘Society must guard against excesses that might ironically deny the elderly their autonomy by
forcing it upon them.’

136 This was the warning issued by Marshall Kapp in 1989. Following

$DL$, there does seem to be a clear commitment to retain the inherent jurisdiction to safeguard
the decision-making of older adults, particularly for those who have been the victims of ‘elder
abuse’, but the argument presented in this chapter is that the courts’ approach to the vulnerable
older adult is confused, and remains grounded in historical and outdated ideas of what it means
to be ‘vulnerable’. Moving forwards in developing the jurisdiction for vulnerable older adults
who may be the victims of elder abuse, the courts may be wise to heed Kapp’s warning. In

137 turn, this chapter suggests that the retention of the jurisdiction is not necessarily unwelcome

and may well be more flexible than the Mental Capacity Act in responding to compromised
decision-making for older adults who experience abuse, but in order to be that responsive a
more nuanced understanding of what it means to be vulnerable, and in particular what it means
to experience vulnerability in old age is required. Given the fledgling nature of the post-Mental

135 ibid. [80].
137 Indeed, MacFarlane LJ insinuates that abandoning the inherent jurisdiction as a means of safeguarding
decision-making for older people could potentially be in violation of state obligations under Article 8 of the
European Convention: DL v A Local Authority (n 9) [67]. For an argument that the jurisdiction may certainly be
better equipped for dealing with the capacity of adults with mental impairments to consent to sexual relations see:
Clough (n 16). See also: Jonathan Herring and Jesse Wall, ‘Autonomy, Capacity and Vulnerable Adults: Filling
Capacity Act cases on the scope of the inherent jurisdiction, the arguments put forward here are tentative, but in turn serve to highlight broader ethical and legal issues for further research. What is the interplay between the jurisdiction, vulnerability and human rights principles? Can the inherent jurisdiction provide a better, more appropriate way of thinking about cases where a person may have an impairment that may cause their capacity to make decisions to fluctuate, such as dementia, or a mental illness? Unfortunately, only when the courts begin to engage the jurisdiction rather than forcing such cases under the Mental Capacity Act will these areas open up for discussion, and will we be able to envisage a more responsive judiciary. At present, however, we will have to wait and see just how ‘responsive’, and in what way, the courts are willing to become.
8.1 Introduction

The number of people with dementia in the United Kingdom stands at approximately 800,000, and is estimated to reach 1 million by 2025. The prevalence of dementia doubles for every five-year age group, meaning the oldest age groups are those most likely to be affected, and it currently costs the economy an estimated £26 billion a year. Furthermore, dementia impacts the older individual in unique and significant ways, gradually causing memory loss, alterations in mood, as well as changes in personality and emotions, and frequently leading to other mental health issues such as clinical depression, paranoid delusions, or neurologically debilitating illnesses such as strokes. The overall effect of dementia, then, is a gradual decline in cognitive functioning such that the individual becomes increasingly reliant on caregivers to meet their everyday needs.

Given the prevalence and form that dementia takes, it is unsurprising that there has been a lengthy academic debate over how the illness interacts with an older person’s decision-making capabilities. To date, the ethico-legal literature has been predominantly concerned with the validity of medical advance directives – and more specifically, the extent to which advance directives by someone without dementia can be binding on their later self with dementia. In

---

1 SCC v LM [2012] EWHC 1137 (COP) [84].
2 This chapter is a development of the following article: Laura Pritchard-Jones, “This Man with Dementia” – ‘Othering’ the Person with Dementia in the Court of Protection’, Medical Law Review (in press).
3 Dementia is used to refer to a collection of similar symptoms, caused by different illnesses, such as Alzheimer’s, vascular dementia, Lewy Bodies Dementia, Parkinson’s and Huntington’s.
this respect, the debate has focussed on the ‘personhood problem’ – whether the person with dementia is the same ‘person’ as their former ‘un-demented’ self.\(^6\) If they are not the same person, as Dresser argues,\(^7\) then previously stated wishes have little normative force and should have minimal impact on their ‘post-dementia’ selves. A key problem with this literature, however, is that dichotomises the dementia patient, and frequently presents them at two extremes: the ‘un-demented’, and the ‘entirely demented’\(^8\) person.\(^9\) This approach masks the spectrum of symptoms that a person with dementia in fact experiences. Persons with dementia experience a gradual change in cognitive functioning, with fluctuations and lucid periods during their illness.

Furthermore, the existing bioethics literature focuses heavily on assessing the importance of cognitive functioning and psychological continuity for personhood,\(^10\) which is also problematic for those with dementia, who, by virtue of the illness, experience a decline in both.\(^11\) It is therefore, as Rai argues, ‘important…to recognise that loss of cognitive functions does not mean total loss of emotion and human values’.\(^12\) The fact that a person with dementia will have declining rational thought processes, ‘does not mean they have lost the ability to feel, care, or


\(^8\) The term ‘demented’ is highlighted here to denote the fact that it is used in some of the ethico-legal literature in this area, yet is not frequently used elsewhere as it is considered stigmatising for persons with dementia.

\(^9\) In England and Wales, an individual is legally treated as being the ‘same’ person, therefore in law the literature on the personhood problem is only hypothetically relevant.

\(^10\) This reliance on cognitive functioning for personhood is replicated in some areas of law. As Herring notes, legal death is related to the death of the brain stem, which implies that ‘once the brain stem has gone, all that gives life value has been lost…’: Jonathan Herring, Medical Law and Ethics (5th edn, OUP 2014) 479.

\(^11\) It is such concerns that have led to some developing a ‘relational’ theory of personhood. See, for example, Kenneth Gergen, Relational Being: Beyond Self and Community (OUP 2009).

\(^12\) Gucharan Rai, Medical Ethics and the Elderly (2nd edn, Radcliffe Medical Press 2004) 125.
value’. Focussing solely on cognitive functions as a key marker of ‘personhood’ arguably pays little attention to the feelings, emotions, and relationships of the person with dementia. That the existing literature unduly focusses on cognitive abilities and psychological continuity has been criticised for ignoring the reality of life for those with dementia – they are, as is any individual, always situated within a complex web of relationships with other individuals, organisations and the state. To adopt Hughes’ term, they are a ‘situated embodied agent’ – a person ‘who acts and interacts in a cultural and historical context in which he or she is embedded’.

Although dementia has become increasingly subjected to a political and legal gaze in recent years, as yet there has been little systematic engagement with the way in which the courts in England and Wales interact with persons with dementia. This chapter analyses how the Court of Protection engages with persons with dementia when making best interests decisions on their behalf under section 4 of the the Mental Capacity Act 2005, and in particular, how the court considers the perspective of the person with dementia. Although the person’s own wishes are also an important feature of the initial capacity assessment process, many people with dementia who come before the court will be deemed to lack capacity under the Mental Capacity Act and it is therefore especially salient to consider these issues in relation to best interests decision-making.

---

13 Jonathan Herring, Older People in Law and Society (OUP 2009) 92. A similar argument is made by Dresser, who seeks to move away from cognitive functioning alone as the marker of personhood: see Dresser (n 7).
15 Hughes (n 14) 87.
16 This chapter focuses predominantly on health and welfare decisions, which represent only a small number of contested best interests decisions.
Through an analysis of these decisions – and by drawing on feminist and disability theory - it is argued that the court’s approach to the person with dementia has, on occasions, been constructed around a ‘comparator’ that renders the person with dementia as ‘Other’ – unjustifiably marginalising them, and portraying them as ‘deviant’.18 In this respect, the argument presented in this chapter goes beyond Donnelly’s early concerns that section 4 of the Act risked paying only ‘tokenistic’ regard to the views of the person lacking capacity.19 This is notwithstanding the fact that ‘best interests’ as a legal tool has, in fact, developed over a number of years to better incorporate the person’s own views into the decision-making process, and to remove stigma associated with cognitive impairments,20 thereby developing in such a way as to avoid opportunities for such ‘othering’. In Section 9.5, it is argued that by adopting an intersubjective approach, and by exploring the complex labyrinth of relations that an individual with dementia has, the court can go some way to avoiding this process of ‘othering’.

It is worth noting from the outset that this chapter is not concerned with undertaking an in depth analysis of the binary notion of capacity contained within the Act for persons with dementia. This has been discussed elsewhere.21 The chapter focusses on the issue of whether the Court of Protection utilises the process of ‘othering’ when making best interests decisions on behalf of persons with dementia who are deemed to lack capacity.

---

18 Although these tensions are ones that have had a large corpus of academic literature dedicated to them, they have yet to be applied to dementia in a legal context such as proffered in this chapter.
21 Herring (n 17), and more broadly, see: Jonathan Herring and Jesse Wall, ‘Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act’ (2015) 35(4) Legal Studies 698-719.
8.2 ‘Othering’ the Person with Dementia

The notion that certain individuals are ‘othered’, or that they somehow hold a fundamentally lower moral status because of differences in their embodiment or psychological functioning is well documented in a number of scholarly domains. Feminist and disability theorists, among others, have long argued that because of the masculine, healthy bodied, rational, autonomous, and self-sufficient ideal that is inherent within law and society, anybody who does not conform to this is considered ‘Other’ – deviant from this pre-defined and idealistic norm. As Shildrick argues in respect of disability and illness ‘[o]nce it is broken, that is diseased, damaged, or otherwise unwhole…[t]he body is now perceived, but is experienced as other’. In effect, when a person does not conform to what is perceived to be the idealistic norm, their differences are seen, but the person is categorised as ‘abnormal’ because of these differences - something to be contained, feared and kept at arm’s length. In a legal context, this process may impact on how the court perceives and interacts with the person. This process, as Keywood argues in relation to legal decisions involving women with anorexia nervosa, ‘…produces an identity of madness, of otherness, which of itself purports to necessitate her differential medical treatment’. Those who do not meet this normative standard are deemed to have a fundamentally lower moral status because of differences in their corporeal or cognitive

---

22 See chapter 6 of this thesis (n 23).
functioning, which, in turn, serves to reaffirm the initial idealistic paradigm, and further entrench power imbalances between the person and the courts.

The very terms of the Mental Capacity Act potentially make this process of ‘othering’ in mental capacity jurisprudence more likely. In distinguishing a binary between those who have or do not have capacity based, in part, on a diagnostic element, and only intervening in relation to those who do not have capacity, the Act itself already explicitly recognises and asserts a ‘difference’. This difference is between the person with dementia, for example, who is found to lack capacity and therefore loses decision-making power under the Act, as opposed to ‘normal’ persons who have capacity - and for whom the Act does not deem intervention appropriate and who therefore retain the power to make their own decisions. Moreover, when a person does lack capacity, there is already clear evidence before the court of how they fail to live up to the standard contained within the Act itself – their failure to fulfil the functional test contained in section 3.

At this point, however, it is important to note a distinction. Asserting a ‘difference’ is, in itself, unproblematic. Indeed Tom Shakespeare, citing Lennard Davis – both prominent disability theorists - argues that impairments can be understood as differences without a problem: ‘Disability is not so much the lack of a sense or the presence of a physical or mental impairment

26 Section 2(1) of the Mental Capacity Act 2005 states that: ‘…a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’
27 For a discussion of this point from the standpoint of the social model of disability see: Beverley Clough, “‘People Like That’": Realising the Social Model in Mental Capacity Jurisprudence’ (2015) 23(1) Medical Law Review 53-80.
28 There is a presumption of capacity until proven otherwise: Mental Capacity Act 2005, s 1(2).
29 This is not akin to arguing for the removal of the threshold of mental (in)capacity. For such an argument, see: Govert den Hartogh, ‘Do we Need a Threshold Conception of Competence?’ (2015) 19(1) Medicine, Health Care and Philosophy 71-83. Indeed, it is argued in Section 8.5 that even within the framework of the Act, the Court of Protection is able to avoid the process of ‘othering’.
30 A person is deemed unable to make a decision if they are unable to understand or retain information relevant to the decision, to use or weight the information, or communicate their decision: s 3(1)(a)-(d).
as it is the reception and construction of that difference’.\(^{31}\) Moreover, Shakespeare goes on to argue that these differences, in the form of impairments, \textit{should} be taken into consideration, for example, in the allocation of welfare benefits, or psychological and social support mechanisms.\(^{32}\) What the literature on ‘othering’ is keen to stress, however, is that this process of differentiation becomes ‘othering’ - and therefore problematic - when negative moral judgments and assumptions are assigned to the ‘Other’ so as to marginalise or dehumanise them, or assert that they have a lower moral status, because of such differences. As MacKinnon notes in a feminist context,\(^{33}\) and as Davis noted,\(^{34}\) the problem of ‘othering’ is not so much in the assertion of a difference, but in what is done with recognition of that difference. The problem lies in the voice of the ‘Other’ being at the bottom, which is then used - to adopt Keywood’s terminology - to \textit{validate} their ‘differential treatment’.\(^{35}\)

Used in this manner, ‘othering’ essentially requires two elements. The first is the presence of a comparator – or some ideal of what a ‘normal person’ should be able to do – an entity not entirely unfamiliar in mental capacity law.\(^{36}\) In feminist discourse this comparator is the self-sufficient, rational and autonomous, masculine identity. In disability discourse, particularly for critics of the medical model of disability, this is the construction of the norm as the fully functioning, healthy and unimpaired body. The second crucial feature of such an ‘othering’

\(^{32}\) Shakespeare (n 31) 63.
\(^{34}\) Davis (n 31).
\(^{35}\) Keywood (n 25).
\(^{36}\) In \textit{Re C (A Patient)} [1992] 1 FLR 51 it was held that if there was no indication of the person’s wishes prior to becoming incapacitated, the Court could explicitly assume the standard of ‘a normal decent person, acting in accordance with contemporary standards of morality’. In \textit{Aintree University Hospitals NHS Trust v James} [2013] EWCA Civ 65 [59], Arden LJ held that ‘[i]f the court has any doubt as to an individual’s wishes or as to whether treatment should be given, it should proceed on the basis that the individual would act as a reasonable individual would act’. The Supreme Court reversed this aspect of the Court of Appeal’s decision.
analysis is that there must be stigma associated with the person by virtue of their failure to meet
this standard. As Weicht notes, in the case of dementia, it is that it is undesirable, feared and
rejected – the ‘confused, helpless’ dementia sufferer. As will be shown in Section 9.4, these
two elements to the process of ‘othering’ are not mutually exclusive. Indeed, they are mutually
dependent for the process of ‘othering’ to occur, and they operate in a circular way. The reason
a person or class of persons can be marginalised or classed as deviant is because of the initial
comparator, and their failure to meet this ideal, which is then used as evidence to prove the
correctness of the idealistic standard. ‘Othering’ as a process, then, does not take place between
individuals – someone who lacks capacity is not necessarily deemed ‘other’ to someone with
capacity. ‘Othering’, as characterised for the purpose of this chapter, is between persons or
groups of persons, and the more abstract and invidious notion of the rational and able-bodied
ideal outlined above.

This process of ‘othering’ is particularly prevalent among persons with dementia in society
more generally. As both Francis and Kitwood note, the loss of cognitive functions because
of dementia ultimately ends up depersonalising or medicalising the individual such that they
become almost a non-human entity – ‘a pathetic ghost’, or suffering a ‘living death, a never
ending funeral, and a private hell of devastation’ – forsaking the “unified” person in favour
of a medicalised and stigmatised notion of the person with dementia. Empirical research also

37 Bernhard Weicht, ‘Embracing Dependency: Rethinking (In)dependence in the Discourse of Care’ (2011) 58(2)
39 Leslie Francis, ‘Decisionmaking at the End of Life: Patients with Alzheimer’s or other Dementias’ (2000-2001)
35 Georgia Law Review 539-592, 541.
40 Tom Kitwood, Dementia Reconsidered: The Person Comes First (Open University Press 1997).
41 Dresser, ‘Missing Persons: Legal Perceptions of Incompetent Patients’ (n 7) 663.
42 Pia Kontos, ‘Embodied Selfhood: An Ethnographic Exploration’ in A Leibing and L Cohen (eds), Thinking
about Dementia: Culture, Loss, and the Anthropology of Senility (Rutgers University Press 2006).
12 Ageing & Society 269-287. Similarly, Nedelsky argues that ‘...when a “syndrome” is recognized it invites
individual psychological analysis – rather than systematic relational analysis.’ Jennifer Nedelsky, Law’s
suggests that this is an existential reality for those living with dementia. Given their diagnosis and subsequent declining abilities, there remains a constant struggle for the person with dementia. This struggle is between, on the one hand, feeling like a valued and meaningful member of society who can continue to perform the everyday tasks they were able to perform before they had dementia, and, on the other, feeling worthless and disempowered because of social attitudes about dementia and because of the symptoms associated with the condition. This devaluation can occur to a large extent from how others interact with the person with dementia, and consequently impacts negatively on a person’s sense of self-worth. Identifying an individual in terms of their diagnosis creates a moral and psychological distance between what is considered ‘them’ (the person with dementia) and ‘us’ (the healthy person). Sabat and Harré convincingly argue that if, for example, perceived difficult behaviour by persons with dementia ‘is founded on story lines that paint the sufferer as inadequate, confused, helpless…then that person will be so positioned and will have his…behaviour interpreted by others in such a way as to confirm the initial storyline’. Rather than seeing behaviours such as aggression or frustration as ‘just another symptom of dementia’, greater emphasis should be placed on understanding what are perceived to be the symptoms of dementia, and more importantly, understanding how dementia affects each particular person. In order to do this there is no choice but to better understand the current lived experiences of the person with


46 Sabat and Harré (n 38) 460.
dementia, and as shall be explored and argued later, one way this could be achieved is by adopting an intersubjective approach.\textsuperscript{47}

If, as is contended in this chapter, ‘othering’ is indeed present within certain Court of Protection judgments, then not only is such ‘othering’ problematic because it goes against the very ethos of empowerment that underpins the Mental Capacity Act - but also perpetuates the marginalisation widespread in society more generally of persons with dementia. Empirical research – outlined in chapter 4 - also indicates that such marginalisation based on their medical condition adds to feelings of disempowerment for persons with dementia. In a recent survey by the Alzheimer’s Society into awareness of the Mental Capacity Act among persons with dementia and their carers, for example, one respondent with dementia notes this in a particularly powerful statement:

I don’t understand why people don’t think to tell us such important things, yes I have a diagnosis of dementia but that doesn’t mean I shouldn’t be told about my rights and the things that affect me. From what you have told me today I can use the law to plan ahead for my future, as well as to know that I should be involved in decisions and helped to make them. Everybody with dementia should be told about this, and a failure is just making assumptions about our condition, something you said this law said shouldn’t happen.\textsuperscript{48}

In light of these arguments, the next section considers how the law has in fact developed so as to better incorporate the person’s own perspective into the decision-making process, thereby explicitly attempting to avoid opportunities for such ‘othering’.

\textsuperscript{47} In light of this, even if ‘will and preferences’ does replace best interests, the courts may still face the same interpretative problems: United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 12, and UNCRPD General Comment No 1 ‘Equal recognition before the law (Art. 12)’ (11 April 2014) CRPD/C/GC/1.

8.3 Integrating the Person Lacking Capacity into Best Interests Decision-Making: An Attempt to Avoid ‘Othering’?

The best interests of a person lacking capacity were originally determined by the Bolam standard - that is, ‘a practice accepted as proper by a responsible body of medical men skilled in that particular art.’ Towards the end of the 1990s, however, the courts began to move towards a broader welfare-based conceptualisation of best interests - coinciding with the extension of best interests decision-making from medical issues, to residence and contact decisions, as well as policy impetus to expressly include the wishes of the individual. In Re A (Mental Patient: Sterilisation) for example, which involved the proposed sterilisation of a young man with Down’s Syndrome, Butler-Sloss LJ held that ‘best interests encompasses medical, emotional and all other welfare issues’. It is important to understand this shift as it represents the origins of the conceptual analysis ventured in this chapter. Critics rightly argued that a purely Bolam approach to best interests was too paternalistic and devalued and silenced the person lacking capacity – leaving decision-making in the hands of professionals based on medical best interests with little or no input from the person themselves, or their carers. As Martha Holstein argues in the context of caregiving relationships, ‘[i]f one is not asked about how one feels about the arrangements that control one’s life, then one is reduced to a zero.’

---

49 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 [587]; F v West Berkshire Health Authority [1990] 2 AC 1 [78]. This approach continued throughout the early 1990s: Airedale NHS Trust v Bland [1993] AC 789.
52 Re A (Mental Patient: Sterilisation) [2000] 1 FLR 549.
53 ibid. 555, echoing her earlier approach to best interests in Re MB (Medical Treatment) [1997] EWCA Civ 3093.
Consequently, as Munro argues,\textsuperscript{56} if we do not want to treat someone as a ‘zero’ under the Mental Capacity Act, if we want to respect them as persons, then it is logical that we should seek their perspective on decisions, and moreover, that their perspective should be taken seriously.

In line with this retreat from Bolam, and following the Law Commission’s 1995 proposals for reform of the law in relation to mental incapacity,\textsuperscript{57} also came greater elucidation on what factors to consider when assessing best interests. This included the ‘balance-sheet approach’ which involved striking a balance between any benefits of the proposed treatment or intervention, and any counterbalancing dis-benefits.\textsuperscript{58} Although oft cited with approval,\textsuperscript{59} a key problem with the ‘balance-sheet’ method is that it does not expressly state where an individual’s own perspective on the issues fit in to the best interests determination.\textsuperscript{60} In Local Authority X v MM and KM,\textsuperscript{61} however, decided before the 2005 Act entered in to force, the Court held that:

One of the most important factors to be taken into account is the vulnerable adult’s wishes and feelings. The fact that [she] lacks the relevant capacity does not mean that her wishes and feelings simply fall out of account...\textsuperscript{62}

\textsuperscript{57} Law Commission, Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction (Law Com No 128, 1995).
\textsuperscript{58} Re A (n 52) [560].
\textsuperscript{59} See, for example: Local Authority X v MM and KM [2007] EWHC 2003 (Fam), An NHS Trust v Dr A [2013] EWHC 2442 (COP).
\textsuperscript{60} It is also potentially problematic (albeit necessary given the nature of the inherent jurisdiction) that this approach begins with the proposed treatment or intervention, and then follows with the question of whether this is in the individual’s best interests. It does not ask ‘what is in this person’s best interests?’ but instead asks ‘is procedure X in this person’s best interests?’ In effect, it already begins its best interests analysis from an overtly biased position.
\textsuperscript{61} Local Authority X v MM and KM (n 59).
\textsuperscript{62} ibid. [121].
That the patient’s own perspective is of importance in best interests decision-making is now statutorily enshrined in the Mental Capacity Act 2005, which, as Quigley notes, has made huge strides forward. To this effect, the Act states that the decision maker must consider the person’s past and present wishes and feelings, as well as any beliefs and values that would be likely to influence their decision if they had capacity (as far as they are ascertainable) when making best interests decisions. Moreover, the Act also attempts to tackle stigmatising attitudes by stating that best interests, nor a finding of a lack of capacity, is to be determined ‘merely’ by a person’s age, appearance or any aspect of their behaviour – although utilising the word ‘merely’ indicates that a person’s age, appearance or behaviour may be a consideration when making best interests decisions.

The importance of the individual’s perspective being taken into consideration during best interests decision-making has recently been strenuously reiterated by the House of Lords Select Committee post-legislative scrutiny of the Mental Capacity Act, and by the Supreme Court in Aintree University Hospitals NHS Trust v James. In light of these, the views of the person concerned have been increasingly seen as central to the decision to be made with the Court of Protection recently stating that ‘[t]he onset of mental incapacity is not an opportunity for moral correction’, and, more emphatically:

64 Mental Capacity Act, s 4(6)(a)-(b).
65 Mental Capacity Act, s 1(3), and Mental Capacity Act 2005, s 4(1) respectively.
66 As noted above, a similar tension exists in the capacity assessment process. Section 1(3) of the Act states that ‘person is not to be treated as unable to make a decision merely because he makes an unwise decision’ (emphasis added). Skowron indicates that ‘[t]his begs the question of how much reliance on the outcome of a person’s decision is acceptable’ (emphasis added): Paul Skowron, ‘Evidence and Causation in Mental Capacity Assessments: PC v City of York Council [2013] EWCA Civ 478’ (2014) 22(4) Medical Law Review 631-639, 634.
67 ‘The general lack of awareness of the provisions of the Act has…allowed decision-making to be dominated by professionals, without the required input from families and carers about P’s wishes and feelings’. House of Lords Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: Post-Legislative Scrutiny (The Stationery Office 2014) para. 107.
68 Aintree University Hospitals NHS Trust v James [2013] UKSC 67 [45].
69 Re Peter Jones [2014] EWCOP 59 [65].
…a conclusion that a person lacks decision-making capacity is not an “off-switch” (emphasis in original) for his rights and freedoms…the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would therefore be wrong in principle to apply any automatic discount to their point of view.\textsuperscript{70}

There are, in addition, other policy programmes and legislation that enshrine the importance of the person’s own views, as well as attempting to remove the stigma associated with cognitive impairments, and are especially relevant for older persons with dementia. Article 12 of the UNCRPD, which the United Kingdom has both signed and ratified, emphasises that measures relating to the exercising of legal capacity for persons with disabilities are to be made based on the individual’s will and preferences, and if these are not ascertainable, then the ‘best interpretation of an individual’s will and preferences’.\textsuperscript{71} Moreover, a recent statement by the Committee on the Rights of Persons with Disabilities states that detention solely based on the presence of a disability should be prohibited.\textsuperscript{72} Similarly the Mental Health Act 1983 Code of Practice also states that a patient should be involved in their treatment planning and supported

\textsuperscript{70} Wye Valley NHS Trust v B [2015] EWCOP 60 [11] (emphasis added). See also at [13]: ‘In some cases…the wishes and feelings, beliefs and values of a person with a mental illness can be of such long standing that they are an inextricable part of the person that he is. In this situation…[it] is more real and more respectful to recognise him for who he is: a person with his own intrinsic beliefs and values. It is no more meaningful to think of Mr B without his illnesses and idiosyncratic beliefs than it is to speak of an unmusical Mozart.’


to participate in decision-making, and have their views considered and fully recorded.\(^{73}\) Initiatives specifically aimed at older individuals also emphasise the importance of having the right to make their own decisions in old age, rather than having decisions made for them. Although not legally binding, the recent Welsh Declaration on the Rights of Older Persons, for example, states that ‘I have the right to exercise my free will and make choices. My opinion is the most important when decisions are being made about me and my life’,\(^{74}\) and the Charter of Rights for People with Dementia and their Carers in Scotland\(^{75}\) emphasises the importance of ‘full and effective participation and inclusion in society’, as well as ‘respect for difference and acceptance of persons with disabilities’\(^{76}\).

This legal, political, and social shift - particularly in respect of best interests - from a medicalised version to one that centralises the voice of the individual concerned is particularly welcome for those with dementia. Much research indicates that a diagnosis of dementia brings with it stigma, and perceived ‘social death’\(^{77}\), and, perhaps linked to this stigmatisation, that persons with dementia are still frequently denied the respect they are due whether they are deemed to lack capacity or not. The Alzheimer’s Society,\(^{78}\) for example, recently found that a majority of participants with dementia often felt excluded from decision-making processes, a

\(^{73}\) Department of Health, *Mental Health Act 1983: Code of Practice* (The Stationery Office 2015) paras. 1.7 - 1.10. The Care Act 2014 also states that in promoting an individual’s well-being, the relevant local authority must begin with the assumption that the individual is best placed to judge her own well-being (Care Act 2014, s 1(3)(a)), and must have regard to the individual’s views, wishes, feelings and beliefs when assessing their care needs (Care Act 2014, s 1(3)(b)).


\(^{75}\) Scotland has its own legislation on incapacity: Adults with Incapacity (Scotland) Act 2000, and issues concerning incapacity do not fall under the Mental Capacity Act 2005.


\(^{78}\) Cox (n 48).
finding that mirrors an abundance of other research in this area.\textsuperscript{79} This perhaps indicates a failure in translating legal standards into practice.\textsuperscript{80} Where individual instances have presented themselves to the Court of Protection, the Court has taken a dim view of such failures. In \textit{Essex County Council v RF},\textsuperscript{81} for example, DJ Mort was particularly critical of the local authority, which had deprived a 91-year-old gentleman with dementia of his liberty for seventeen months. Not only had the authority failed to record RF’s wishes and feelings during the initial capacity assessment, but he had been forcibly removed from his home in a state of partial undress, being told he was being taken to a hotel and threatened with police intervention if he failed to cooperate, and was, naturally, in a very distressed state throughout.\textsuperscript{82} In awarding significant damages to RF in light of the violation of his Article 5 and 8 rights, the judge stated that ‘[i]t is hard to imagine a more depressing and inexcusable state of affairs. A defenceless 90-year-old gentleman in the final years of his life was removed from his home of 50 years and detained…against his wishes’.\textsuperscript{83}

The presence of dementia and old age, then, has been viewed, by some members of the judiciary, as a particularly aggravating feature of such cases – and as a time of life where one of the fundamental goals must be to ensure respect for a person’s identity and personal relationships. According to Hedley J, in residence decisions for the elderly, there is ‘…an importance in place which is not generally recognised by others; not only physical place but


\textsuperscript{80} This was also a major theme in the recent House of Lords post-legislative scrutiny on the Act: Above (n 67).

\textsuperscript{81} \textit{Essex County Council v RF} [2015] EWCOP 1.

\textsuperscript{82} \textit{ibid.} [15].

\textsuperscript{83} \textit{ibid.} [68]. See also \textit{Re MM} [2011] 1 FLR 712, which involved the suspension of contact between a woman with dementia residing in a care home, MM, and her partner, RS. It was held to be a violation of RS’s Article 8 rights.
also the relational structure that is associated with place’. The developments purveyed in this section are therefore to be welcomed, both legally and socially, - even if they are still in the process of being fully implemented on the ground - particularly for persons with dementia. Ethically, they are perhaps of even greater significance – they send a symbolic message that individuals with dementia are still persons, and moreover, they are still persons with an identity; both emotionally and psychologically, where they have, on occasions, previously been denied this status. The development of the best interests framework for decision-making has become increasingly targeted towards avoiding ‘othering’, or more specifically, avoiding unjustifiably portraying those who are deemed to lack capacity as ‘deviant’, or stigmatised, based on the fact that they have dementia. As Donnelly argues, best interests in this area of law has moved towards recognising that the person remains able to contribute to the decision-making process, and shows respect for their autonomy, even after they lack capacity.

Despite the increasing importance that is given to the voice of the person who lacks capacity in best interests decision-making outlined above, there remain a number of barriers to fully integrating them in to the decision-making process – barriers to viewing the voice of the person lacking capacity as central to the decision. As both Herring and Series point out, and as Baroness Hale remarked in Aintree University Hospitals NHS Trust v James, the views of the

---

84 Re GC [2008] EWHC 3402 (Fam) [21].
85 Following recent scandals at a number of south Wales care homes, as well as the Mid-Staffordshire inquiry, there have been many instances of this type of treatment being reported in the media: ‘Stafford Hospital Worker ‘called patient an animal’, BBC News (London, 12 February 2013) http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-21430513 (last accessed 25 August 2015); ‘Care home nurse struck off after abusing patients’, The Northern Echo (14 March 2013), http://www.thenorthernecho.co.uk/news/10291382.print/ (last accessed 25 August 2015); Patrick Sawer, ‘Bullying care worker jailed after attacking dementia patients’, The Telegraph (19 December 2014), http://www.telegraph.co.uk/news/uknews/crime/11304361/Bullying-care-worker-jailed-after-attacking-dementia-patients.html (last accessed 25 August 2015).
86 Donnelly (n 19).
89 Aintree University Hospitals NHS Trust v James (n 68).
person lacking capacity are not *themselves* definitive of best interests – they are not constitutive of what is in an individual’s best interests and consequently there is no legal obligation on the court to facilitate them unconditionally. They only carry weight in relation to what they can tell the assessor about what may or may not be in this person’s best interests, and to the extent that they can be accommodated within the overall best interests assessment.\(^90\)

To this end, different courts have interpreted the weight to be attached to the individual’s wishes and feelings differently – from having ‘great’\(^91\) or ‘significant’\(^92\) weight, to only being a part of the overall balancing exercise.\(^93\) In *ITW v Z*\(^94\) it was held that the actual weight attributed to them is always case and fact specific, and will be assessed in light of all the circumstances of the case, including the degree of the person’s incapacity (the more borderline the incapacity the greater the weight to be attributed to them), the strength and consistency of the views, the effect on the person if they thought their wishes were not being implemented, the extent to which the wishes and feelings are rational or sensible, and the extent to which the wishes and feelings can be accommodated in the court’s overall assessment of best interests.\(^95\)

Given this guidance, those with milder dementia may have greater weight attached to their wishes and feelings than those in the more advanced stages of dementia, but either way, their own subjective perspective – their wishes, feelings, values and beliefs – must always ‘fit’ within the objective best interests framework. It is this ambivalence that has led some commentators to criticise the lack of hierarchy within the considerations contained in section 4 of the Mental Capacity Act. Ruck Keene states that this ambivalence ‘…routinely…lead[s]...
to undervaluing...the individual’s wishes and feelings and decisions being made that are very far from right for that individual as an individual human being, although the current proposals by the Law Commission are that section 4 of the Act should be amended so as to allow a presumption in favour of the person’s views, unless there is ‘good reason’ to depart from them.

A final barrier to fully integrating the person with dementia who lacks capacity into the decision-making process is that, at the time of writing, there is no legal obligation to join the person as a party to proceedings in the Court of Protection. This is an issue, which again, has its critics, and may be a violation of the right to a fair trial guaranteed by Article 6 of the European Convention on Human Rights. It has, however, recently been subjected to debate by the courts, and the current position is that the person involved need not be joined to proceedings, but efforts must be made, inter alia, to elicit the person’s wishes and feelings and make these known to the Court without causing the person unnecessary distress.

The majority (although as noted above, not the entirety) of the shift in best interests since F v West Berkshire in 1990 has therefore been aimed at centralising the person lacking capacity in the decision-making process, and portraying them as persons whose views are inherently

---

97 Law Commission, Mental Capacity and Deprivation of Liberty (Law Com CP No 222, 2015) para 12.47. This position has, however, been criticised by Jackson J in Wye Valley based on the uncertainty as to what is meant by ‘good reason’: Above (n 66) [17].
98 The Court of Protection (Amendment) Rules 2015, s 3A.
99 Alex Ruck Keene, ‘(Re)presenting P before the Court of Protection’, (The Mental Capacity Act 20115 – Ten Years On Conference, Liverpool, September 2015).
100 Munro argues that such a position may be in conflict with the decision of the European Court of Human Rights in Shukaturov v Russia (2012) 54 EHRR 27, which held that representative of a person’s wishes by an ‘interested party’ was inadequate: Munro (n 56) 69.
102 Re NRA [2015] EWCOP 59 [164].
valuable, *in their own right*, in shaping best interests decisions, rather than as passive, deviant, and stigmatised based on their cognitive impairment. In the next section, however, it is argued that on occasions, the courts have failed to use best interests decisions involving persons with dementia to this effect. It is argued that ‘othering’ remains both implicit and explicit in some best interests judgments.

8.4 ‘Othering’ the Person with Dementia through Best Interests

8.4.1 Creating the Comparator.

The first element of ‘othering’, outlined above, is creating an idealised standard by which the court can measure those who come before it in best interests decision-making. *Dorset County Council v EH*,\(^ {103}\) a case involving the residence of an 82-year-old woman, EH, with dementia, highlights this well. In deciding that it would be in EH’s best interests to be placed in a care home, Parker J states that:

…EH’s circumstances are such that she cannot be considered to have true independence or autonomy at present. Many of her actions and reactions are not volitional…Her independence and autonomy is causing her emotional and physical distress. It is her “independence and autonomy” that puts her at risk.\(^ {104}\)

According to the court, then, there is a perceived ambivalence between having independence and autonomy as the court conceptualises them, and the type of independence and autonomy that EH *seems* to have. Despite indicating that she does not view EH as really having independence or autonomy (i.e. already EH does not have the qualities that mark out the qualities the ‘normal’ person should have because of her dementia), if we look more closely at the wording, what the court is in fact stating is that she *does* have some form of independence.

---

\(^{103}\) Dorset County Council v EH [2009] EWHC 784 (Fam).

\(^{104}\) ibid. [128] (emphasis in original).
and autonomy, it is just not the type of independence or autonomy that she should have. It is not, according to the court, the valuable kind of independence and autonomy that is enjoyed by ‘normal’, ‘healthy’ individuals without dementia – it is not, to use Parker J’s language, ‘true’ autonomy, characterised by ‘volitional’ actions and reactions.\textsuperscript{105} Similarly, although EH goes out every morning to buy a newspaper, this is qualified by the fact that ‘it is not clear that she reads it or appreciates it’\textsuperscript{106} – implying that it would only be a meaningful activity if she could do with the newspaper what ‘ordinary’ people could do – further entrenching the ideal of what an independent and autonomous person should be able to do. Furthermore, and as Harding\textsuperscript{107} argues, through the use of language such as ‘wandering’, the court transforms EH from someone with purpose – who enjoyed ‘walking’ – to someone without purpose, who simply wanders aimlessly to the local shop. Indeed, recent literature on dementia care has emphasised the need for a shift in such discursive practices given the ability of the term ‘wandering’ to pathologise persons with dementia.\textsuperscript{108}

Although \textit{Dorset County Council v EH} was an early case under the Mental Capacity Act 2005, it is argued that this element of ‘othering’ – the comparator – still manifests itself in subtler ways. In \textit{IIBCC v LG},\textsuperscript{109} which concerned the contact and residence of LG, a 96-year-old woman with dementia, the judge states that the world of an individual with dementia is a ‘bewildering’ and ‘frightening’ place.\textsuperscript{110} It is a world in which ‘personal autonomy is no longer

\begin{flushright}
\textsuperscript{105} Although not involving a person with dementia, this approach is also present in \textit{NCC v PB and TB} [2014] EWCOP 14 [113]: ‘…[t]he inherent jurisdiction exists to protect, liberate and enhance personal autonomy…[t]o be maintained in optimum health, safe, warm, free from physical indignity and cared for is in itself an enhancement of autonomy’.\textsuperscript{106} \textit{Dorset County Council v EH} (n 103) [46].


\textsuperscript{108} Megan Graham, ‘From Wandering to Wayfaring: Reconsidering Movement in People with Dementia in Long-Term Care’ (2015) \textit{Dementia} (Online First) DOI: 10.1177/1471301215614572.

\textsuperscript{109} \textit{IIBCC v LG} [2010] EWHC 1527 (Fam).

\textsuperscript{110} \textit{ibid.} [109] and [116].
\end{flushright}
realistically possible'\textsuperscript{111} and one that is characterised only by LG’s ‘ravaged memory.’\textsuperscript{112} In effect, the world that LG now inhabits is not the world that most people without dementia supposedly inhabit – a world that is supposedly not bewildering or frightening – and a world characterised by the presence of the ability to act autonomously. In adopting this approach, the court not only explicitly differentiates LG by stating that she exists in a completely different world, but, in a manner reminiscent of the medicalised individual with dementia criticised above, predominantly identifies LG by reference to her dementia and the impact it has on her memory.\textsuperscript{113} In both \textit{Dorset County Council v EH} and \textit{IIBCC v LG} then, one may see Shildrick’s argument that ‘[t]he integrated and fully functioning body remains an implicit standard’\textsuperscript{114} coming to life in the Court of Protection’s judgments. In effect, there appears to be a version of ‘normal’ that the court has in its mind when making best interests decisions for persons with dementia. Not only does it use this version of ‘normality’ to create a distance between itself and the person with dementia, but also to reaffirm the correctness of the abilities that purportedly inhere in this idealistic standard.

\section*{8.4.2 Deviance and Marginalisation}

As Jennings notes, ‘[i]n too much dementia care today we ask how to come to terms with a diminished thing, when instead we should seek to attain a re-placed plenitude’.\textsuperscript{115} In effect, because we – or in this instance, the court – have an idea of what qualities this ideal paradigm possesses, the person with dementia is characterised as deviant from this by focusing on their

\footnotesize
\begin{itemize}
\item \textsuperscript{111} \textit{ibid.} [122].
\item \textsuperscript{112} \textit{ibid.} [155].
\item A more radical interpretation of \textit{IIBCC v LG} suggests that the behaviour of the daughter, who is suffering with mental health issues, is also interpreted in the same manner. At [103] the Court states that ‘[t]he court is left with a lady presenting as profoundly disabled and behaving bizarrely’.
\item \textsuperscript{114} Shildrick (n 24) 50. This approach is even present in \textit{Re S and S (n 91)}, one of the most favourable cases to wishes and feelings, where Judge Marshall QC states at paragraph 57 that there could be a presumption in favour of P’s wishes and feelings: ‘…where P can and does express a wish or view which is not irrational (\textit{in the sense of being a wish which a person with full capacity might reasonably have})’ (emphasis added).
\end{itemize}
failures – the fact that they fail to meet this standard, or fail to ‘see’ what they should see, because of their dementia. The person with dementia is measured up to a supposedly objective standard of what a reasonable person would be able to do and see, a standard they may fail to meet precisely because of their dementia, and such failure is used as evidence of their deviance from the ideal standard outlined above. This ‘deficiency’ approach to dementia has been heavily criticised; Goodin and Gibson argue that ‘[e]ven in the case of elders with moderately advanced dementia, we ought not ride roughshod over such evaluative capacities as they still retain’, a point that I will return to in due course.

The language used in the cases already criticised above highlights this element of ‘othering’ well; ‘a world where personal autonomy is no longer realistically possible’ and where, in IIBCC v LG, LG has a ‘ravaged’ memory. A number of additional cases demonstrate this in a more subtle manner, however. EM v SC and CM involved the residence of EM, a 92-year-old man with dementia who had an abusive and neglectful son. Both the social worker, and the consultant psychiatrist emphasised what they perceived to be EM’s deficiencies: ‘he appeared unable to appreciate or assimilate the information and opinions of others about the potential risks and potential difficulties in returning home.’ In effect, he was unable to accept what other people thought were in his best interests, or other individuals’ perceptions of his situation. In SCC v LM, a case involving the residence of JM, a 79-year-old man with Alzheimer’s, Cardinal HHJ declared that it would be in JM’s best interests to remain at the care home. During the very brief attempt made to summarise JM’s wishes at paragraph 79, they are referred to as ‘inconsistent’ twice, and although he undoubtedly wanted to live elsewhere, this

again is qualified and then dismissed, because ‘he is by no means certain of where…his view is inconsistent’, \(^{120}\) and later, ‘[j]ust because he expresses a wish to live with her, \textit{about which he is not consistent anyway}, does not mean he has a capacity to make a decision on the matter’. \(^{121}\)

One final aspect of the cases which highlights even more subtle ways the court ‘others’ the person with dementia in best interests decision-making, is how, on occasions, they have been marginalised through the camouflaging or outright hiding of the person’s wishes and feelings from the litigation because they are considered unable to contribute to the decision-making process in a manner the Court can comprehend.\(^{122}\) \textit{Milton Keynes Council v RR}\(^{123}\) involved a decision by the Court of Protection that RR, an 81-year-old woman with vascular dementia, had been unlawfully deprived of her liberty, following unsubstantiated safeguarding concerns. In doing so, they limited contact with her son, SS, her main carer, for a significant period of time. Although painting a very vivid picture of what type of lady RR has been throughout her life, portraying her as someone who was ‘very independent’\(^{124}\) but had ‘put her roots down and engaged actively with her local community, her friends and her local church’,\(^{125}\) in effect, painting the picture of how she was before she had dementia - again, arguably that of the ‘healthy’ or ‘pre-dementia’ comparator - the Court explicitly states that she cannot express her

\(^{120}\) \textit{ibid.} [80].
\(^{121}\) \textit{ibid.} [113] (emphasis added). Other judgments indicate that this may also be a feature of other cases emanating from the Court of Protection. Another example this is present in the assessment by the social worker of the capacity of Mrs Ross, an 82-year-old woman with dementia, in \textit{Cardiff County Council v Ross} [2011] Case No. 12063905. Although the Court ultimately declared that it would be in her best interests to go on the cruise that was the subject of the litigation, the social worker that initially assessed her capacity determined that ‘…her ideas/beliefs are not based in reality and she has no insight into her need’ (at [7]).

\(^{122}\) Donnelly criticises an early property and affairs case under the Mental Capacity Act, \textit{In the Matter of G (TJ)} [2010] EWHC 3005 (COP) on the same basis, suggesting that ‘the speed with which Morgan J dismissed the possibility of Mrs G’s participation draws attention to the risks of a dismissive approach to section 4(4) based on what is ‘reasonably practicable’: Mary Donnelly, ‘Determining Best Interests under the Mental Capacity Act 2005: \textit{In the Matter of G (TJ)} [2010] EWHC 3005 (COP)’ (2011) 19(2) \textit{Medical Law Review} 304-313, 317.

\(^{124}\) \textit{ibid.} [4].
\(^{125}\) \textit{ibid.} [5].
wishes and feelings as to contact with SS,\textsuperscript{126} without explaining why this is the case. There is no exploration as to whether she can express herself in her own particular ways – displaying contentment in the home, or a lack of distress, for example.\textsuperscript{127} This evidence would have been at the very least indicative of her feelings towards her current care arrangements. One is left with the impression from the court’s processes that perhaps because RR is unable to communicate verbally, or rationally, in a manner that is in accordance with the idealistic paradigm, she is deemed as unable to express her wishes and feelings at all – or even as not having any views at all given her advanced state of dementia.

Indeed, ascertaining a person’s current perspective is not impossible even in the most advanced stages of dementia - novel approaches to ascertaining an individual’s current perspective have been utilised in other cases. In \textit{WCC v GS},\textsuperscript{128} for example, involving the residence of an 83-year-old woman with Alzheimer’s, the Court noted that at the care home, ‘GS appears to be happy and settled,’\textsuperscript{129} and received images of the individual in question in her care home, which demonstrated her contentment – even going so far as to say that ‘given her age and physical and mental condition, it would probably be very dangerous to undertake such a move.’\textsuperscript{130}

The picture painted by both the courts and some of the professional opinion throughout these cases is characterised by an inability to see things the way the local authority or the courts see things, and this is used as evidence of the correctness of the idealistic standard that forms the

\textsuperscript{126} \textit{ibid.} [30]. It is also perplexing as to why a return to her home to be cared for by her son, SS, and his partner, TT, not examined given that the safeguarding concerns were unsubstantiated.

\textsuperscript{127} For a critique of this aspect of the decision, see: Lucy Series, ‘Another Local Authority Behaving Badly’, (16 May 2014) available at \url{https://thesmallplaces.wordpress.com/2014/05/16/another-local-authority-behaving-badly/} (last accessed 16 May 2016).

\textsuperscript{128} \textit{WCC v GS} [2011] EWHC 2244 (COP).

\textsuperscript{129} \textit{ibid.} [19].

\textsuperscript{130} \textit{ibid.} [48]. Although not involving a person with dementia, Jackson J took a similar approach in \textit{Wye Valley NHS Trust v B} (n 70), by visiting and speaking with B himself.
original comparator. It is a failure to respect the unique subjective character of experience\textsuperscript{131} - in this case, the subjective character of experience of the person with dementia before the court. As noted throughout this chapter, the experience of dementia \textit{does} entail a change in functioning, and it is important that the courts confront the strength of an individual’s particular abilities when making best interests decisions. As such, this chapter does not seek to argue that exactly the same weight should be given to every wish enunciated by the person with dementia in the decision-making process, or that the wishes of the person with dementia should override all other concerns that feed in to the decision-making process. Because of how dementia, as a cognitive impairment, operates, in some cases, particularly in the more advanced stage of the condition, their wishes may conflict or change on a regular basis, for example. The way the courts have considered the perspective of the person with dementia in the cases purveyed here, however, risks pathologising the person with dementia, or rendering them the ‘Other’ – and it is focusing on their deficiencies and their diagnosis as evidence of their ‘otherness’ that is problematic. It is a mechanism by which the court reinforces the correctness of the idealistic standard. To return to Weicht’s quote, it ‘enables a reaffirmation of all that is valued’\textsuperscript{132} – of the rational, competent, functionally intact comparator. This, in turn, highlights the need to be wary of Coggon’s assertion that ‘[s]ometimes…it is perfectly legitimate to recommend a situation informed by existing social and institutional norms and practices’,\textsuperscript{133} particularly where existing social norms and practices devalue the voice of the person with dementia, which may take hold within the courts’ decision-making processes. In the next section I argue that by adopting an intersubjective approach, there may be the possibility of being more attuned to the person’s own perspective, and, furthermore, has the potential to subvert the idealised image of

\textsuperscript{131} Thomas Nagel, ‘What is it Like to be a Bat?’ (1974) 83(4) The Philosophical Review 435-450, 436. This is explained further in the next section.

\textsuperscript{132} Weicht (n 37) 213.

the ‘secure, distinct, closed and autonomous’ individual that remains an implicit standard in such cases. While such an approach may not necessarily combat every difficulty in incorporating the person’s own voice into the best interests decision-making process undertaken by the court, it is argued here that it may provide the court with a lens by which it can, to adopt Atkins’ language, be more ‘appropriately subjective’.135

8.5 “I Was Ever a Fighter, so – One Fight More” – The Potential of an Intersubjective Approach

In order to ‘other’, there has to be something by which we ‘other’ – a standard by which we measure those with dementia as deficient. As noted earlier, a central aspect of this conceptualisation of ‘othering’ is understanding relationships – and particularly, as Stefan notes,137 relationships of dominance and subordination. In this chapter, it is relationships between the older person with dementia, the court and the comparator. This is the essence of the critique provided thus far. In this section, however, I argue that this process can be subverted by adopting what is termed an ‘intersubjective’ approach, derived predominantly from the work of Thomas Nagel138 and Kim Atkins.139 Such an approach entails a recognition that in addition to wishes, feelings, values, and beliefs, each person also has a certain ‘perspective’ on things – a subjective way of experiencing life. Atkins elaborates on this by stating that

…in the case of human subjectivity our subjective sense of self is not merely bodily. That is, we gain a sense of self and a concrete understanding of our bodily

134 Shildrick (n 24) 51.
137 Stefan (n 23).
138 Nagel (n 131).
139 Atkins (n 135).
states intersubjectively. That means that what it is like to be in any particular state is always informed by a familial, social and historical context.\(^{140}\)

By drawing on Atkins’ assertion, and focussing more clearly on contextual information about a person’s relationships, and embeddedness within their network of relationships, and by focussing in on what Nagel terms their ‘subjective character of experience’\(^{141}\) – that is, focusing on what it is like to be that particular person with dementia, the court can go some way to subverting the process of ‘othering’ that, it is argued, inheres in the cases above.

On a practical level, these relationships, and the contextual information required for an intersubjective approach, also have a legal role within the best interests decision-making process. Under section 4(7) of the Act, for example, the Court of Protection – or anyone making best interests decisions - must take into account the views, *inter alia*, of anyone engaged in caring for the person with dementia who lacks capacity, for example.\(^{142}\) This is for obvious reasons - as Donnelly notes, ‘[a] carer who is a family member may have a nuanced and complex understanding of the person which a professional may lack’.\(^{143}\) This is not to deny that the position of persons with dementia does indeed pose challenges for the Court of Protection – and other best interests assessors – in making best interests decisions. It challenges because of the nature of the illness, and in certain circumstances it may well be particularly difficult to ascertain an individual’s perspective, especially during the later stages of dementia – although as I have indicated above, this is not necessarily an impossible task if the courts take more innovative approaches.

\(^{140}\) *ibid.* 73 (citation omitted) (emphasis added).

\(^{141}\) Above (n 131).

\(^{142}\) A failure to do so where practicable, will result in the Court imposing liability: *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

\(^{143}\) Donnelly (n 19) 18. In this context Donnelly is discussing the requirement to consult with a range of different people in making best interests decisions under s 4(7), however it could also be argued that the same point applies in relation to abstract values such as religious beliefs: Anita Ho, ‘“They Just Don’t Get It!” When Family Disagrees with Expert Opinion’ (2009) 35(8) *Journal of Medical Ethics* 497-501.
Dementia also poses opportunities for best interests decision-makers, however, which must be seized upon by the courts during the decision-making process. Although there is a tendency to view persons with dementia as experiencing a loss of social identity, given their age they in fact frequently have a lifetime of experience, beliefs, values, and relationships, that can inform the best interests decision-making process and help maintain their social identity. It is argued, however, that only when the court takes an intersubjective approach, which necessarily entails focusing on these relationships - both on a macro level (relationships with organisations or institutions such as the state or their church, for example), and a micro level (relationships with other individuals or self-relations) - will they be able to overcome the characterisation of persons with dementia as ‘Other’. This is not to say that such an approach helps the court pay more attention to their perspective understood in a technical manner – that is, it does not require the court to simply look at more of the person’s ‘wishes, feelings, values, and beliefs’ understood in a narrow sense. Nor does it suggest that a person’s own wishes should always be the trump card in the decision-making process. What a proper application of this idea does is ensure that the court avoids ‘othering’ by being sensitive to the different ways each person, including persons with dementia, choose to live their lives. In effect, it allows the court to pay appropriate attention to the person’s perspective, by exploring the relationships – both positive and negative – that form their subjective character of experience.

In the cases analysed here, it is suggested that there are two ways an intersubjective approach as defined in this section can achieve this goal. The first is that such an approach requires ‘unifying’ the person with dementia, to use Stirling’s terminology. This entails exploring the

144 Jennings (n 115) 173.
145 Above (n 135) 78.
146 Stirling (n 43) 155.
person in both their past and their present states as one entity - recognising that the background of the person with dementia does not simply ‘fall away’ at a particular point in time - rather than being viewed in isolation as their ‘undemented’ or ‘demented’ states as the preceding section suggested the courts have had a tendency to do. As Nedelsky notes, however, this requires greater attention to detail, and in particular greater attention to detail than has been seen in the judgments criticised above. Second, in requiring greater analysis of their subjective character of experience, the courts must place more emphasis on examining the effects of dementia on that particular person, rather than the court holding out a generic idea of what it is like to have dementia, which emerges from the cases criticised above.

To highlight the potential of this approach, three particular judgments are considered: *A London Borough v VT*[^149] (*VT*), *A Local Authority v JH*[^150] (*JH*) and *Westminster City Council v Sykes*[^151] (*Sykes*). All three cases concerned the residence of persons with dementia. In *VT*, the Court was asked to determine whether it was in the best interests of a 78-year-old man with ‘significant’[^152] dementia, to reside in care accommodation in London, or be returned, as per his past and present wishes and intentions, to live the remainder of his life in Nigeria - his country of birth. The Court decided that it would be in his best interests to return to Nigeria. In *JH*, the issue was whether it was in the best interests of a 75-year-old woman, Mrs H, with a number of medical conditions, one of which was vascular dementia, to return home to live with her husband of 30 years, Mr H, or be moved to a care home. In a lengthy, detailed and sensitive

[^147]: Nedelsky (n 43) 79.
[^148]: It may be that the greater practical potential for this argument lies in section 4(6)(b) of the Mental Capacity Act – values and beliefs. If wishes and feelings are interpreted as pertaining to a particular decision, then values and beliefs may be interpreted as wider ranging – they relate more to the identity of the person with dementia, and may pose less potential for conflict than wishes and feelings. For a fuller analysis of the difference between ‘wishes and feelings’ and ‘values and beliefs’ see: Munro (n 56) 61, and for a philosophical argument regarding the capacity to ‘value’ during dementia, see: Jaworska (n 14).
[^150]: *A Local Authority v JH* [2011] EWCOP 2420.
[^151]: *Westminster City Council v Sykes* (n 136).
[^152]: *A London Borough v VT* (n 149) [24].
judgment, Eldergill J determined that it would be in her best interests to return home, with a package of care provided by the local authority. Finally, Sykes involved the issue of whether it was in the best interests of Manuela Sykes, an 89-year-old woman with no close family but with a close network of relationships with friends and through her church, and who had been an active and outspoken political campaigner in the past, to reside in a care home, or return home with a package of care from the local authority, and furthermore, whether her identity should be made public. The Court of Protection, in a judgment again by DJ Eldergill, declared that she should be allowed to return home with a package of care, and, in a rare occurrence, that her identity should be made public.

8.5.1 ‘Unifying’ the Person with Dementia

All three cases involved adults from different contexts and lives characterised by different relationships, but with an identical issue for the Court of Protection to determine – where would it be in the best interests of these adults with dementia to reside? The biographical detail presented in all three judgments is thorough, but moreover – and crucially for an intersubjective approach - the judges in each case are keen to emphasise how the views expressed by the individuals on their residence have been brought about because of how they have lived their lives and the unique web of relationships they are situated within. In effect, they attempt to ‘understand’ the standpoint or the ‘story’ of the person, rather than simply taking them at face value, or dismissing their views as irrational, or a ‘symptom’ of their dementia. This, more sensitive, and critical approach is one that has long been advocated by researchers on

153 This language is akin to narrative identity theory – a full discussion of which is outside the scope of this chapter. The approach advocated here, however, does highlight how relationships can illustrate a person’s narrative continuity. See: Jeffrey Blustein, ‘Choosing for Others as Continuing a Life Story: The Problem of Personal Identity Revisited’ (1999) 27 Journal of Law, Medicine & Ethics 20-31. For an interesting personal reflection on a narrative approach in the context of old age and death generally see: Atul Gawande, Being Mortal: Illness, Medicine and What Matters in the End, (Profile Books 2014).
selfhood in dementia. Sabat and Harré argue,\(^\text{154}\) for example, that this background contextual information is essential to co-operating in constructing selfhood – and particularly a self that the person with dementia can remain actively and reciprocally involved in creating.

In discussing ST’s wishes and feelings in \(VT\), for example, DJ Ralton indicates that it is a value held by many Nigerians of ST’s generation that they would expect to retire back to Nigeria at some point, as well as being customary for families to look after each other, only using outside caregivers as and when they need, as well as ST having expressed a ‘consistent rational intention and wish’\(^\text{155}\) to return to Nigeria to ‘end his days’ there. Although use of language such as ‘consistent and rational’ might imply the presence of the comparator criticised earlier, the judge is keen to stress that this is internal consistency and rationality – that is, it is consistent and rational according to what ST’s wishes have been previously. It is not only cognisant of ST’s expressed past and present wishes, but also takes account of his heritage, and the customs of his place of birth – rather than simply relying on wishes expressed when he is deemed to lack capacity. It considers whether such wishes are or are not consistent with his prior wishes, and his more widely held values of returning to his home country. In emphasising ST’s cultural background and, importantly, ST’s relationship to his culture, the approach taken by DJ Ralton presents neither a fixed image of ST either previously, or in his current state as a person with dementia, but is a ‘unified’ approach to ST’s life – linking and explaining his attitudes before he was diagnosed with dementia to the same views being expressed now. The identity of ST with dementia, in effect ST now, may be seen to assume a subsidiary role to ST’s life viewed in its entirety, and his lifelong relationship with his culture.\(^\text{156}\)

\(^\text{154}\) Sabat and Harré (n 38) 453.
\(^\text{155}\) A London Borough v VT (n 149) [35]-[37].
\(^\text{156}\) Similar declarations are made in London Borough of Redbridge v G [2014] EWCOP 17, where the Court emphasises the importance of G’s ‘church family,’ and declaring that it would be in G’s best interests to be reintegrated in to her social networks (at [84]), and in Sykes, where the judge highlights the importance of her engagement with her friends, family and members of her church, ‘to help establish relationships and habits’ [§10].
In a similar vein, the judgment in *JH* is also sensitive to the priority that both Mr and Mrs H afford to their marriage, as well as the value of Ms Sykes’ self-relations in *Westminster City Council v Sykes*. In *JH*, for example, Eldergill J outlines in detail Mrs H’s commitment and dedication both to her husband and to her marriage, and why this should inform the decision-making process – at one point stating that both *Mr and Mrs H* ‘…take a traditional view of marriage and their vows and have never regarded it as a provisional and reviewable arrangement which could and might be brought to an end…’.\(^{157}\) In *Sykes*, this approach is particularly pronounced. The Court relies heavily on the continuity of Ms Sykes’ identity, frequently describing her as a ‘fighter’, as having a ‘strong sense of self and identity’ and opinionated, with a ‘strong will to change the world, to influence others and to draw their attention to the plight of those she believes need and deserve more care, such as…people experiencing dementia’,\(^{158}\) and uses this, as well as evidence of her previous openness in discussing her own dementia and her experience of caring for her mother who had dementia, to authorise both a trial period at home and the release of her identity, emphatically stating that being named ‘confers dignity, the dignity of being heard, rather than undermines her dignity, the indignity of being forgotten’.\(^{159}\)

Finally, in each of the cases, the Court employs a greater attempt to understand the current perspective of the person with dementia on its own evidentiary merit, rather than masking it, or as portraying their perspective as evidence of an idealistic paradigm. In *JH*, Eldergill J states that Mrs H is ‘generally happy at home in [Mr H’s] company. She watches television and whilst

---

\(^{157}\) *A Local Authority v JH* (n 150) [§14].

\(^{158}\) *Westminster City Council v Sykes* (n 136) [§10]. Feminist criticisms of this approach may nonetheless argue that the Court still presents a picture of the masculine ideal in articulating this particular image of Ms Sykes – the image of the strong willed public persona.

\(^{159}\) *Westminster City Council v Sykes* (n 136) [§13].
watching talks about what is on. She enjoys listening to music…’.

In Sykes, the Court notes that Ms Sykes may become distressed in the care home given her clear and strong wishes to return home. Furthermore, and as alluded to above, the Court justifies these grounded pictures of those with dementia by reference to broader ethical values and beliefs. For example, the judge notes that Mrs H is ‘still able to appreciate and express the value of being at liberty and being allowed autonomy’ – according to what autonomy and liberty now mean to her, not the idealistic notions of autonomy and liberty that are present in the judgments in Dorset County Council v EH and IIBCC v LG. This is also a feature of Sykes, where DJ Eldergill states that her ‘…strong sense of self, her belief in the importance of the individual, her desire for freedom and autonomy are magnetic factors, operating at positive and negative poles by providing both the pull of freedom and the counterforce of resistance to outside care’. In effect, in the cases outlined here, the courts do not focus on the person as being an ‘either/or’ entity – ‘either’ someone without dementia, ‘or’ someone with dementia; they do not focus on the artificiality of distinguishing the person in both their pre- and post-dementia states, nor hold them up to some unattainable ideal. They focus on emphasising ST, Mrs JH, and Ms Sykes’ subjective character of experience through an analysis of what values such as autonomy mean to them, through an analysis of their inter- and intra-personal relationships over time, thereby arguably transcending the binary that allows for the construction of the person with dementia as ‘Other’.

---

160 A Local Authority v JH (n 150) [§14].
161 ibid. [§14]. He also adopts a similar stance in the recent similar case of Bedford Borough Council v C [2015] EWCOP 25. Although finding that there have been strained relations with Mr C in the past, he highlights how Mrs C’s distress over certain emotional topics does not necessarily mean she is scared of her husband and could be attributable to other features, such as being separated from him (at [89]). The Court backs this up by examining the fact that Mrs C appears ‘happy and content at the matrimonial home during…visits…she is more animated and verbally responsive when at home; she often expresses a wish to have…contact with her husband; she is generally responsive to Mr C and initiates affectionate contact…’ (at [90]), and is even ‘downcast’ after her visits home are over (at [88]).
162 Westminster City Council v Sykes (n 136) [§10].
8.5.2 Understanding the Effects of Dementia

If an intersubjective approach requires the court to focus on the person’s subjective character of experience, then this particular element of that process is crucial – it effectively entails a consideration of what it is like to have dementia for *that particular person* before the court, not what the court suspects it might be like to have dementia in general as they arguably do in the decisions criticised above. As noted earlier, dementia does entail declines and changes in cognition and abilities, but the critical question is, as Kitwood argues,\(^{163}\) how the evidence of such changes should be interpreted and used by the courts. For example – such as, in *VT* for example, the environment in L Care Home (ST’s current place of residence). DJ Ralton notes that, at the care home, ST has presented such ‘challenging’ behaviour, such as barricading himself in his bedroom. This, it is suggested, is due to the fact that ST is unhelpfully but unavoidably surrounded by other residents with more advanced dementia, is under a high degree of control, and is demonstrably unhappy in the care home.\(^{164}\) It goes further, however, and points out that ST is in fact more co-operative when attended to by caregivers he recognises.\(^{165}\)

Likewise, in *JH*, Eldergill J explains why Mrs H’s behaviour may have sometimes been uncooperative during her time in hospital (such as refusing to eat or drink, or to leave her bed), rather than characterising it solely as a symptom of her dementia. He indicates that the lack of co-operation may be due to the hospital environment, stating that the evidence indicates that Mr H is able to elicit her co-operation at home because of the long established routine they have – preferring to sleep in and remain undisturbed until midday. As such, given that her

---

\(^{163}\) Kitwood (n 40).

\(^{164}\) *A London Borough v VT* (n 149) [39]. In *Sykes* the judge also acknowledges her view that paid carers who visited her at home had been ‘patronising and insensitive’ and ‘offensive or inconsiderate’: *Westminster City Council v Sykes* (n 136) [§10].

\(^{165}\) *A London Borough v VT* (n 149) [39].
long-established routine does not fit with that of an institution, the chances of her co-operating in a residential facility is also minimal. Similarly, in *Sykes*, the Court demonstrates sensitivity to both the emotional and personal aspects of having dementia, as well as its cognitive impacts. The judge remains sensitive to the ways in which dementia does indeed affect cognitive functions, and crucially, how this may explain an individual’s behaviour and interactions with professionals. For example, in discussing Ms Sykes’ care needs, the judge states that:

It is recorded that she has a tendency to become defiant when [issues around Ms Sykes’ residence] are raised. This is logical and understandable because, unless one has a memory of previous difficulties, the professional view must appear patronising and intrusive, and the problems made-up or grossly-exaggerated.\(^\text{166}\)

If it is indeed true, as Atkins argues, ‘the individuality, the specificity, of each person’s perceptual and cognitive faculties endows each subject with a certain unique “take” on experiences which are nonetheless socially and historically situated,’\(^\text{167}\) - then the discussion of the three cases here highlights the importance of exploring relationships (familial, social and historical) on all levels - between the persons with dementia, their spouses, the local authorities as well as with their past and present identities and culture or religion – for the court to gain a better understanding of the person’s “take” on their experiences. They also highlight the need to be more sensitive to the interactions that take place between professionals - including the Court of Protection - and persons with dementia, as well as the way dementia affects each individual person. As DJ Eldergill states in *Sykes*, ‘[t]he law requires objective analysis of a

\(^{166}\) *Westminster City Council v Sykes* (n 136) [§7]. In some respects, however, one of these judgments in fact goes much further than simply trying to understand the person with dementia. In *JH*, Eldergill J also goes some way to trying to understand Mr H’s ‘difficult’ and ‘uncooperative’ behaviour. This behaviour is explained not only because of the ‘trauma’ Mr H has had to endure due to his wife’s declining health, but also because of the hostility, and entrenchment of his dealings with the local authority and its representatives. Eldergill J is critical of the local authority’s assertions that Mr H has never been willing to compromise his position, stating that ‘[w]hat [the local authority] mean is that he is not willing to concede the relevant point and neither are they’: (at [§14]). He goes on to describe the local authority’s approach as ‘entrenched’ (at [§14]).

\(^{167}\) *Atkins* (n 135) 73.
subject not an object'. This is the essence of an intersubjective approach. In adopting such an approach, it is argued that the court can make ‘a place within our collaborative existences for each other’s specific values and differences’. They make room for the perspective of the person with dementia, while avoiding the ‘othering’ process.

8.6 Difficulties with this Approach

Adopting an intersubjective approach to cases involving persons with dementia as has been advocated in this chapter is not necessarily a panacea, and it is therefore important to note some of the potential difficulties with such an approach. Some may argue that such an approach leaves the individual with dementia at the mercy of potentially abusive relationships either individually or institutionally. As Nedelsky notes however, approaches that emphasise the importance of exploring relationships, such as advocated here, necessarily require attention to detail, and are simply good practice whoever the decision maker is. We must have confidence that such detail would highlight potentially abusive relationships to the court as it has done in other cases. Similarly, by undertaking this level of detail, the court will be more transparent as to those relationships that are beneficial for the wellbeing of the person with dementia overall, even if the relationship may be detrimental on some counts – an example of which is Re MM. This case concerned the suspension of contact between MM, an 80-year-old woman with dementia residing in a care home, and RS, her close friend. Contact had been suspended following a misinterpretation of the Mental Capacity Act by the care home in which she was residing, who believed that it was for MM’s next of kin – her daughters – to make best...

---

168 Westminster City Council v Sykes (n 136) [§10].
169 Atkins (n 135) 75.
170 Nedelsky (n 43) 79. For an argument on the importance of such contextual information in capacity assessments, see: Natalie Banner and George Szmukler, “‘Radical Interpretation’ and the Assessment of Decision-Making Capacity’ (2013) 30(4) Journal of Applied Philosophy 379-394.
171 Quigley (n 63) 237.
172 See, for example, IIBCC v LG (n 109), EM v SC and CM (n 117) and Stoke City Council v Maddocks [2012] EWCOP B31.
173 Re MM (n 83).
interests decisions on their mother’s behalf if she lacked capacity. MM’s daughters then initiated the suspension of contact between MM and RS. This was held to be a violation of the RS’s Article 8 rights, and that, notwithstanding the fact that there were some concerns over RS’ aggressive behaviour around MM, that contact should be reinstated given MM’s demonstrable happiness when seeing RS:

“As soon as she saw RS face her face lit up in a smile. She called him by name and when asked if she recognised him she commented I knew him as soon as I saw him. She held his hand firmly and asked what he has been doing with himself…MM interacted extremely well with RS.”

Neither must we be quixotic about the practicalities of such an approach in terms of the ultimate decision that can be made in light of the increasingly contentious issue of local authority resources. The Court of Appeal in Re MN recently affirmed that the Court of Protection ‘…has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party…than the adult if he had capacity would be able to obtain himself.’

In effect, best interests is confined to the options in front of the Court, and the Court cannot direct a local authority to provide a particular care plan unless it is already an option before the Court. The decision in Re MN, recently applied in North Yorkshire County Council v MAG may therefore prove to be particularly problematic in residence decisions where a local authority refuses to provide a care plan at home, and where the individual in question has only a small network of family caregivers to rely upon, yet an intersubjective approach indicates that it would be in the person’s best interests to continue to reside at home, if that option were available. If a package of a care plan at home is not an option before the

174 ibid. [28].
175 Re MN [2015] EWCA Civ 411.
176 ibid. [80].
177 North Yorkshire County Council v MAG [2016] EWCOP 5.
Court, then under *Re MN*, the Court cannot direct that it would be in the person’s best interests. This tension is a valid one, and unfortunately remains until, or even if, the decision in *Re MN* is reconsidered.

### 8.7 Conclusion

The courts’ approaches in the cases outlined above have led, on occasions, to a portrayal of the person with dementia as ‘Other’ during the best interests decision-making process. The argument put forward here is that by adopting an intersubjective approach - emphasising the importance and complexity of their relationships, as well trying to *understand* the symptoms, behaviour and personalities of those with dementia - the court can be more attentive to their subjective character of experience. What is required for the court to do this effectively, however, is explicit recognition of the fact that for those with dementia - and indeed those without - life is inescapably and overwhelmingly characterised and defined by a labyrinth of intra- and inter-personal relationships and connections; both personally and societally. The Court of Protection must be prepared to examine those relationships in detail if it wants to make a decision that is, to use Lady Hale’s language, right for that person ‘as an individual human being’.

As the actor Christopher Eccleston summises in discussing how he coped with his father’s dementia, what this entails is ‘instead of trying to pull people with dementia into your world, you have to enter theirs’.

---

178. *Aintree University Hospitals NHS Trust v James* [2013] UKSC (n 68) [45].

CHAPTER 9: CONCLUSION

This thesis has sought to explore the adequacy of mental disability law as it is applied to older adults – and specifically older adults who experience abuse, ageism, and who may lack capacity due to dementia. By drawing on the feminist, and relational theories outlined throughout, it has first sought to argue that the law in its current state is not adequately equipped to deal with wider oppression, which may compromise a person’s autonomy in subtler ways than direct abuse, coercion, or undue influence. Moreover, it has also sought to argue that in other areas – such as in using the notion of ‘vulnerability’ or best interests decision-making under the Mental Capacity Act 2005 – it is not adequately implemented in respect of older persons. The reasons suggested for this throughout is that the law is built – in the main – on the caricature of the liberal, atomistic, individualistic, rational, healthy bodied, and autonomous self, so often found within law – and so often criticised by jurisprudential scholars.¹

It has not been contended at any point in this thesis that the law should not intervene in older peoples’ lives – it is hard to imagine that anybody would argue that Mr and Mrs L in DL,² Ms G in London Borough of Redbridge v G,³ or Mrs EH in Dorset County Council v EH,⁴ for example, did not deserve the protection of the law; nobody would want to see these persons go without legal assistance. As Kong argues:

Private relationships of abuse, manipulation, coercion do inhibit an individual’s potential to develop autonomy skills, and the failure to intervene can itself

⁴ [2009] EWHC 784 (Fam).
signal the neglect of positive duties of support to encourage the autonomy of those with impairments.\(^5\)

The crucial argument presented in this thesis is not therefore that the law was wrong to respond in these cases, but that the contextually focussed theories advocated here can help unveil how the law perhaps chose to respond in the wrong way; either through actual response invoked – such as in *NCC v PB* – or through the manner in which such a response was invoked by the courts – such as in the best interests cases criticised in chapter 8.

A further aim of this thesis has also been to highlight that while the law can indeed be criticised on some fronts, therein also lies potential. While such theories can validly be used as a tool of criticism as demonstrated throughout, they can also be used as an aid. They hold the potential to guide the law in the right direction; the potential to shine a light on ways that the law can be implemented in a more sensitive way in respect of older persons. Crucially, they hold a key to ways in which the law can navigate the complexity of relationships that an older person has both on an individual level, and on a macro level with state organisations such as the local authorities, and the courts, rather than concealing them in the name of simply trying to choose between the binary of either protecting the older person, or protecting their autonomy.

It is worth noting that the application of such ‘relational’ theories within the law, particularly vulnerability and relational autonomy, have recently come under criticism from those who argue that such theories risk invoking overly-paternalistic responses.\(^6\) Yet as noted above, applications of these theories are designed not only to unmask the flaws in the legal regime,

---


but how it can be applied in a more sensitive manner. In effect – striving to overcome the very
thing that such commentaries criticise; overly-paternalistic responses. A further criticism made
of such theories is that they are nebulous, and therefore difficult to apply in practice. In a recent
article, Series offers one such criticism, and argues that ‘[I]egal scholars should exercise
cautions when praying in aid ‘relational’ approaches; because of their diversity it is far from
self-evident how these should translate into legal frameworks or everyday life.’ ⁷ It may be
counter argued, however, that this is only the case if we are not clear in what way we intend to
use the word ‘relational’, or in what way we envisage such a relational approach having an
effect. As Norrie notes, writing in the context of criminal justice,

> [t]heory does not lead immediately to systematic practical conclusions, but that
does not mean that it is irrelevant to practice or that it cannot illuminate it. In truth,
practice can never escape theory. *It is only a question of how adequate and explicit theory is.* ⁸

Ultimately what such approaches do, that traditional liberal notions of autonomy, vulnerability,
and personhood that underpin mental disability law for older people do not, is enable greater
consideration to be given to the power imbalances between older people and others in society –
including the power imbalances that may operate between older people who are abused,
subjected to ageism, or older people who have dementia and the courts. Moreover, they provide
an opportunity for the law and the courts to consider how best to redress these power
imbalances. In light of this particular aim of such theories, throughout the chapters of this
thesis, a key concern has been to define the sense in which the word ‘relational’ is deployed in
each context, rather than use it as a catch-all term - which may be the source of Series’

dissatisfaction. Through this thesis, ‘relational’ has been used simply to denote ‘paying greater attention to the person’s relationships’ – both positive and negative; caring, intimate and familial relationships, relationships with the state in its various guises, and self-relations. This chapter now turns to providing a brief summary of the arguments provided in the three chapters (chapters 6, 7, and 8) that formed the journal papers, as well as offering some reflections on how the arguments in the three chapters interlink, and some preliminary reflections on how the arguments made may be developed further in future research.

9.1 Ageism and Autonomy

Chapter 6 – ‘Ageism and Autonomy: Explorations Through a Relational Lens’ - sought to argue that traditional accounts of autonomy – and therefore capacity – rely heavily on functional abilities, or fail to pay sufficient attention to the relationships that older persons are engaged in. As O’Donovan and Gilbar note, ‘…an individualistic interpretation of autonomy, which sees the patient as separated from others, where his or her decisions are made independently of, or even indifferently to, others, is insufficient.’ O’Donovan and Gilbar write that in the context of medical law – a sphere of law in which criticisms of hyper-individualism are not novel. Yet such an argument still holds true in respect of mental disability law. The Mental Capacity Act 2005, for example, retains a functional and binary assessment of capacity – which mirrors the functional and binary accounts of autonomy that have been criticised by relational autonomists. Furthermore, it is evident from DL v A Local Authority that the Mental

---

Capacity Act 2005 does not encompass situations where a person is in an abusive interpersonal relationship, which may threaten their autonomy, but does not lack capacity under the Act – the court has preferred to invoke the inherent jurisdiction to deal with such cases. Moreover, cases using the inherent jurisdiction following DL have not been forthcoming, suggesting that it may not be a popular mechanism for local authorities to wish to pursue. In light of this, then, there is even less chance that the law will be able to respond where ageism – understood as a series of negative attitudes about older persons because of their age, or because of features associated with old age such as frailty, or poorer cognitive abilities - operates so as to undermine a person’s autonomy.

Yet there are two points that emerge from the above. First, if ageism underlies the actions of the son, DL, in DL v A Local Authority – explored in greater detail in chapter 7 - then it is entirely arguable that the court is in fact responding to ageism by deploying the jurisdiction, but in order to be able to respond, the ageism must also come with abuse. In effect, if the son’s abuse was motivated by ageist attitudes towards his parents, then in invoking the inherent jurisdiction to safeguard the decisions of GRL and ML is also trying to safeguard their decisions from the ageism that underpins the abuse. Yet it is highly contestable whether this is an effective or an efficient mechanism. It would certainly seem dramatic to suggest invoking the inherent jurisdiction for every instance of ageism – such a response is simply not practicable, not least because ageism comes in many guises – and may be subtle, pervasive, and hard to detect. The second point is that it is debatable whether the law as it currently operates – either as a substituted decision-making regime under the Mental Capacity Act – or a quasi-substituted decision-making regime under the inherent jurisdiction (as shown in chapter 7) – is the most appropriate way to respond to ageism. If the essence of the argument in chapter 6 is that ageism threatens an older person’s maximal autonomy when it impacts on how that
person relates to herself – when it threatens the person’s self-trust, self-esteem, or self-worth – then it seems antithetical to argue that in such instances we should remove decision-making power from that person completely. Such an approach seems reactionary, and disempowers the older person even further.

If ageism does threaten an older person’s autonomy by impacting on how an older person self-identifies, and as argued in chapter 6, the inherent jurisdiction is not a practical mechanism by which to respond, what can be done to tackle this? A point raised in chapter 6 but left relatively unexplored, is the potential of extra-judicial tools such as education, and training, to respond in a more effective, and localised way. The development of a human rights agenda for older persons, for example, may have the potential to bring with it a shift in the way society views older persons in a predominantly negative light – and which contributes to ageism. Such a shift is arguably being brought about in respect of persons with impairments courtesy of the UNCRPD. It is entirely possible, then, that a new international human rights convention may do the same in respect of older persons – as some have suggested. A full discussion of this, however, is beyond the scope of this thesis.

9.2 The ‘Vulnerable Older Adult’

Chapter 7 - ‘The Good, the Bad and the ‘Vulnerable Older Adult’ - sought to argue that while there is evident commitment to the retention of the High Court’s inherent jurisdiction, particularly to safeguard older adults, post-DL courts have been reluctant to invoke the jurisdiction, and furthermore, confused as to its application. This may be due to confusion as

---


to what the court conceives of as the vulnerable older adult, as argued in chapter 7. For the inherent jurisdiction to be any force for good – as has been argued elsewhere that it could be\(^\text{14}\) - in safeguarding older people and their decision-making, then it must develop a more convincing normative account of what it talks of when it has the ‘vulnerable older adult’ in mind. It also requires a greater delineation of what it sees as the contours of the Mental Capacity Act, in relation to the inherent jurisdiction. This latter point will be particularly necessary in order to begin dealing with borderline cases of mental incapacity, such as *London Borough of Redbridge v G*, or *NCC v PB*,\(^\text{15}\) in a more appropriate way. Failing to delineate this contour between the two regimes - or even following the Singaporean Court of Appeal’s decision in *Re BKR*\(^\text{16}\) and invoking the Mental Capacity Act in almost all cases where older adults have a cognitive impairment and suffer abuse or undue influence, without exploring their situation in any more detail - in fact adds another ‘layer’\(^\text{17}\) of vulnerability to the older person’s experiences.

Interestingly, declarations by the Supreme Court in other contexts – that of assisted dying - indicate that the courts do envisage undue influence and incapacity as separate phenomena. Baroness Hale’s dissenting judgment in *R (Nicklinson) v Ministry of Justice*\(^\text{18}\) for example, explicitly states that she sees a clear difference between undue influence and capacity:

> It would not be beyond the wit of a legal system to devise a process for identifying those people, those few people, who should be allowed help to end their own lives. There would be four essential requirements. They would firstly

---


\(^{15}\) [2014] EWCOP 14.


\(^{18}\) *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38.
have to have the capacity to make the decision for themselves. They would secondly have to have reached the decision freely without undue influence from any quarter.19

What is required, however, is greater elucidation by the courts as to the relationship between undue influence, and incapacity. More importantly, what is required is greater elaboration on the types of interventions seen as appropriate for both. It has also been suggested that reflecting on recent theoretical evaluations of vulnerability may assist the court in this respect by ensuring the court is cognisant of the way in which it may exacerbate an older person’s experience of vulnerability in the name of protection, or protection of their autonomy. In effect, it provides a theoretical lens by which to transcend the age-old protection/autonomy binary that so often finds itself enunciated – as shown throughout the chapters in this thesis - in cases involving older adults.

9.3 Dementia in the Court of Protection

Chapter 8 sought to undertake a review of best interests decision-making cases emanating from the Court of Protection involving persons with dementia who lack capacity. By drawing on predominantly feminist and disability theory and philosophy, it was argued that on occasions, the court has a tendency to ‘other’ the person with dementia. The court has done this through constructing an idealistic standard endowed with liberal qualities of rationality and autonomy, against which the person with dementia appears deviant, and is subsequently marginalised in the decision-making process. This is notwithstanding that the shift within best interests from its original establishment in 199020 that has sought to not only centralise the voice of the person in the decision-making process, but that has also sought to move away from attributing stigma

---

19 ibid. [314] (emphasis added).
20 F v West Berkshire Health Authority [1990] 2 AC 1.
based solely on the presence of a cognitive impairment. Yet chapter 8 also sought to indicate that there is potential within the law around best interests decision-making as it currently exists. This potential is realisable when those charged with making best interests decisions on behalf of a person with dementia adopt an intersubjective approach. This entails a decision-making process that is informed by an awareness of the effect that dementia has on a person rather than using it as evidence of their deviance. It also requires a far greater contextual analysis of the person’s relations through a consideration of the wishes of the person before they had dementia, tied together with greater analysis of their wishes now.

One potential option for implementing such an approach in practice – alluded to in chapter 8 - would be to adopt a system of substituted decision-making which attempts to make the decision on behalf of the incapacitated person as they themselves would have made it if they had capacity, rather than based on a best interests framework. Yet it is difficult to see how such an approach would work without further elaboration. It is difficult to see how this type of substituted decision-making would not simply have led the Court in *Dorset County Council v EH* to conclude in exactly the same way as it does, that ‘Mrs EH would have prioritised her safety and security and therefore would have wanted to be moved into a care home’. Indeed, Harmon,21 Dresser,22 and Stefan23 - whose criticisms have informed the theoretical context throughout this thesis - criticise this scheme of substituted decision-making in the American context on precisely this front. In light of this, for an intersubjective approach to work in practice, there must be something more. There must be something more than simply making the decision that the incapacitated person would have made if they had capacity. It is this

---

'something more’ that chapter 8 sought to elucidate by arguing that what is in fact required is tying together what decision the person would have made if they had capacity, with greater acknowledgement of their continuing capabilities through the dementia, as well as a greater awareness and sensitivity towards the effects of a dementia on that particular person. These latter points being particularly crucial. They are crucial because they entails a shift away from suggesting that a person is deviant because they have dementia – an image so often portrayed in the literature purveyed in chapter 4, and chapter 8 – towards a simple acknowledgement as Tom Shakespeare advocates, that certain impairments do entail differences, without necessarily portraying that difference as a deviance.

A further possibility, which sits at the peripheries of what is discussed in chapter 8, is that an intersubjective approach in fact requires certain qualities or attributes within the decision maker. For Eldergill, it is compassion:

> While there can be law without compassion arguably there can be no justice without compassion. This is because rendering to everyone their due involves not causing them to suffer more than is their due. Ensuring this necessitates that the judge is in sympathy with the suffering he or she is inflicting on the people involved in the case and alleviates it where possible; otherwise the suffering meted out is excessive and so unjust.

For other commentators, making decisions on behalf of other people requires epistemic humility – it requires the best interests decision-maker to be aware of the limits of what he or

she can possibly know about a condition such as dementia, but as Dresser argues, and as outlined in chapter 4, this does not mean the decision-maker should shirk an attempt to examine the effects of such conditions. Indeed, as argued in chapter 8, an intersubjective approach necessitates it. A full discussion of the scope of these qualities, and which qualities are needed, is again outside of the scope of this thesis, yet one thing remains clear. Above all else, an intersubjective approach requires far greater attention to detail – and particularly detail of a person’s relationships – than has previously been undertaken by the courts. It is securing this attention to detail that is crucial in ensuring a properly intersubjective implementation of best interests.

9.4 Concluding Comments

The arguments presented in this thesis suggest that mental disability law as it applies to older persons continues to disclose its underlying liberal philosophy that reveres the qualities of independence and self-sufficiency, and that takes the fully functioning body as the ideal. As noted throughout, criticisms of this philosophy underpinning the law are not novel – feminist and disability jurisprudence have long since criticised law’s unduly individualistic premise. Whether we are old or not, such philosophies should be denounced. Nowhere is this more crucial than when old age meets the law, however, and nowhere is a reliance on overly liberal or atomistic philosophies that revere the fully functioning ideal more dangerous. Old age can indeed be a time of prosperity, and continued good health. But as demonstrated in this thesis, it can also be a time of decline – both physical and cognitive. It may also be a time where

---

28 This is not to argue that individualism has no place within the law. As outlined in chapter 4, and chapter 6, individualistic elements of autonomy such as its conceptualisations as a set of functional skills, or the idea that it allows persons to shape their own lives, remain important. Yet throughout this thesis I have sought to use relational theories to demonstrate that the law is unduly individualistic, and fails to recognise, and centralise, the importance of exploring relationships in respect of older persons.
maintaining relationships – and developing new relationships of care - takes on a new and crucial significance. It may also be a time where susceptibility to abuse or exploitation may increase. The law must not run or hide from these difficult issues – as I have argued it has done on occasions. The law must develop in such a way as to explore these facets of old age in more depth to guide its responses. What has been argued here is that a focus on more nuanced theories of relational autonomy, vulnerability, ‘othering’, and intersubjectivity can highlight where the law has failed to do this – but significantly, can also highlight how the law could do this better. To reiterate a point made in the conclusion to chapter 6 – the issues such as ageism, abuse, and dementia that may affect older people should not be shoehorned in to existing legal and theoretical frameworks and responses. Legal frameworks, and their underpinning theories, must adapt to reflect the reality of experiencing these issues in old age. In this respect, old age in fact brings with it great potential that can and must be seized upon by lawyers and professionals. Old age brings with it the potential of having a lifetime of knowledge about the person – and their relationships - to draw upon:

What happens to all the years they have lived, the things they have learned, the selves they have evolved from and the selves they are becoming? Years are not empty containers: important things happen in that time. Why must these years be trivialised? They are the stuff of which people’s lives are made.29

Nowhere is it more important to recognise this fact than in mental disability law.

BIBLIOGRAPHY


Bartlett P, ‘Sex, Dementia, Capacity and Care Homes’ (2010) 31 Liverpool Law Review 137-154


Belsey C and Moore J (eds), The Feminist Reader (Macmillan 1997);


Black K and Dobbs D, ‘Community-Dwelling Older Adults’ Perceptions of Dignity: Core Meanings, Challenges, Supports and Opportunities’ (2014) 34(8) Ageing and Society 1292-1313


Boyle G, ‘The Role of Autonomy in Explaining Mental Ill-Health and Depression among Older People in Long-Term Care Settings’ (2005) 25 Ageing & Society 731-748


Brannelly T, ‘Sustaining Citizenship: People with Dementia and the Phenomenon of Social Death’ (2011) 18(5) Nursing Ethics 662-671

-- ‘Citizenship and People Living with Dementia: A Case for the Ethics of Care’ (2016) 15(3) Dementia 304-314


Brown K, ‘‘Vulnerability’: Handle with Care’ (2011) 5(3) *Ethics and Social Welfare* 313-321


-- *Frames of War: When is Life Grievable?* (Verso 2010)


Bužgová R and Ivanová K, ‘Elder Abuse and Mistreatment in Institutional Settings’ (2009) 16(1) *Nursing Ethics* 110-126

-- ‘Violation of Ethical Principles in Institutional Care for Older People’ (2011) 18 *Nursing Ethics* 64-78


-- ‘Ageism and Age Categorization’ (2005) 61(2) *Journal of Social Issues* 361-374


Campbell S and others, ‘Living with Uncertainty: Mapping the Transition from Pre-Diagnosis to a Diagnosis of Dementia’ (2016) 37 *Journal of Aging Studies* 40-47

Carel H and Kidd IJ, ‘Epistemic Injustice in Healthcare: A Philosophical Analysis’ (2014) 17(4) Medicine, Health Care and Philosophy 529-540


Clare L, ‘We’ll Fight it as Long as we Can: Coping with the Onset of Alzheimer’s Disease’ (2002) 6(2) Aging and Mental Health 139-148

--- ‘Managing Threats to Self: Awareness in Early Stage Alzheimer’s Disease’ (2003) 57(6) Social Science and Medicine 1017-1029


-- ‘People Like That’: Realising the Social Model in Mental Capacity Jurisprudence’ (2015) 23(1) Medical Law Review 53-80


-- and Brazier M, ‘Never Too Old for Health and Human Rights’ (2014) 14 Medical Law International 133-156


Commission for Social Care Inspection, Raising Voices: Views on Safeguarding Adults (Commission for Social Care Inspection 2008)

Committee on Homosexual Offences and Prostitution, Report of the Committee on Homosexual Offences and Prostitution (The Stationery Office 1957)


Davis L, Bending Over Backwards: Disability, Dismodernism and Other Difficult Positions (New York University Press 2002)


De Beauvoir S, Old Age (P O’Brien tr, Middlesex, Penguin 1977) -- The Second Sex (H M Parshley tr, Vintage 1997)


Den Hartogh G, ‘Do we Need a Threshold Conception of Competence?’ (2015) 19(1) Medicine, Health Care and Philosophy 71-83

Department for Constitutional Affairs, The Mental Capacity Act Code of Practice (The Stationery Office 2007)

Department of Health, No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse (Department of Health 2000)


-- Ageism and Age Discrimination in Primary and Community Care in the United Kingdom (Centre for Policy on Ageing 2009)

-- Ageism and Age Discrimination in Secondary Health Care in the United Kingdom (Centre for Policy on Ageing 2009)

-- Ageism and Age Discrimination in Social Care in the United Kingdom (Centre for Policy on Ageing 2009)

-- Long Term Conditions Compendium of Information (3rd edn, Department of Health 2012)

-- Methodology for Estimating ‘‘Wider Societal Benefits’’ as the Net Production Impact of Treatments (2014)


‘A Legal Overview’ in C Foster, J Herring and I Doron (eds), The Law and Ethics of Dementia (OUP 2014)


Doron I (ed), Theories of Law and Ageing: The Jurisprudence of Elder Law (Springer-Verlag Berlin Heidelberg 2009)


-- and Soden D (eds), Beyond Elder Law: New Directions in Law and Aging (Springer 2012)


Dunn C, ‘The Effect of Ageing on Autonomy’ in H Lesser (ed), Justice for Older People (Rodopi 2012)


Dunn M, Clare I, and Holland A, ‘To Empower or to Protect? Constructing the ‘Vulnerable Adult’ in English Law and Public Policy’ (2008) 28(2) Legal Studies 234-253


Life’s Dominion: An Argument About Abortion and Euthanasia, (HarperCollins 1990)


Emmett C and others, ‘A Relative Safeguard? The Informal Roles that Families and Carers Play when Patients with Dementia are Discharged from Hospital into Care in England and Wales’ (2014) 28 International Journal of Law, Policy and the Family 302-320


Faulkner L, ‘Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults’ (1982) 16 Family Law Quarterly 69–91


Fennell P, ’Best Interests and Treatment for a Mental Disorder’ (2008) 16 Health Care Analysis 255-267


-- ‘The Vulnerable Subject and the Responsive State’, (2011) 60 *Emory Law Journal* 251-275


-- ‘Equality, Autonomy and the Vulnerable Subject in Law and politics’ in M A Fineman and A Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate 2013)


Flynn M, ‘In Search of Accountability: A Review of the Neglect of Older People Living in Care Homes Investigated as Operation Jasmine’ (Welsh Government 2015)

Foster C, *Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law* (Hart 2009)


Hughes J, ‘Views of the Person with Dementia’ (2001) 27(2) *Journal of Medical Ethics* 86-91


Friedman M, Autonomy, Gender, Politics (OUP 2003) 157


Gergen K, Relational Being: Beyond Self and Community (OUP 2009).


-- ‘Ageing Abjection and Embodiment in the Fourth Age’ (2011) 25(2) Journal of Aging Studies 135-142


Gilligan C, In a Different Voice (Harvard University Press 1993)

Gilson E, The Ethics of Vulnerability: A Feminist Analysis of Social Life and Practice (Routledge 2014)


Goldman S, ‘How Well is the Mental Capacity Act being used in Care Homes?’,(Community Care, 11 May 2016) http://www.communitycare.co.uk/2016/05/11/well-mental-capacity-act-used-care-homes/

Goodin R and Gibson D, ‘The Decasualisation of Eldercare’ in EF Kittay and EK Feder (eds), The Subject of Care: Feminist Perspectives on Dependency (Rowman & Littlefield 2002)


Gott M and others, ‘Older People’s Views about Home as a Place of Care at the End of Life’ (2004) 18 Palliative Medicine 460-467


Government Office for Science, ‘The Barriers to and Enablers of Positive Attitudes to Ageing and Older People, at the Societal and Individual Level’ (Government Office for Science, 2015)


Gwynne J, ‘“Mrs Robinson Seeks Benjamin”: Cougars, Popular Memoirs and the Quest for Fulfilment in Midlife and Beyond’ in I Whelehan and J Gwynne (eds), Ageing, Popular Culture and Contemporary Feminism (Palgrave Macmillan, 2014)


-- “Old Age” (Or, Do We Need a Critical Theory of Law and Aging?), (2014) 35(1) Windsor Review of Legal and Social Issues 1-21

-- ‘Dementia, Autonomy and Guardianship for the Old’, in C Foster, J Herring, and I Doron (eds), The Law and Ethics of Dementia (Hart 2014)


Harmon L, ‘Falling off the Vine: Legal Fictions and The Doctrine of Substituted Judgment’ (1990) 100(1) Yale Law Journal 1-72

Harrington J, ‘Privileging the Medical Norm: Liberalism, Self-determination and Refusal of Treatment’ (1996) 16(3) Legal Studies 348-367


Herring J, ‘Where are the Carers in Healthcare Law and Ethics?’ (2007) 27(1) Legal Studies 51-73


-- Older People in Law and Society (OUP 2009)


-- ‘Forging a Relational Approach: Best Interests or Human Rights’ (2013) 13(1) Medical Law International 32-54

-- Medical Law and Ethics (5th edn, OUP 2014)

-- Vulnerable Adults and the Law, (OUP 2016)


Hughes J, ‘Views of the Person with Dementia’ (2001) 27 Journal of Medical Ethics 86-91


Johnstone M, Alzheimer’s Disease, Media Representation and the Politics of Euthanasia: Constructing Risk and Selling Death in an Ageing Society (Ashgate 2013)


Jolley D, Court Report: Lancashire Care Association, CO/2278/2002


Kapp M, ‘Medical Empowerment of the Elderly’ (1989) 19 The Hastings Center Report 5-7


King’s College London and the London School of Economics, ‘Dementia UK: The Full Report’ (Alzheimer’s Society 2007)
Kittay EF and Feder EK (eds), *The Subject of Care: Feminist Perspectives on Dependency* (Rowman & Littlefield 2002)


Kitwood, T *Dementia Reconsidered: The Person Comes First* (OUP 1997)


--- *Mentally Incapacitated and Other Vulnerable Adults: Public Law Protection* (Law Com CP 130, 1993)

--- *Mental Incapacity*, (Law Com No 231, 1995)

--- *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* (Law Com No 128, 1995)

--- *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (Law Com No 222, 2015)

Lee D, ‘Residential Care Placement: Perceptions Among Elderly Chinese People in Hong Kong’ (1997) 26 *Journal of Advanced Nursing* 602-607
Leibing A and Cohen L (eds), *Thinking about Dementia: Culture, Loss, and the Anthropology of Senility* (Rutgers University Press 2006)

Lesser H (ed), *Justice for Older People* (Rodopi, 2012)


Local Government Ombudsman, *Investigation into a complaint against Cambridgeshire County Council (Reference number 13016935)*, (20 January 2015)


Luhmann M and Hawkley L, ‘Age Differences in Loneliness from Late Adolescence to Oldest Old Age’ (2016) *Developmental Psychology* (Online First) DOI:10.1037/dev0000117


--- and Rogers W, and Dodds S (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (OUP 2014)


DOI:10.1080/15528030.2015.1046632


-- *Feminism Unmodified: Discourses on Life and Law* (Harvard University Press 1987)

-- *Towards a Feminist Theory of the State* (Harvard University Press, 1991);


Macquarrie C, ‘Experiences in Early Stage Alzheimer’s Disease: Understanding the Paradox of Acceptance and Denial’ (2005) 9(5) *Aging & Mental Health* 430-441


236
Mental Health Foundation, ‘Dementia, Rights, and the Social Model of Disability: A new Direction for Policy and Practice?’ (Mental Health Foundation 2015)


Moi T, *Sexual/Textual Politics* (Methuen 1985)


Mowlam A and others, *UK Study of the Abuse and Neglect of Older Persons: Qualitative Findings* (Comic Relief and Department of Health 2007)


Nagel T, ‘What is it Like to be a Bat?’ 83(4) *The Philosophical Review* 435-450


Nursing and Midwifery Council, Case 83A0008E, 27 March 2008

Nursing and Midwifery Council, Case 09E0079C, 14 February 2013


Older People’s Commissioner for Wales, *Dignified Care: The Experiences of Older People in Hospitals in Wales* (Older People’s Commissioner for Wales 2011)


Peel E, “‘The Living Death of Alzheimer’s’ versus ‘Take a Walk to Keep Dementia at Bay’: Representations of Dementia in Print Media and Carer Discourse’ (2014) 36(6) Sociology of Health and Illness 885-901


Perkins M and others, ‘Relational Autonomy in Assisted Living: A Focus on Diverse Care Settings for Older Adults’ (2012) 26 Journal of Ageing Studies 214-225


Poole M and others, ‘Going Home? An Ethnographic Study of Assessment Capacity and Best Interests in People with Dementia Being Discharged from Hospital’ (2014) 14 BMC Geriatrics 56-71

Powers S and others, ‘I wish they would remember that I forget:’ The Effects of Memory Loss on the Lives of Individuals with Mild-to-Moderate Dementia’ (2015) Dementia (Online First) DOI: 10.1177/1471301214553236


Priaulx N, The Harm Paradox: Tort Law and the Unwanted Child in an Era of Choice (Routledge 2007)


Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Stationery Office 2013)


Ruck Keene A, ‘The Inherent Jurisdiction: Where Are We Now?’


-- ‘Capacity is Not an Off-Switch’ (Mental Capacity Law and Policy, 1 October 2015) http://www.mentalcapacitylawandpolicy.org.uk/capacity-is-not-an-off-switch/


-- ‘Singapore, the MCAs and Undue Influence’ (1 June 2015)


Series L, ‘Another Local Authority Behaving Badly’, (16 May 2014) [https://thesmallplaces.wordpress.com/2014/05/16/another-local-authority-behaving-badly/](https://thesmallplaces.wordpress.com/2014/05/16/another-local-authority-behaving-badly/)


--- and Winsby M, ‘A Relational Perspective on Autonomy for Older Adults Residing in Nursing Homes’ (2010) 14 *Health Expectations* 182-190


Shildrick M, *Leaky Bodies and Boundaries: Feminism, Postmodernism and Boundaries* (Routledge 1997)

--- *Embodying the Monster: Encounters with the Vulnerable Self* (Sage 2002)


Steeman E and others, ‘Living with Dementia from the Perspective of Older People: Is it a Positive Story?’ (2007) 11(2) *Aging & Mental Health* 119-130


Steinbock-Hult B and Sarvimäki A, ‘The Meaning of Vulnerability to Nurses Caring for Older People’ (2011) 18(1) *Nursing Ethics* 31-41


The Northern Echo, ‘Care home nurse struck off after abusing patients’, (14 March 2013), http://www.thenorthernecho.co.uk/news/10291382.print/


Tiilikainen E and Seppänen M, ‘Lost and Unfulfilled Relationships Behind Emotional Loneliness in Old Age’, (2016) Ageing and Society (Online First) DOI: 10.1017/S0144686X16000040


United Nations Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12: Equal Recognition Before the Law (April 2014)


Verkerk M, ‘A Care Perspective on Coercion and Autonomy’ (1999) 13(3-4) Bioethics 358-368
Volkert J and others, ‘The Prevalence of Mental Disorders in Older People in Western Countries’ (2013) 12 Ageing Research Reviews 339-353


Weiss R and Bass S, Challenges of the Third Age: Meaning and Purpose in Later Life (OUP 2002)

Whelehan I and Gwynne J (eds), Ageing, Popular Culture and Contemporary Feminism (Palgrave Macmillan, 2014)


-- ‘State Responsibility and the Abuse of Vulnerable Older People. Is there a Case for a Public Law to Protect Vulnerable Older People from Abuse?’ in J Bridgeman, H Keating and C Lind (eds), Responsibility, Law and the Family (Ashgate 2008)


-- ‘Ageing and Health’, (Factsheet No. 404, September 2015)
http://www.who.int/mediacentre/factsheets/fs404/en/


APPENDIX


Ageism and Autonomy in Health Care: Explorations Through a Relational Lens

Laura Pritchard-Jones

Abstract Ageism within the context of care has attracted increasing attention in recent years. Similarly, autonomy has developed into a prominent concept within health care law and ethics. This paper explores the way that ageism, understood as a set of negative attitudes about old age or older people, may impact on an older person’s ability to make maximally autonomous decisions within health care. In particular, by appealing to feminist constructions of autonomy as relational, I will argue that the key to establishing this link is the concept of self-relations such as self-trust, self-worth and self-esteem. This paper aims to demonstrate how these may be impacted by the internalisation of negative attitudes associated with old age and care. In light of this, any legal or policy response must be sensitive to and flexible enough to deal with the way in which ageism impacts autonomy.

Keywords Ageism · Autonomy · Care · Health care · Decision-making · Older persons · Relational autonomy · Self-relations

Introduction

Ageism, or the ‘process of systematic stereotyping of and discrimination against people because they are old’ [9, p. 35], within health and social care has attracted significant attention in recent years. Concerns over its presence have been advanced in both academic and non-academic literature [6, 20–22, 29, 41, 46, 71]. With projections estimating a rapid increase in the number of older people over the coming years; 15.5 million over the age of 65 in the United Kingdom by 2020, and 6 million over the age of 80 by 2030 [18], increasing levels of chronic long term health conditions [23], as well as increasing fiscal constraints on healthcare systems,
there are concerns that ageism will intensify [78]. At the same time, the concept of autonomy has developed a prominent role within health care. The notion of autonomy fostered in healthcare law and ethics, however, has been criticised for its overly individualistic conceptualisation in that it pays limited attention to an individual’s broader social context and inherent interdependence [31, 57, 62]. Consequently, the range of recognised ‘threats’ to autonomy, such as lacking capacity\(^1\) or undue influence\(^2\) are also interpreted in a narrow, individualistic and binary way. In this paper, I appeal to aspects of relational autonomy\(^3\) to argue that ageism, understood as a set of negative attitudes about old age or an older person because of their age, may equally operate to threaten an agent’s ability to act in a maximally autonomous way when making health related decisions, because of the effect such ageism has on an individual’s self-relations such as her feeling of self-worth, self-esteem and self-trust.\(^4\) While there is increasing literature on old age and relational autonomy [27, 40, 70, 77], as well as on the advantages of relational autonomy in other contexts [15, 42, 43], the dynamics of how ageist attitudes interact with relational perspectives on autonomy remains unexplored. It is this lacuna I hope to go some way towards filling in this article. This understanding is of increasing importance not only given the concerns highlighted above about ageism within the care context, but also because of evolving debates around whether there ought to be a specific international human rights convention for the protection of older people.\(^5\) Autonomy plays an important role within human rights principles, and it is therefore essential that we have a model of autonomy that truly reflects the threat posed to decision-making by ageism if specific human rights legislation to protect older people is under consideration. The issue being explored in this paper, then, is an ethical one, but one that exists within a legal framework, and that clearly has legal ramifications.

In order to examine the issue raised here, I will begin by providing a brief overview of the prevailing individualistic account of autonomy in philosophical and ethics literature. Drawing on the critiques of this account, I will assert that this conceptualisation alone cannot account for the ways in which ageism may affect an older agent’s ability to act with maximal autonomy, especially when making health-related decisions because of the effect the internalisation of ageist attitudes may have on an agent’s self-relations. I will conclude by providing some thoughts on how the argument presented in this paper may perhaps be translated into practice, in light of the critiques of relational autonomy.

---

\(^1\) Re C [1994] 1 All ER 819 [74] and subsequently ss. 2–3 Mental Capacity Act 2005; and for an academic critique of these provisions, see [56].

\(^2\) See Re T (Adult: Refusal of Medical Treatment) [1993] Fam 95 [69, 75].

\(^3\) Relational autonomy has been described as an ‘umbrella term’, focusing on the analysis of ‘implications of the intersubjective and social dimensions of selfhood and identity for conceptions of individual autonomy…’ [58, p. 4].

\(^4\) These characteristics are sometimes considered as part of the broader concept of self-respect: [5].

\(^5\) United Nations Open-Ended Working Group on Ageing, established by General Assembly resolution 65/182, 21st December 2010; [81].
Individual Versus Relational Autonomy

Two predominant ways of thinking about autonomy have emerged in the literature; the individualistic and the relational. The first focuses largely on an agent’s internal functional capacity for decision-making and asserts that the content of the decision made is irrelevant. As long as the agent is able to fulfill the procedural requirements he or she will be considered autonomous. One oft-cited definition of such an account is possession of a ‘second-order capacity to reflect critically upon one’s first order preferences and desires, and the ability either to identify with these or to change them in light of higher order preferences and values’ [28, p. 108]. An operational example of such an account of autonomy can be found in capacity assessment tests. Under the Mental Capacity Act 2005, for example, an individual must be able to understand and retain information relevant to the decision in question, use the information to help her reach the decision and finally, be able to communicate her decision. The Act also permits unwise decisions to be made if these criteria are fulfilled. This individualistic, act-specific account, frequently enunciated through (and confused with) capacity assessments, dichotomizes autonomy in that it asks whether an agent is able to satisfy certain procedural or functional requirements. If yes, then the agent is autonomous (has capacity); if not, then she is deemed non-autonomous (not to have capacity). As Donnelly argues, capacity in the legal sense has become seen as the ‘gatekeeper’ to autonomy [26, at p. 90]. If a patient is deemed to have capacity (of which there is a presumption under the Mental Capacity Act) then that person is deemed autonomous, or more specifically, the decision they are purporting to make is assumed to be autonomous. There is little subsequent (or even prior) examination of the nature of the assumed autonomy. In light of this, both autonomy and capacity are considered binary constructs—either we are capacitous (and therefore autonomous) or we are not. This point will be considered further in section IV. Most procedural accounts of autonomy therefore require ‘critical reflection, authenticity, and content neutrality’ [12, p. 411]; they ask whether the person possesses the necessary cognitive functions and if so, the decision made is to be considered an autonomous one even if it is also considered to be ‘unwise’. As several critics have argued, however, behind this account of autonomy lies a mythical liberal (male) agent; the self-sufficient,

---

6 There is considerable variation in the terms used to describe the two visions of autonomy. Alternatives for the individualistic include: procedural, internalist, liberal and content-neutral. Alternatives for the relational include: externalist, socio-relational. This paper is not concerned with the subtle differences between each of these theories, and the terms individualistic or procedural autonomy are used to reflect the former, and relational to reflect the latter.

7 Mental Capacity Act 2005, s 3(1)(a)–(d).

8 Mental Capacity Act 2005, 2 1(4).

9 Mental Capacity Act 2005 s. 1(2) ‘A person must be assumed to have capacity unless it is established that he lacks it.’

10 Although this paper is not concerned with the feminist criticisms of the autonomous agent as being ‘male’ per se, i.e. the distinction between a feminine and masculine construction of autonomy, it is worth noting that a number of feminists have been critical of the atomistic conception of autonomy given its propensity for being orientated towards the masculine conception of the self. Naffine for example, argues that ‘[t]he autonomy of the individual…was explicitly reserved for the male’ [60, p. 105]. Similarly,
self-determining individual who encounters no physical or psychological encroach-
ment on his person from others, and for whom dependency is undesirable;\textsuperscript{11} an
individual who is able to extract her or his thought process from the influences of
others. Despite these strong criticisms, autonomy retains its position as an important
principle in both law and ethics because it upholds certain ideas that are deemed
valuable [34]. It epitomises the notion that we may live a life that is true to
ourselves, true to our own authentic choices, and avows an inherent respect for our
subjective experiences, our embodiment and our individuality.\textsuperscript{12} Indeed, for older
people, empirical research [3, 7, 51] suggests that autonomy (in some format) is a
particularly important concept; it denotes retention of independence at a time when
there may be increasing frailty, dependency, engagement with health and social care
services, and negative stereotyping of their capabilities. The criticisms directed
towards autonomy outlined above are of its interpretation as individualistic; the
suggestion that we make decisions in a perfunctorily procedural manner, not
necessarily in the values autonomy upholds per se\textsuperscript{13} or in the value autonomy has
for older people. As we shall see, however, an individualistic conceptualisation of
autonomy does not adequately reflect the everyday lived experiences (both positive
and negative) of older people.

In contrast to the individualistic construction, the concept of relational autonomy
attempts to ‘incorporate our experience of embeddedness in relations, \textit{both the inherent, underlying reality of such embeddedness, and the oppressiveness of its current social forms}’ (emphasis added) [62, p. 10]. On the one hand, it is causally
relational because it is \textit{affected by} relationships with others on both a macro and a
micro level; it does not exist or operate in a vacuum subject only to the will and
constraints present \textit{within} an individual as the procedural account would imply.
Even the individualistic conception of autonomy recognises that autonomy may
certainly be compromised where there are individually coercive relationships
operating in relation to specific decision-making. One example of this is \textit{Re T} [75], a
case concerning the validity of the refusal of a blood transfusion by a young,

---

\textsuperscript{10} Footnote 10 continued

Gilligan argues that ‘the capacity for autonomous thinking, clear decision-making, and responsible
actions—are those associated with masculinity and considered undesirable as attributes of the feminine
self’ [37, p. 17]. See also: [17, 59].

\textsuperscript{11} Martha Fineman, one of the leading critics of autonomy on this count, argues that ‘[t]he liberal
subject…is indispensable to the prevailing complementary ideologies of personal responsibility and the
noninterventionist or restrained state…The image of the human being encapsulated in the liberal subject
is reductive and fails to reflect the complicated nature of the human condition’ [32, p. 17]. See also: [31,
55, 63].

\textsuperscript{12} These ideas may seem individualistic in themselves, and therefore paradoxical to the argument that
autonomy should be understood relationally, however there is a clear distinction to be made between
saying that the values that autonomy upholds are individualistic, and that autonomy itself is
individualistic. Simply because the values may be interpreted in an individualistic manner does not
necessarily mean that their gatekeeper (autonomy) should also be.

\textsuperscript{13} There is, of course, a body of literature that argues that autonomy is a ‘thoroughly noxious’ concept
[44], however this seemingly ignores the \textit{values} autonomy upholds, which is a primary focus of this paper
and of relational autonomists in general. The assumption in this paper is that autonomy itself is an
important concept because of the values it embodies, but the procedural account is unduly atomistic, and a
relational model should be understood as the more appropriate conceptualization.
pregnant Jehovah’s Witness. Lord Donaldson held that in instances where undue influence may be present, the real question is ‘does the patient really mean what he says or is he merely saying it…because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?’ [75, at 113]. Lord Donaldson’s use of the term ‘no longer think and decide for himself’ in particular is a resounding reinforcement of the impact that undue influence may have on a liberal account of autonomy as non-interference. Relationality, however is more expansive in that it is able to situate an individual within her broader social context and recognise that autonomy may also be threatened where there is stigma attached to being a member of a societal group, and that this may in turn impact on the way an individual makes certain decisions because of the disproportionate impact such stigmas have on a person’s self-relations.\footnote{Decisions made under such conditions may attract what Stoljar terms the feminist intuition, ‘which claims that preferences influenced by oppressive norms of femininity cannot be autonomous’ [79, p. 95]. Oshana explains this by arguing that being autonomous under the procedural conceptualisations of autonomy does not lack any socio-relationality, but that the agent’s ‘psychological condition…is alone important for her autonomy’ [67, p. 85].} As Oshana [67] notes, this is not to suggest that individualistic accounts have no relational elements, but it suggests that the way we view such factors should be extended from simply looking at how actions threaten autonomy (such undue influence outlined in Re T, above), to considering how broader and subtler oppressive forces such as attitudes and beliefs about individuals and groups because of their membership to that group may also threaten maximal autonomy and the authenticity of a decision.\footnote{It is worth noting here, however, that Marina Oshana presents a ‘perfectionist’ account of autonomy, that is, someone who willingly and voluntarily surrenders their autonomy, such as the deferential wife, cannot be considered autonomous in doing so. The argument presented in this paper should be distanced from this perspective for two reasons. Firstly, because this perfectionist relational account fails to realise the idea that autonomy is a more flexible, non-binary concept (see below, n. 17). Secondly, Oshana’s account does not rely on the idea of self-identification as a central tenet of autonomy, which this article does.} In this sense, relational autonomy is concerned with how autonomy interacts with an individual’s relationships on all levels; micro, macro and indeed her relationship with herself. A relational conceptualisation goes even further, however, and recognises that relationships may also strengthen an individual’s ability to act with maximal autonomy. It may be seen as \textit{constitutively} relational in the sense that interdependence and positive relationships with others are an \textit{essential} element to autonomy in the first place. In other words, individuals are simply not able to act in a maximally autonomous way without relationships or a social context within which to operate.\footnote{See, for example: [36, 64, 83].} Indeed, and as Oshana argues, ‘the objective social criteria according to which we judge someone as autonomous…are independent of the individual’s internal state’ [67, p. 85]; in order to be considered autonomous, we must be considered by others to have the requisite properties to act autonomously. In light of this, then, maximal autonomy requires positive relationships of recognition on both a micro (individual) and macro (societal) level. Drawing on a relational account of autonomy allows us to retain the value implicit in the concept but also recognise that autonomy is a far more flexible concept than it has traditionally been understood.
In addition, a more expansive relational conceptualisation, and in particular one that is concerned with an individual’s relationships on all levels, including self-relations, both presupposes and reinforces the idea that the ability to act autonomously is not black and white; it is more intuitively understood as existing on a spectrum from minimal to maximal. This more accurately reflects the idea that oppressive attitudes and socialization such as ageism have differing degrees of impact on different individuals, and therefore on their ability to act autonomously, as well as better reflecting the idea that self-relations are not a simple binary idea either. As an individual, I do not look at myself in either a ‘positive’ or a ‘negative’ light. I may look at different aspects of my being, my personality or appearance with different degrees of positivity or negativity. A relational conceptualisation allows us to focus on the precise ways in which subtle attitudes such as ageism may impact on the way an individual views herself, and therefore her autonomy, rather than simply asking whether a person is able to fulfil certain functional criteria.\(^{17}\) Finally, relationality does not focus solely on the decision-making process. In the context of old age, and in particularly Fineman’s [31] account of relationality which emphasises interdependence, forces us to recognise that while many older people retain the ability to make autonomous decisions on the procedural account, some may find it difficult to execute these choices without dependence on others. For many older people,\(^{18}\) autonomy could be understood as a two-fold process; decision-making, and the execution of their decisions. If simply making decisions is all that is required of the procedural account, without any means of executing them, then the decision and its contents are rendered meaningless; autonomy risks becoming an empty concept, bereft of value for many older people who do depend on others on a daily basis to give effect to their choices.\(^{19}\)

---

\(^{17}\) This idea in particular has been used in different contexts by different authors. For example, Schwartz [76] argues that the notion of ‘perfect’ autonomy does not exist, but rather that we should recognize its existence on a spectrum from minimal to maximal autonomy. Similarly, Donnelly [26, p. 41], drawing on the work of Joseph Raz, advances the idea that autonomy is an ‘achievement’, moving beyond this dichotomization of autonomy found in traditional health care law and ethics. She suggests that our ability to act autonomously is, in fact, continuously evolving towards a state of achievement, rather than being fixed.

\(^{18}\) This idea is not just applicable to older people, but applies to any one of any age. The idea that autonomy is a two-fold process as presented here is, however, easier to see when illustrated in the context of old age where individuals may exhibit greater situational or pathogenic vulnerabilities, that is, those vulnerabilities that are context specific (situational) or those that are ‘generated by…morally dysfunctional or abusive interpersonnel and social relationships and socio-political oppression or injustice’ (pathogenic) [54, p. 9].

\(^{19}\) Although this aspect to relationality will not be discussed in any depth in this article, an example of this can be found in the McDonald [72] case. In \(R (McDonald) v Royal Borough of Kensington & Chelsea [2011] UKSC 33\), the applicant sought judicial review of the decision of her local authority to remove the provision of night time care to help her access the toilet. This service was replaced with incontinence pads. Ultimately the Supreme Court held, Lady Hale dissenting, that the removal of assistance to use the toilet was lawful, and did not violate the applicant’s article 8 rights. On the analysis presented here, the provision of night time care would be indicative of enabling a maximally autonomous decision under the circumstances (the circumstances being that Elaine McDonald was not able to use the toilet without such assistance). Removal of the night time assistance reduced her ability to act in a maximally autonomous way. On the spectrum of autonomy presented in this paper, night time carers would represent a step towards maximal autonomy, incontinence pads would be on the spectrum somewhere below this. Of
Ageism in Care and its Impact on Self-relations

If ‘ageism’ refers to a set of attitudes towards an individual (or group of individuals) solely based on age then logically it denotes attitudes towards someone of any age, but importantly it must be because of their age. The empirical research suggests that the main features of the prevailing stereotype of the older person, the focus of this paper, are as being less capable and of lower status, [39, 80], or as Butler enunciates, ‘senile, rigid in thought and manner, old-fashioned in morality and skills…’ [9, at p. 35]. It is interesting to note for the purposes of this paper, then, that the prevailing ageist and negative stereotype of the older person is as someone who lacks the ability to act autonomously; who is entirely dependent on others. At the core of this representation, as with any stereotype, is a lack of individual recognition, preferring to consider older people, and the older population as a homogenous group, and burdensome [80]. This highlights the first of two key distinctions that emerge from the literature on ageism; the contrast between ‘macro’ and ‘micro’ level ageism. These terms denote the levels on which ageism may operate; ‘macro’ referring to ageism found on a broad organisational or societal level such as in the media or popular culture, whereas ‘micro’ level ageism denotes ageist attitudes held by individuals. Macro ageism may frequently buttress micro level ageism, but more invidiously, it may be hidden under the guise of other objectives, such as health care rationing policies. Although ‘macro’ ageism will not be discussed in detail here, it is important to be aware that individual ageism may be frequently reinforced, and caused by, macro level ageism. The second, more critical, distinction that emerges from the literature is between attitudes and behaviours; the difference is ‘between ageism, which is a feeling or belief, and age discrimination, which involves behaviour or treatment’ [41, p. 12]. Clearly these two concepts are not entirely unconnected; age discrimination will, for the most part, naturally happen as a result of ageism. As has been established, the focus in this paper is on the way ageism, that is, the attitudes underpinning actions such as age discrimination, impacts on the autonomy of an older person. The way ageist attitudes affect autonomy is a far more interesting concept, and difficult to pinpoint, than the way age discrimination or actions affect autonomy. If a doctor withholds information about a particular

Footnote 19 continued
course this case also highlights how difficult courts would find it if they had to uphold only maximal autonomy, especially in light of increasing fiscal constraints on social care provision: [11].

20 A continuous feature of empirical research in this area suggests that older people are continuously homogenized and misrepresented, or portrayed negatively in popular culture in many countries [82, 84].

21 Recent proposals by the National Institute for Clinical Excellence (NICE) [24, 61], for example, suggest taking into consideration a treatment’s ‘wider societal benefit’, such as the patient’s capacity to return to work, as well as unpaid activities such as child-care, volunteering and domestic work. These proposals could potentially be ageist on two counts. Firstly, by placing these considerations at the centre of treatment decisions it places greater value on younger generations, who are more likely to be engaged in activities such as those listed above. Secondly, the term ‘wider societal benefit’ brings with it the assumptions that those who do not qualify are of little ‘benefit’ to society. Although not explicit, the ageism implicit in NICE’s proposals are both etymological and substantive; they reflect and reinforce the more broader assumptions made about older people as disengaged or unproductive, and of little social value [16].

 Springer
treatment from an older patient because of the patient’s age, and because he does not think it is a worthwhile treatment for someone ‘old’, the link between the withholding of information and how the patient’s autonomy is compromised is easy to see; the patient does not have access to information that enables the exercise of autonomy.\footnote{This is not a purely hypothetical example. Evidence of such practices have been highlighted in particularly in the following reports: [20–22, 46].} Similarly, if an older person residing in a care home is subjected to physical or verbal abuse by someone who knows that, because of their age, they are unable to defend themselves, and threatened with ‘repercussions’ if they tell, it is not difficult to see how this may directly threaten their autonomy either. The scope of this paper is to highlight how a decision may \textit{appear} unproblematic on an individualistic account of autonomy, but casting a relational lens on the decision, and in particular an account which emphasises the importance of self-relations within autonomy, demonstrates how autonomy may be threatened by the impact negative attitudes about old age have on an individual’s self-relations. In order to do this, it will be helpful to consider two brief examples:

Elizabeth, 83, lives in a nursing home. Although she generally does not mind living there, there is one carer who is rough when attending to her, calling her a ‘whingeing old bag’ and when asked by Elizabeth to be less rough, replied by saying, “Shut up, you have to take this sort of treatment at your age, you’re not really a human anymore, you’re just an animal”.\footnote{Similar facts were found in recent Nursing and Midwifery Council fitness to practice hearings: [65, 66].} Elizabeth does not report the incidents because she believes that the treatment is to be expected now she lives in a nursing home. To Elizabeth the conduct is perfectly normal; she \textit{is} less worthy of respect because she is ‘old’ and lives in a care home. The attitude that because of her age this sort of behaviour is acceptable has been normalised.

Cassie, 70, is diagnosed with early stage breast cancer. She expresses concern for the total mastectomy that her doctor recommends, and indicates that her preference would be for a lumpectomy instead. Upon hearing her thoughts, her doctor laughs at her and asks ‘Why worry about keeping your breasts at your age?’ Cassie relents, and believes her doctor will think she is silly for wanting to keep her breasts at her age if she were to pursue her preferred treatment.\footnote{This example is derived in part from one presented by Clough and Brazier’s in their recent article [16, p. 3]. This is also a good example of the ‘macro’ and ‘micro’ level ageism distinction highlighted above; the doctor’s ageist attitude may well have been informed by broader assumptions about older people, particularly older women, as ‘asexual’ [19, 80].}

In both of these scenarios there is clear wrongdoing. It could be argued that Elizabeth’s decision not to denounce what is effectively verbal abuse is not fully autonomous, as she seems to have mistaken beliefs relating to what is to be expected in her circumstances. Cassie’s autonomy, too, may be questioned, particularly if the range of options the doctor offers her is limited based on her age. The analysis in this paper, however, seeks to highlight how the \textit{attitudes} behind either the carer or the doctor’s actions, (of the carer or of the doctor) may threaten Elizabeth and Cassie’s autonomy. Can the concept of relationality point us in the direction of how to account for the ways in which the attitudes that underpin the wrongdoing in these
scenarios may also constitute a threat to Elizabeth and Cassie’s autonomy? More specifically, can the concept of self-relations shed any light on this matter? The perspective derived from relational autonomy is that self-relations instil a confidence in ourselves to act with authority; they enable us to validly consider ourselves as authors of our own lives, and makers of our own decisions. If, then, we are not able to view ourselves as a ‘…competent deliberator…’ it is hard to see how one can take oneself seriously in one’s practical reasoning about what to do’ [2, p. 132]. This argument sits ill-at ease with individualistic accounts of autonomy, which simply require a set of functional procedural conditions to be fulfilled before an agent can be considered autonomous. The two ideas (self-relations and procedural or individualistic autonomy), however, are not wholly incompatible or irreconcilable. So, in order to be able to reflect critically on a particular choice or decision, relational autonomists who assert the importance of positive self-relations might suggest that we must also possess a self-confidence that we have the ability to reach a minimum level of critical reflection in the first place, or therefore that a decision made in light of a lowered sense of self-worth may not be maximally autonomous. If a procedural account of autonomy requires us to rely on our critical reflection and on our capacity for critical reflection, then this dual reliance is only possible if we have self-trust and self-worth [38, pp. 103–104]. Simply going through the procedural motions would render autonomy a vacuous concept. Without self-trust or self-worth, we may very well be acting autonomously on the procedural account, but the decisions would not necessarily mean anything to us. Furthermore, if negative self-relations also affect our ability to view ourselves as someone worthy of respect and therefore deny our personal authority with which to act with conviction when making decisions, this is counterintuitive given the very reason we value autonomy in the first place. If, as argued earlier, the value of autonomy is in its ability to enable us to live a life that is authentically ours, then not having trust or confidence in our ability to make decisions that serve that purpose clearly goes against this very value. Negative self-relations seemingly preclude us from being able to realise the very reason we attribute worth to the concept of autonomy in the first place. It is these aspects of self-relations that may be damaged by ageism, through an internalisation of the attitudes, such as weakness, worthlessness or inferiority, which may underpin such actions, as demonstrated in the two examples. The older person, such as Elizabeth or Cassie in the examples above, may no longer have the reflective or evaluative abilities required to act with a maximal degree of autonomy, because she has internalised the ideas and assumptions based on her old age and this in turn precludes her from viewing herself as a competent agent, or someone worthy of being considered a competent or valuable agent in her own right by others. To be clear, the analysis provided here does not necessarily suggest that on every occasion where there are ageist attitudes will there be a threat

25 This argument has been made previously in relation to victims of domestic violence. See, for example, [76, pp. 453–454].

26 Of course, she may very well retain the potential to become a maximally autonomous agent if her cognitive functioning remains maximally operative: [4, p. 658]. The argument presented here is not concerned with the way that oppression may hinder our cognitive development.
to maximal autonomy;\textsuperscript{27} the important factors here is that there will almost certainly be a threat to maximal autonomy when the ideas espoused by the ageist attitudes have been \textit{internalised}, or normalised, by the older person and this has, in turn, affected her decisions.

So, to return to the examples provided above, in Elizabeth’s scenario the \textit{attitudes} espoused by the carer have threatened Elizabeth’s autonomy because of what it has instilled or reinforced in her; a lowered sense of self-worth in that she now believes she is less deserving of a respectful attitude because of her advanced age and the consequences of her old age (living in a nursing home). She effectively has a lowered sense of self-worth based on her old age. In turn, this has taken away her ability to see herself as a competent, worthwhile agent, and critically reflect over the decision to report or not. Similarly, Cassie now has a lowered sense of self-worth as a result of having internalised the attitudes expressed by her doctor; she views her physicality, and more specifically her female embodiment, as less important now because she is older. The internalisation of the ageist attitudes held and espoused by her doctor has influenced her decision into one that she may have otherwise made differently. Objectively, she may display what appears to be rational, un-coerced\textsuperscript{28} self-determination, but an appeal to the model of relational autonomy presented in this paper allows us to recognise that her negative self-relations preclude her from making a maximally autonomous decision over her choice of treatment.\textsuperscript{29} This is, of course, only one analysis of Cassie’s situation. There may, and almost certainly will be, additional factors in her decision-making, part of which is discussed below in a contrasting scenario. However, the possibility that ageism may operate in a way that is perhaps more subtle than in, for example, the first scenario, should alert us to explore more intricately the different facets of what autonomous decision-making in healthcare means for older people, as Donnelly advocates \textsuperscript{26}.

Consider an alternative example, whereby instead of maintaining silence because she feels she is older and worthless, Elizabeth recognises that the actions of her carer are wrong, and that she doesn’t deserve such treatment solely because she lives in a nursing home. However, she chooses not to report the behaviour because overall, she likes the nursing home and doesn’t want to be seen as a troublemaker,\textsuperscript{30}

\textsuperscript{27} Although this may very well be the case. For example, if an older person is discriminated against because of an age based rationing policy then this may still have an impact on that particular person’s autonomy \textit{because} of her age, but it is not akin to saying that her autonomy is curtailed because the way she views herself has changed.

\textsuperscript{28} This is to take coercion in the legal sense such as in \textit{Re T} \cite{75} where there is direct coercion by one party over another’s decision.

\textsuperscript{29} These points are of particular contemporary relevance given the increasing debate over the legalization of assisted suicide, and more specifically, the fact that the universal prohibition on assisted suicide is designed to protect those who may seek help ending their lives simply due to lowered self-worth, for example: \textit{R (Nicklinson & Anor) v Ministry of Justice} [2014] UKSC 38 \cite{73}, at 311–315.

\textsuperscript{30} Charpentier and Soulières’ recent study indicates that the desire to not be seen as a troublemaker is very much present when deciding what course of action to take by older people in residential homes: ‘I’m not doing anything to jeopardize my stay here. I like it here. So it’s best to keep quiet.’ (Mr. P., age 82 [translation]); ‘If we complain too much we get a reputation as old complainers! Grumpy old complainers! It’s easy to put negative labels on us. My philosophy is that if you want to be liked you have to be likeable. I do my best not to upset anyone.’ (Ms. M., age 96 [translation]) \cite{13}, p. 350. A similar
especially as hearing of this mistreatment would deeply upset her son with whom she has a close relationship. Similarly, let us imagine that Cassie, offended by the doctor’s words, nevertheless pursues a lumpectomy, as she does not want to undergo highly invasive treatment, which would mean taking too much time away from caring for her husband who suffers from dementia. On these facts, the choice to keep quiet or over which treatment to undergo is not because the ways in which Elizabeth or Cassie self-relate have necessarily changed. There is no indication in this example that the attitudes that underpin either the carer or the doctor’s behaviour have impacted on either Elizabeth or Cassie’s self-relations or self-identification. This does not, of course, make the actions condonable, nor does it mean that their decisions are maximally autonomous. The difference between the examples, however, is one of subjective recognition. In all instances there is an objective element to the circumstances; some form of wrongdoing has, in fact, occurred, irrespective of whether or not it is recognised as such by Elizabeth or Cassie. The key difference between the scenarios, however, is the presence of subjective recognition by individual; whether the act is subjectively recognised as improper by the person who experiences it. In the most recent example, Elizabeth subjectively recognises the impropriety of the actions but makes a conscious decision not to act on it, albeit in pursuit of the desire for a quiet life and not to upset her son; to force her to report may constitute a greater threat to her autonomy than to respect her choice not to. In the first example, however, no action can be taken (by Elizabeth) because she does not recognise the wrongness of the act, or the ageism that lies behind it. Focussing on this highlights the fact that the failure to ‘see’ ageism is central to its internalisation. Indeed, recent studies [10, 13] have indicated a significant difference in the rates of mistreatment or neglect reported by staff compared to those reported by care receivers, or have explicitly demonstrated a lack of recognition by older people of conduct that is improper. This discrepancy may suggest that there has been, to some extent, an internalisation of the idea that such conduct is acceptable, or ‘normal’, for older people, particularly those who encounter such treatment within the health and social care system. More worryingly, this also implies that such conduct may consequently be significantly underreported. It is for these reasons that it is necessary, in the next section, to highlight some possible practical dimensions to translating such a theory into practice.

Footnote 30 continued

story (that of Betty) is presented by Les Bright: ‘Unhappiness and depression gave way to fear, itself accompanied by a decision to do or say nothing that would inflame the situation further’ [8, p. 193].

31 We could, of course, always argue that there is an acceptance in this example of the subjugated role, or that autonomy is compromised because Elizabeth doesn’t want to upset her son, however neither of these threats are necessarily to do with the attitudes underpinning the actions in the first place.

32 A study conducted in the Czech Republic by Buzgová and Ivanová [10] reported that only 11 % of care receivers noted some form of abuse, while even less (5 %) witnessed an act of mistreatment directed towards themselves or another older person in the institution. On the other hand, 27.8 % of staff surveyed noted that they themselves had psychologically abused a patient, and 42.1 % had observed another staff member psychologically and verbally abusing patients.
The Problems of Relational Autonomy: Putting it into Practice

The argument presented in this paper in terms of conceptualising the link between ageism and autonomy is largely theoretical. Nevertheless, this raises the question of how such an argument can be translated into practice. Can ageism be recognised in law or policy as a threat to autonomy, and if so, how? Clearly this task will not be easy, not least because, as mentioned earlier, the law operates so as to dichotomize autonomy through the legal concept of capacity; either an agent has capacity and is therefore autonomous in the eyes of the law, or not. In this section, however, I hope to highlight some of the practical dimensions of adopting a relational approach, which necessitates more flexibility than simply dealing with these under the rubric of mental capacity law. It is worth noting first that relationality has been criticised primarily on the basis of its potential for increased paternalistic responses [14, 45], such as mandatory reporting, or increased surrogate decision-making. John Christman [14], for example, argues forcefully that a relational approach could not only be dangerous, marginalising the voices of those who already oppressed as non-autonomous, but also because of the potential for relational autonomy to allow forcible state intervention when someone does not meet the relational model of autonomy he critiques (which will inevitably, he argues, always be the case). He summarises by suggesting that ‘[i]t is one thing to publically criticize modes of social practice that denigrate their participants, but it is another to define autonomy in a way to claim that those participants are not fully functioning agents at all’ [14 at p. 158]. Although Christman’s criticisms have intuitive force, there are a number of key points to make here. Firstly, Christman’s critique is predominantly directed towards Oshana’s account of perfectionist relational autonomy [67], which itself rests on the assumption that autonomy, like capacity, is a binary construct, and a notion that I have explicitly rejected above. The arguments in this paper rest on the construction of autonomy and autonomy capabilities more flexibly; that autonomy exists on a spectrum. The account that places self-identification as a core feature of autonomy, such as presented in this paper, by its very definition cannot rest on an either/or construction of autonomy because the way an individual self-identifies in light of external relationships is not an either/or concept. Not only does Christman’s critique predicate itself on the binary construction of autonomy then, but so does the perfectionist account that he critiques. Indeed Christman himself recognises that other relational autonomy theorists promote the existence of autonomy on a spectrum, and he quotes Nedelsky to this effect.66 Christman’s concerns, then, are perhaps best read as a critique of the perfectionist account of relational autonomy rather than a wholesale...

---

33 Christman argues that ‘[t]o label such persons as non-autonomous because they do not stand in the proper social relations to their alleged “superiors” means that deliberations about the meaning of equality and legitimate authority is circumscribed to exclude voices who are otherwise…competent and authentic in ways that the procedural account of autonomy require’ [14, at p. 157].

34 Above, n.15.

35 Above, n.17.

36 ‘While traditional accounts of authenticity refer only to the isolated agent reflecting on his or her own desires, relational accounts “think of autonomy in terms of the forms of human interactions in which it will develop and flourish” (emphasis added), [14 at p. 148], quoting Nedelsky [62, at p. 16].
rejection of all relational accounts. Furthermore, if the predominant concern with relational theories is that responses may be inadequate, insufficient or overly paternalistic, this does not necessarily mean that we should simply adopt the individualistic account of autonomy so as to avoid difficult questions about whether the responses are working or are best suited to a given task. As feminist scholars have argued in relation to law’s responses to gender inequality, it may be that the law itself in its current format is insufficiently equipped to deal with more nuanced and relevant theories. Indeed, it is arguable that such overly paternalistic responses would be a misreading of the argument presented in this paper. Adopting such responses where autonomy is compromised by the internalisation of ageist attitudes may only serve to diminish the older person’s self-relations even further. Taking decision making out of their hands compounds the idea that she is less capable by removing control over the decision to a third party. Such a response only asks whether the person’s autonomy is compromised or not when in fact a legal response should be addressing why autonomy is compromised on those particular set of facts. By exploring the threats to autonomy in more detail, be they ageism-related or not, the courts (if we are to seek a legal response) are better able to respond in a way that emphasises the task of promoting maximal autonomy. As Friedman argues in relation to domestic violence, the best response may very well be to bolster the agent’s self-relations so that not only is she able to recognise instances of such mistreatment, but also, and perhaps more importantly in light of the arguments put forward here, she is able to recognise the negative attitudes that underpin such acts. One method of achieving this sort of outcome in England and Wales, however, may be by utilising the High Court’s inherent jurisdiction. The decision of the Court of Appeal in DL confirmed that the inherent jurisdiction has survived the implementation of the Mental Capacity Act as a ‘safety net’ to protect those who may not lack capacity under the Mental Capacity Act’s provisions, yet nevertheless remain vulnerable because of other factors. Although rightly avoiding the impossible task of providing an exhaustive list of when an adult may be considered ‘vulnerable’, the court in DL explicitly recognised that instances of ‘elder abuse’ may meet this

---

37 See, for example, Naffine.

38 This has been a predominant criticism of mandatory reporting systems to tackle elder abuse: [30, 48].

39 It is questionable whether such a response can be effected by the law. This would, of course, depend on the type of interference suffered warranting legal intervention, which is why I am tentatively advancing this suggestion. Whether the law (in the form of the inherent jurisdiction or the MCA) should intervene in turn raises questions as to when the law ought to intervene. Clearly it would be impossible, and undesirable, to suggest that the court involves itself wherever it suspects ageism, particularly as ageism and its effects may well be very subtle and unidentifiable. In light of this, it is also important to explore alternative responses, such as the importance of human rights principles, the role of regulatory bodies, and the role professional education for health care workers can have in combatting ageism, which is generally outside the scope of this paper, but may provide fertile ground for further research.

40 [25] This case raised the legal issue of whether the inherent jurisdiction of the High Court remained to protect ‘vulnerable adults’ who do not fall within the remit of the Mental Capacity Act 2005. The case concerned an elderly couple who had been subjected to mistreatment by their son, DL, but nevertheless who retained capacity under the Mental Capacity Act. The Court of Appeal held unanimously that the inherent jurisdiction had survived notwithstanding the implementation of the Mental Capacity Act.

41 [25, at 61], citing Lord Donaldson terminology in Re F (Mental Patient: Sterilisation) [1990] 2 AC 1.
criterion and therefore be sufficient to invoke the jurisdiction.\footnote{42 A full analysis of the remit of the jurisdiction post-Mental Capacity Act is beyond the scope of this article, and has been discussed elsewhere \cite{47}. However if, in theory at least,\footnote{43 In reality it is impossible to conceive of a decision that is made completely free from external pressures and therefore the most that can be hoped from any legal intervention is a removal of external pressures that may render the decision unauthentic.} its primary function remains to ‘[facilitate] unencumbered decision-making…free of external pressure’ \cite{50, at 62}, under the arguments presented here the inherent jurisdiction, buttressed by other policy measures such as state appointed advocates,\footnote{44 Such advocates can be appointed in certain circumstances to those who lack capacity under the Mental Capacity Act ss. 35–41, however it may be that one response is to expand the role of such advocates to be included within the inherent jurisdiction. For a general overview of the benefits of a state appointed advocate system for people with disabilities, see \cite{33}.} or a system of supported decision-making as found in other jurisdictions,\footnote{45 See, for example, \cite{49, 68}.} may be better suited to understanding and encompassing ageism and promoting maximal autonomy for older people. The responses suggested here may, in addition, be better able to promote \textit{positive} relationships. The Court of Protection in the case of \textit{London Borough of Redbridge v G} \cite{52, 53} has recently highlighted the role of positive relationships within older peoples’ lives. The case concerned a 94-year old lady, G, who had been subjected to coercion at the hands of her live-in carer, C, and it fell to the Court of Protection to determine whether G lacked capacity under the Mental Capacity Act, or if not, whether it would be possible to invoke the inherent jurisdiction to protect her from C’s influence. There are criticisms to be made of the judgments handed down by Russell J in this case, notably the fact that G was found to have dementia and therefore lacked capacity under the Mental Capacity Act, when in reality the clear cause of her ambivalent decision-making was C’s influence. However, one feature of the judgments does bear thinking about further and is a welcome acknowledgment of how positive relationships can build positive self-relations. For nearly 80 years G had been a member of the same church, and at points Russell J even refers to G’s relationship with the church and her fellow churchgoers as being her ‘church family’ \cite{52, at 84}. The emphasis that Russell J places on G’s positive relationships with members of her church is timely; it indicates a welcome acknowledgement by the Court of how relationships may operate to promote a person’s wellbeing and sense of self. In light of the decision in \textit{Aintree},\footnote{46 \cite{1} The case concerned the application of Aintree University Hospitals NHS Foundation for a declaration that it would be in David James’ best interests to have certain intrusive medical treatments withheld in the even of a deterioration in his clinical condition (he was, at the time of the application, in a state of low consciousness). Mr James’ family, however, argued that while they understood that he could never regain full health, he still gained some pleasure from his current quality of life, in particular the visit from his family and friends. The Supreme Court found that when determining ‘best interests’, a subjective approach should be favoured. They also noted, however, that the Court of Appeal, despite erring in taking an objective stance, had, in fact, been correct to overturn the original decision given that Mr James’ condition had deteriorated by the time the case reached the Court of Appeal, and it would no longer be in his best interests to provide invasive life-sustaining treatment by that point.} where it was held that decision-makers, in determining what course of action would be in a patient’s best interests under the Mental Capacity Act, must take into consideration a person’s welfare in ‘the widest
sense, not just medical but social and psychological' [1, para. 39], there is no reason why a similar approach may not be adopted by the courts in relation to other vulnerable adults, such as those whose autonomy may be threatened by the internalisation of ageist attitudes. Notably, Russell J’s decision in this particular case demonstrates an acknowledgment of the importance of (re)developing positive relationships to promote a person’s wellbeing. Surely a recognition therefore that this in turn enhances their autonomy, and that autonomy is therefore not a binary concept would be the next logical step in this process? Along with accentuating the need to minimise ageism, the arguments presented in this paper also logically indicate that positive social networks should also be emphasised further in any response, whether it is a judicial, social or policy response, to ageism-encumbered decision making. It is promising to note that following Aintree and London Borough of Redbridge v G, the courts are perhaps gradually beginning to understand the importance of such relationships when making decisions, and particularly care-related decisions.

Concluding Remarks

By using a relational lens, the arguments presented in this paper have sought to illustrate how ageism, understood as a set of attitudes about older people or an individual older person, may be internalised and threaten autonomy. There will, of course, be additional factors involved in any decision-making process for older people. The aim here has not been to disentangle all these factors. It is to specifically draw attention to how ageist attitudes, as just one of these factors, may threaten an older person’s autonomy. In order to be cognisant of this what we must ask is not ‘how can ageist attitudes in health and social care be understood in light of the existing individualistic model of autonomy’? The answer to this is that these accounts of autonomy are not adequately suited to this task. What we should be asking is, ‘how can autonomy be (re)-constructed so as to address the effect of ageist attitudes within health and social care?’ This, in turn, potentially has broader ramifications; we should not try to fit the issues that older people face into existing legal and ethical frameworks, but we should be developing new ones to account for and deal with these issues.

References


47 By using Aintree as an analogous case here, I am not advocating the use of the Mental Capacity Act in such cases. There are, of course, those where the older person may well lack capacity under the Act’s provisions, however the use of Aintree is simply to highlight that holistic and semi-relational approaches to an individual’s welfare have begun to be recognized by even the highest appellate court in other contexts, and therefore there is no impediment, at least in theory, as to why this type of approach could not be taken elsewhere.
50. *LBL v RYJ and VJ [2010] EWHC 2665 (COP).*
74. Re C [1994] 1 All ER 819.
75. Re T (Adult: Refusal of Medical Treatment) [1993] Fam 95.
The good, the bad, and the ‘vulnerable older adult’

Laura Pritchard-Jones

To cite this article: Laura Pritchard-Jones (2016) The good, the bad, and the ‘vulnerable older adult’, Journal of Social Welfare and Family Law, 38:1, 51-72, DOI: 10.1080/09649069.2016.1145838

To link to this article: http://dx.doi.org/10.1080/09649069.2016.1145838

Published online: 24 Feb 2016.
The good, the bad, and the ‘vulnerable older adult’

Laura Pritchard-Jones
School of Law, University of Manchester, Manchester, UK

ABSTRACT
Recent declarations by the Court of Appeal indicate that the inherent jurisdiction has survived the implementation of the Mental Capacity Act 2005 for adults considered ‘vulnerable’ and whose decision-making is threatened by reasons other than mental impairment – such occasions may include instances of elder abuse. In this paper I argue, however, that the post-Mental Capacity Act courts have adopted a confused and outmoded concept of the vulnerable older adult, in particular where decision-making is threatened by abusive interpersonal relationships experienced by an older individual. This has particular implications in terms of the types of remedies imposed by the courts on older adults in such circumstances. In this article I suggest that by being more cognisant of recent more nuanced understandings of vulnerability, the courts may be better suited to identifying, and responding to perceived sources of vulnerability in a way that is more empowering for the older adult.

KEYWORDS
Capacity; decision-making; elder abuse; inherent jurisdiction; older adults; vulnerability

CONTACT Laura Pritchard-Jones laura.pritchard-jones@manchester.ac.uk

© 2016 Taylor & Francis

Introduction
The mistreatment of older adults, sometimes termed ‘elder abuse’ is frequently defined as ‘a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person’ (World Health Organisation, 2002, p. 3; see also Dixon et al., 2010) and encompasses a broad spectrum of abuse such as psychological, physical, financial and sexual. Recent studies (O’Keeffe et al., 2007) place the prevalence of such abuse as between 2.6–4%. The impact such abuse has on an older individual, and particularly an older adult’s decision-making ability, is becoming an increasing concern for policy-makers and academics alike, with emphasis being placed on how such abuse may engender a fear of reprisals in its victims, as well as affecting their self-esteem and self-worth (Joint Committee on Human Rights, 2007; Ch. 8; Mowlam, Tennant, Dixon, & McCreadie, 2007; Ch. 5–6; Pritchard-Jones, 2014). Before 1 April 2015, identifying and responding to the domestic abuse of older persons was a matter left to local authorities, under the No Secrets (Department of Health, 2000) guidance published in 2000. This minimal approach to safeguarding has been heavily criticised; in 2008 the Commission for Social Care Inspection reported that the existing legal framework for
adult protection is ‘neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years’ (Commission for Social care Inspection, 2008, para. 2.1). As a consequence, calls were made for a comprehensive statutory safeguarding scheme (Herring, 2012; Williams, 2008), which the Care Act 2014 now aims (but, as shown below, fails) to achieve by placing an obligation on local authorities to make enquiries where an adult who, by virtue of his or her ‘needs’ is considered at risk (s. 42 Care Act 2014). 1

At the same time, it is now beyond doubt that the High Court’s inherent jurisdiction has survived the implementation of the Mental Capacity Act (KC v Westminster City Council [2008] EWCA Civ 198; DL v A Local Authority [2012] EWCA Civ 253), and exists alongside the Act to protect those whose decision-making is threatened by reasons other than an ‘impairment of, or disturbance in the functioning of the mind, or brain’ (Mental Capacity Act 2005 s. 2(1)), or to authorise a detention of those who do not come within the deprivation of liberty safeguards under the Mental Capacity Act 2005 (An NHS Trust v Dr .A [2013] EWHC 2442 (COP)). According to Munby J:

… the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent. (Re SA (Vulnerable Adult with Capacity: Marriage) [2005] EWHC 2942 (Fam) at para. 77).

Central to the more recent interpretations of the inherent jurisdiction, then, is this notion of the ‘vulnerable adult’ and despite the long history of this term in law and policy, it is only recently that the philosophical literature has begun to grapple with what it means to be ‘vulnerable’, and question its predominant construction in this context. The recent arguments put forward are that vulnerability is both universal and particular (Fineman, 2008; Fineman & Grear, 2013); a feature that is inherent in all persons by virtue of our embodiment albeit experienced differently by each individual, rather than a term to denote certain sub-groups of the population such as the elderly or those with physical or cognitive impairments.

If existing safeguarding law and policy fails to make sufficient attempt at providing a comprehensive statutory framework for tackling such abuse, and its effect on decision-making, as commentators have noted (Clements, 2015; Collingbourne, 2014), then it may well be that local authorities and the courts increasingly resort to the inherent jurisdiction to safeguard those older adults who experience abusive interpersonal relationships that affect their decision-making, and who do not fall within the scope of the Mental Capacity Act. Indeed, the Court of Appeal has recently noted as such: ‘[t]here is, in my view, a sound and strong public policy justification for [the retention of the inherent jurisdiction alongside the Mental Capacity Act]. The existence of ‘elder abuse’ … is sadly all too easy to contemplate’ (DL v A Local Authority [2012] EWCA Civ 253 at para. 63). In light of this it is important for the Court invoking the inherent jurisdiction to have a clear and consistent approach as to who it considers a ‘vulnerable older adult’. This paper builds upon recent literature applying the ‘new’ vulnerability analysis in other domains (Clough, 2014; Mackenzie & Rogers, 2013; Peroni & Timmer, 2013; Stychin, 2012), as well as existing critiques of the inherent jurisdiction (Dunn, Clare, & Holland, 2008; Herring, 2009), by exploring recent case law involving older adults, and in particular by focusing on three key cases: 2 DL ([2011] EWHC 1022 (Fam); [2012] EWCA Civ 253), London Borough of Redbridge v G ([2014] EWCOP 17; [2014] EWCOP 485; [2014] EWCOP 959; [2014] EWCOP 1361) and NCC v
By focusing on these cases I argue that the courts are using an outmoded and confused concept of vulnerability in relation to older adults, and that this, given the ‘theoretically limitless’ (Re B (Secure accommodation: Inherent jurisdiction) (No. 1) [2013] EWHC 4654 Fam at para. 20) remedies available under the jurisdiction, is problematic in terms of the responses it envisages for instances of such abuse. By adopting a more nuanced and consistent account of vulnerability, the courts may be better suited to identifying the complex nature of decision-making for older adults who experience abuse, and will therefore be able to respond more appropriately in such instances.

The legal context of the vulnerable adult

The historical background

In 1990 the House of Lords, asserting the inherent jurisdiction, held that treatment on a mentally incapacitated adult would be lawful as long as it was necessary, and it was to be deemed necessary if it was in her best interests (Re F (Mental Patient: Sterilisation) [1990] 2 AC 1). Subsequently, there followed a number of cases authorising (or authorising the withdrawal of) medical treatment under the inherent jurisdiction for individuals who were considered unable to give valid consent by reason of mental incapacity (Airedale NHS Trust v Bland (1993) AC 789; Re MB (Medical Treatment) [1997] 2 FLR 426; Re Y (Mental Patient: Bone Marrow Donation) [1997] Fam 110) or because of coercion or undue influence (Re T (Adult: Refusal of Treatment) (1992) EWCA Civ 18). That the use of the jurisdiction was confined only to medical treatment seemed beyond doubt in 1995 by Hale J (as she then was) in Cambridgeshire County Council v R (An Adult) ([1995] 1 FLR 50). In this case, the local authority sought declarations in respect of the family of a 21-year-old woman in its care that, inter alia, it would be lawful to prevent her family contacting her. Hale J held that the declaratory jurisdiction could only be invoked to protect a legal right, and not to limit an individual’s freedom of association. Since then, however, the scope of the jurisdiction has been extended further by the courts in two marked directions. First, following Re F ([2000] EWCA Civ 192), where the Court of Appeal upheld declarations sought by the local authority to restrict the contact of an abused young woman who had a low intellectual age with her natural family, the jurisdiction has been extended to cover decisions other than medical treatment, such as deprivations of liberty (R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458; An NHS Trust v Dr A (2013) EWHC 2442 (COP)), contact (Re G [2004] EWHC 2222 (Fam); Re S [2002] EWHC 2278 (Fam)), residence (Re F [2000] EWCA Civ 192; Re S [2003] EWHC 1909 (Fam)), marriage (Re SK [2004] EWHC 3202 (Fam); Re SA [2005] EWHC 2942 (Fam)) and publication restraint (Local Authority v Health Authority [2004] 1 All ER 480).

Moreover – and particularly important now that the Mental Capacity Act 2005 provides the legislative framework for decision-making for those who are deemed to lack capacity ‘because of an impairment of, or a disturbance in the functioning of, the mind or brain’ (s. 2(1)) – the scope of the jurisdiction has seemingly affirmed the early decision of the Court of Appeal in Re T (1992) EWCA Civ 18, and has been extended to adults who are deemed unable to make decisions for reasons other than mental impairment; more recently called ‘vulnerable adults’. In Re G (Re G [2004] EWHC 2222 (Fam)), for example, the court was asked to determine whether the jurisdiction could be used to make residence and contact
orders for a 29-year-old woman, G, who had a history of mental illness and had previously been subjected to a guardianship order under section 7 of the Mental Health Act 1983. The court held, notwithstanding the fact that at the time of the hearing G had regained mental capacity as to her contact and residence, that the inherent jurisdiction could still be used to grant the declarations sought – a failure to do so would mean that G’s condition would almost certainly deteriorate and she would lack capacity again. Similarly, in Re SA (Re SA [2005] EWHC 2942 (Fam)) the question for the Family Division was whether the jurisdiction could be invoked to protect an 18-year-old who suffered from profound communication difficulties from an unsuitable arranged marriage in Pakistan, notwithstanding the fact that she had capacity to marry. In finding that it could be invoked, Munby J held that:

A vulnerable adult who does not suffer from any kind of mental incapacity may nonetheless be entitled to the protection of the inherent jurisdiction if he is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors. (Re SA at para. 79)

Who is the ‘vulnerable’ adult?

So whom does the law have in mind when it speaks of ‘vulnerable’? Central to the notion of vulnerability deployed by the courts, is the notion of an inherent characteristic meeting a risk of harm. According to Munby J in Re SA, an adult is deemed to be vulnerable if he or she is ‘unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity’ (Re SA at para. 82). In light of this, Munby J goes on to say that ‘SA is plainly a vulnerable adult. She is substantially handicapped by her disabilities. And, particularly because she is deaf and dumb, she may well be unable to take care of herself and protect herself against significant harm or exploitation … ’ (Re SA at para. 120). The approach adopted by Munby J in Re SA has been cited with approval by subsequent courts grappling with cases involving older adults (City of Sunderland v PS and CA [2007] EWHC 623 (Fam); DL v A Local Authority and Ors [2012] EWCA Civ 253), and is one that is not uncommon more generally in the case law. In LBL v RYJ (LBL v RYJ and Anor [2010] EWHC 2665 (COP)), for example, which involved capacity determinations in respect of a young woman who had suffered brain damage at birth and had significant learning difficulties, the court cites a report prepared by the educational psychologist which states that ‘[the individual] has an extremely low IQ, [is] unlikely to be capable of leading a fully independent adult life and in this respect will need help, support and care for the foreseeable future. Her limitations make her vulnerable’ (LBL v RYJ at para. 38).

Similarly, in Local Authority X v MM and KM (Local Authority X v MM and KM [2007] EWHC 2003 (Fam)), the issue was whether MM, who suffered from paranoid schizophrenia and a moderate learning disability, had decision-making capacity with regard to, inter alia, residence, contact and marriage. In his decision, Munby J again ties vulnerability to being at risk of abuse and states that ‘the appropriate role of the law here is to protect the vulnerable, who as such may become easy targets for abuse or who may find themselves in exploitative contexts … ’ (Local Authority X v MM and KM at para. 130). In doing so, he refers to the case of Dudgeon v UK (Dudgeon v UK (1981) 4 EHRR 149). Albeit a case that involved the criminalisation of homosexuality, the European Court of Human Rights in Dudgeon offers an illustrative account of vulnerability as deriving from an inherent characteristic, which is cited with approval by Munby J:
There can be no denial that some degree of regulation … can be justified as ‘necessary in a democratic society’… to provide sufficient safeguards against exploitation and corruption of others, particularly those who are specially vulnerable because they are young, weak in body or mind, inexperienced, or in a state of special physical, official or economic dependence’ (Dudgeon v UK (1981) 4 EHRR 149 at para. 49).

Moreover, Munby J’s approach in Local Authority X v MM and KM automatically ties being ‘elderly’ in with being ‘vulnerable’ – in para. 120 alone he links being ‘elderly’ with being ‘vulnerable’ together three times.

This approach to vulnerability – the presence of an inherent characteristic found in an individual such as their old age or a cognitive impairment, which is deemed to bring with it a risk of harm – is also one that arises in other legal contexts involving older adults. In Watts v UK (Watts v UK (2010) 51 EHRR SE5), for example, which involved a challenge by a 106-year-old woman to the proposed closure of her care home, the court states that:

[T]he presence of cognitive impairments … makes the individual particularly vulnerable, for no matter how much work is done to explain the situation and to help them come to terms with the situation, all that work may be lost because of the failure to register and to remember … these vulnerability factors increase the risk of adverse reactions to the relocation stress … (Watts v UK (2010) 51 EHRR SE5 at para. 53)

In LLBC v TG, JG and KR (LLBC v TG, JG and KR [2007] EWHC 2640 (Fam)), a case concerning the residence of TG, a 78-year-old gentleman with dementia, vulnerability is linked to the fact that TG is ‘elderly’ and ‘infirm’ (LLBC v TG, JG and KR at para. 40).

This idea that a vulnerable adult is someone who is unable to protect herself because of an inherent characteristic, such as age or cognitive impairment, is also one that appears in adult safeguarding policy more generally. No Secrets, the safeguarding policy framework recently superseded by the Care Act 2014, defined a vulnerable adult as:

[S]omeone who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation (emphasis added). (Department of Health, 2000, para. 2.3)

Similarly, s. 42 of the Care Act 2014 now places a statutory obligation on local authorities to make enquiries where it has reasonable cause to suspect that an adult is in need of care and support, is experiencing or is at risk of experiencing abuse or neglect, and the needs that the individual has render him or her unable to protect him- or herself from the abuse or neglect (s.42(1)(a)–(c) Care Act 2014). Both the approach taken to vulnerability by the inherent jurisdiction cases (and the broader cases) then, as well as the policy and statutory provisions surveyed here, present vulnerability as being at risk because of an inherent characteristic – or, more recently under the Care Act 2014, because of something that renders them ‘in need’ of care and support – an impairment, so to speak. In effect, vulnerability depends first and foremost on the existence of an inherent characteristic, which then renders an adult at risk of harm.

(Re)-conceptualising vulnerability

This idea of ‘vulnerability’ (or ‘adult at risk’) promulgated both by the courts and safeguarding law and policy more generally, then, is two-dimensional – the meeting of an inherent characteristic, such as disability or age, with a risk of being subjected to some form
of harm. In essence, an individual must be vulnerable because of something (an internal characteristic), to something (risk of abuse or neglect). The problems with this approach to vulnerability, particularly for older people, are multiple. If part of what renders an older person vulnerable is his or her age, or the impairments that are associated with advanced age such as frailty, or an illness like dementia, as has been alluded to in Watts v UK, LLBC v TH, JG and KR and Local Authority X v MM and KM, and cited with approval in DL, then it seems to follow that simply belonging to a group with that particular characteristic (i.e. old age, frailty or dementia) indicates that the individual is ‘vulnerable’. While an older person, or a person with dementia, may experience a level of vulnerability that a younger person, or a person without dementia does not experience, the approach outlined above fails to make reference to exactly what it is about old age or dementia, for example, that impacts on the ways in which an older adult experiences vulnerability. For example, an older woman with late-stage dementia who resides with her abusive husband in a rural area with limited access to medical treatment and facilities, and who is cared for by a series of different carers provided by a private care agency, will experience vulnerability in a different way to an older man with early stage dementia but who lives with his lovingly devoted wife who cares for him well, and with many high-quality medical facilities nearby. In the first scenario, the woman’s experience of vulnerability may be compounded because of the different intersecting layers: her gender, the abuse she suffers from her husband, the lack of continuity of care, her geographic location and lack of facilities. The dementia of itself does not necessarily render her vulnerable. In other words, the current two-dimensional approach criticised above fails to recognise the multiple sources of an older individual’s particular experience of vulnerability, and may therefore place the older person at risk of an inadequate response to ‘perceived’ sources of vulnerability. In essence, internal characteristics themselves do not generate vulnerability; it is inadequate support mechanisms that generate the experience of vulnerability.

Furthermore, the approach currently promulgated by law and policy is grounded in, and reinforces the essentialising and stigmatising properties of both vulnerability (Peroni & Timmer, 2013), and old age. Tying vulnerability to an internal characteristic such as old age, or a cognitive impairment such as dementia, for example, which are themselves loaded with negative connotations (see for example: Isaksen, 2002; Johnstone, 2013; Martens, Goldenberg, & Greenberg, 2005; Snyder & Miene, 1994), reinforces the idea that being vulnerable (or being at risk) is a ‘bad thing’, a weakness, a fault or something to be feared, as old age, and features or conditions associated with old age have come to be seen. This approach was perhaps most obviously adopted in a recent judgment by Newton J, who stated that, ‘the Court of Protection is concerned with the weak and the vulnerable’ (emphasis added) (A Healthcare NHS Trust v P and Q [2015] EWCOP 15 at para. 7).

Empirical research in fact mirrors the recent theoretical literature on vulnerability, and suggests that many of those tasked with caring for older adults envisage vulnerability as a positive state of being (Steinbock-Hult & Sarvimäki, 2011) – a state that gives rise to opportunities for growth and care. At the same time, the association between ‘traditional’ vulnerability and old age, also mutually reinforces the stereotypical view of old age itself, as well as the need for care and support in old age, as something to be feared, something ‘bad’, or as a negative state of being. This outmoded approach to vulnerability, as Luna (2009, p. 124) argues, is a ‘simplistic answer to a complicated problem’; it belies the universal nature of what it is to be vulnerable, that is, vulnerability exists in each individual, not just those
with certain characteristics. If vulnerability is being at risk of a particular harm or threat, then it exists in every individual by virtue of our embodiment and corporeality, which renders us susceptible to any physical and emotional harm (Butler, 2004, 2010; Gilson, 2014). It exists because of our interdependence – our relationships with others, and even because of the ways in which the society we inhabit may be structured – for example, certain power imbalances may render us susceptible to being harmed. It is this particular feature of vulnerability, the idea that in order to be vulnerable you must be susceptible to something, that Fineman (2008) argues, in fact makes the concept a universal one – one that inheres in all of us, not just certain individuals based on a certain characteristic.

This idea of vulnerability as universal, or as a quality associated with human corporeality, again is not purely theoretical or abstract. Recent empirical research suggests that this alternative conceptualisation of vulnerability in fact has some practical weight – that in relation to older people, vulnerability is characterised by those tasked with caring for older people as simply ‘being human’, and furthermore is not only experienced by the older person as previous constructions of vulnerability would indicate, but is also experienced by caregivers for older adults (Sarvimäki & Steinbock-Hult, 2014; Steinbock-Hult & Sarvimäki, 2011).

**Vulnerability and the older adult**

The most recent cases that give an indication of the courts’ current approach to the vulnerable older adult (and vulnerability more generally) are the three cases that form the analysis for this paper; *A Local Authority v DL, London Borough of Redbridge v G* and *NCC v PB. DL* concerned the treatment of an elderly couple (ML aged 90 and GRL aged 80) by their son, DL, with whom they lived. There had been concern by the Local Authority since 2005 of physical assaults, verbal threats and controlling behaviour by DL, which included controlling the visits by care professionals to his mother, ML, as well as concerns of financial abuse (*A Local Authority v DL, ML, GRL and JP* [2011] EWHC 1022 at para. 6). It was agreed by the Local Authority that neither ML nor her husband, GRL, lacked capacity as to residence and contact with their son under the Mental Capacity Act (although by the time proceedings reached the High Court it was agreed that GRL did lack capacity: *A Local Authority v DL and Others* [2011] EWHC 1022 (Fam) at para. 2), and proceedings were therefore commenced under the inherent jurisdiction. The issue for the courts to determine was a legal one: had the inherent jurisdiction survived the implementation of the Mental Capacity Act 2005? In a unanimous decision the Court of Appeal held that it had.

Since *DL*, two cases in particular involving older adults have arisen where applications were lodged, in part, under the inherent jurisdiction on the basis of the older adult’s vulnerability. *London Borough of Redbridge v G* concerned a lady of 94, G, who lived with C, and C’s husband, F, to whom she had been introduced through membership of her local church. There had been concerns over G’s welfare for a number of years following allegations that C was acting in an overbearing and verbally abusive manner, as well as allegations of possible financial abuse, resulting in five safeguarding referrals between March 2011 and May 2013. The issues that fell to the Court of Protection to be determined were multiple, over a series of judgments, and included, *inter alia*, whether G had capacity as to litigation, her financial affairs, contact with C and F, and contact with the press. Following a determination by Russell J that she lacked capacity as to these issues (*London Borough of Redbridge v G* [2014] EWCOP 485), it was subsequently held that it would be in her best interests to place
restrictions on her contact with both C and F and the press (London Borough of Redbridge v G [2014] EWCOP 17) and orders were granted requiring C and F to move out of G’s property.

NCC v PB and TB concerned an application, again lodged under both the Mental Capacity Act and the inherent jurisdiction (in the event that PB was deemed not to lack capacity under the Mental Capacity Act), concerning, inter alia, the residence of PB, a 79-year-old woman, who had been married to TB for a number of years. There were concerns over PB’s lifestyle with TB, which included unsanitary living conditions, being abandoned on ‘road trips’ and abusive behaviour by TB towards PB. The issue to be determined by the Court was whether she lacked capacity to decide where to live under the Mental Capacity Act or whether her decision-making was fatally impaired because of the nature of her relationship with TB, thereby invoking the inherent jurisdiction. Parker J, sitting in the Court of Protection, found that she lacked capacity under the Mental Capacity Act, and authorised her residence in a care home based on this finding. Both London Borough of Redbridge v G and PB then, concerned individuals with what was deemed to be an impairment or disturbance in the functioning or the mind or brain: G was deemed to have dementia, whilst PB was deemed to have residual schizophrenia or schizo-affective disorder, a diagnosis on which the two experts could not agree (NCC v PB [2014] EWCOP 14 at para. 59), which led the Court of Protection in both cases to hold that they were not capable of satisfying the remainder of the functional test for capacity (s. 3 Mental Capacity Act 2005).

**Outdated vulnerability**

At first glance, the outcome of these cases may seem intuitively appealing – the facts of the cases are highly emotive, and the decisions represent a desire to safeguard older adults from what appear to be abusive relationships, where there are unequal power relations at play, and, as shall be shown later, recent accounts of vulnerability do not necessarily require the courts to take a back-seat or non-interventionist stance. However, the heavy reliance on outdated conceptualisations of vulnerability by the courts in these cases indicates that the judiciary has not made huge strides forwards in their understanding of the vulnerable older adult.

The use of the term vulnerability as a descriptor in these cases illustrates this point well. ‘Vulnerability’ in London Borough of Redbridge v G, for example, is frequently deployed as a descriptor alongside ‘old’, ‘frail’, ‘elderly’ and ‘incapacitous’. In the capacity hearing, Russell J describes G as an ‘old, vulnerable lady’ (London Borough of Redbridge v G [2014] EWCOP 17 at para. 12). In discussing the reporting restrictions, Russell J states that ‘I have done so to protect the privacy of G who is old, frail and vulnerable’ (emphasis added) (London Borough of Redbridge v G [2014] EWCOP 485 at para. 50). In a later hearing, Cobb J holds that ‘There is … a legitimate public interest in the reporting of proceedings in the Court of Protection concerning our vulnerable, elderly and incapacitous. There is a separate legitimate public interest in the court protecting the vulnerable, elderly, and the incapacitous from public invasion into their lives’ (emphasis added) (London Borough of Redbridge v G (No. 2) [2014] EWCOP 959 at para. 19). This, again, mirrors similar descriptive approaches taken by earlier decisions involving older adults, outlined above. The association of vulnerability with old age, and certain corporeal or cognitive impairments associated with old age such as frailty or incapacity (this point will be returned to in a short while), indicates that the courts are deploying the term as a concept that attaches to those who demonstrate such characteristics. In effect, a return to the status or characteristic-based vulnerability criticised above.
This approach to vulnerability is perhaps most starkly (and worryingly) illustrated in PB where, in discussing whether she could have invoked the inherent jurisdiction if PB had not lacked capacity under the Mental Capacity Act, Parker J states that:

‘Unsoundness of mind’ is not the same as ‘incapacity’. PB has a diagnosed psychiatric condition which compromises her decision making. If it is not established that she lacks capacity this would be on the narrowest interpretation of MCA 2005 (‘because of’) and would not impinge upon her diagnosis or her vulnerability, which results from her psychiatric condition. (Emphasis added) (NCC v PB and TB [2014] EWCOP 14 at para. 119)

Although obiter, given that PB was deemed to lack capacity under the Mental Capacity Act, Parker J’s approach here is firmly rooted in the idea that vulnerability stems from PB’s psychiatric condition and is again reminiscent of the status based approach to vulnerability. Parker J’s assertions indicate that the jurisdiction retains a role in respect of those who do suffer from psychiatric conditions but where their impairment does not mean they lack capacity under s.2(1) of the Mental Capacity Act.15 This, combined with the approach in London Borough of Redbridge v G, where vulnerability status was linked to G’s age and physical or cognitive characteristics, indicates that the courts in these cases continue to view vulnerability as resulting from an inherent characteristic, such as age or, as Parker J specifically states, a psychiatric condition. Tying vulnerability to an individual’s inherent characteristic, such as dementia in London Borough of Redbridge v G, or her schizoaffective disorder in PB, presents the court with an easier task than having to engage with the messy reality of the various intertwined factors that contribute to their experience of being vulnerable at an individual level, such as PB’s attitudes towards marriage and her husband, or the fact that G’s reluctance to have C and F removed as her carers may be because she believes her home will be taken from her and she will be placed in her care home (London Borough of Redbridge v G [2014] EWCOP 485 at para. 33). For the courts, it is far easier to attribute vulnerability to something concrete, or medical, such as their age or their psychiatric condition, than it is to try and navigate through a more complex set of circumstances that these two adults find themselves in – it is Luna’s (2009) simplistic answer to a complicated problem in a very practical setting. The Court of Appeal itself in DL even acknowledges that it is easier to identify internal characteristics that generate vulnerabilities, with MacFarlane LJ stating that ‘it is not easy to define and delineate this group of vulnerable adults, as, in contrast, it is when the yardstick of vulnerability relates to an impairment or disturbance in the functioning of the mind or brain’ (DL v A Local Authority [2012] EWCA Civ 253 at para. 64).16

In addition to this, another feature of these particular cases that demonstrate their steadfastness to a status or characteristic approach to vulnerability is in the way they characterise the relationship between ‘vulnerability’ and ‘incapacity’. As noted earlier, prior to the implementation of the Mental Capacity Act, the inherent jurisdiction had developed to protect those whose decision-making was impaired because of mental incapacity. Following Re G and Munby J’s decision in Re SA, however, it is obvious that mental incapacity is not the only basis on which to invoke the jurisdiction, or upon which a person can be vulnerable. According to Munby J in Re SA:

[I]t can be seen that the inherent jurisdiction is no longer correctly to be understood as confined to cases where a vulnerable adult is disabled by mental incapacity from making his own decision about the matter in hand … [t]he jurisdiction, in my judgment, extends to a wider class of vulnerable adults. (Emphasis added) (Re SA at para. 76)
Munby J’s approach, quoted here, is explicitly endorsed by both the High Court and the Court of Appeal in DL (A Local Authority v DL [2011] EWHC 1022 (Fam) at para. 53(4); A Local Authority v DL [2010] EWHC 2675 (Fam) at para. 19; DL v A Local Authority [2012] EWCA Civ 253 at para. 53).17 Although ‘the confluence of mental impairment and undue influence is not all that unusual’ (Re BKR [2015] SGCA 26 at para. 88), as the Singaporean Court of Appeal recently noted, in the cases discussed here, however, the judiciary has a tendency to exhibit semantic confusion as to the distinction between experiencing vulnerability, particularly when experiencing abusive relationships in old age, and being incapacitated (or lacking capacity). In the very first paragraph of the capacity judgment in London Borough of Redbridge v G, Russell J phrases the issue to be determined as whether G’s lack of capacity ‘is because of mental impairment within the meaning of the MCA sections 2 and 3 or if not whether she is a vulnerable adult deprived of capacity by constraint, coercion or undue influence …’ (emphasis added) (London Borough of Redbridge [2014] EWCOP 485 at para. 1). This idea of lacking capacity because of undue influence reappears during Russell J’s summary of the expert psychiatric and social worker evidence: ‘[b]oth [the social worker] and Dr. Barker … share the view that G’s capacity to reach decisions is undermined by the influence and presence of C and F’ (emphasis added) (London Borough of Redbridge v G [2014] EWCOP 485 at para. 1). Russell J, however, is not alone in adopting this confused approach. A similar confusion is present in the arguments made by the Local Authority in DL:

[Counsel’s] submissions have therefore been to delineate the extent of the jurisdiction so that it only covers those cases where it is necessary for the court to act because a person’s capacity to make decisions for themselves has been overborne by circumstances other than those covered by the MCA 2005. (Emphasis added) (A Local Authority v DL [2011] EWHC 1022 (Fam) at para. 50)

This argument is also one accepted by the Lord Justices in DL, with MacFarlane LJ stating that ‘[n]othing in the MCA 2005 makes express provision with respect to individuals who may lack capacity for a reason other than an impairment of, or disturbance in the functioning of, the mind or brain’ (emphasis added) (DL v A Local Authority [2012] EWCA Civ 253 at para. 58).18

This approach is also implicit in PB. In her summary of the expert evidence regarding PB’s capacity, Parker J states ‘… Dr. Barker is not certain about the extent to which PB’s decisions may be based on her beliefs about marriage, and to what extent TB’s influence leads her to be incapacitous all the time’ (emphasis added) (NCC v PB and TB [2014] EWCOP 14 at para. 63). To suggest that a vulnerable person can retain capacity under the Mental Capacity Act but can nevertheless be ‘incapacitated’ (and, furthermore, incapacitated ‘all the time’) because of his or her vulnerability is disingenuous for a number of reasons. First, from a legal standpoint it risks bringing in the best interests standard found under the Mental Capacity Act, with none of the safeguards contained therein19 into the court’s remit of responses in these cases (discussed in more detail below)20 – as Ruck Keene (2014) notes of the decision in PB, ‘how is such an approach to be distinguished from taking a decision on behalf of such an adult?’ It is, furthermore, worrying from an ethical standpoint. Using the term ‘incapacitated’, even in its non-legal sense, shifts the ultimate reason, or even the ‘blame’, for not being able to make an autonomous decision back to the individual who has been abused. Saying that an individual may be ‘incapacitated’ because of external forces such as coercion or undue influence indicates that it is a failure on their behalf that they are unable to make the decision – a defect within that individual’s abilities to resist external pressure, so
to speak, and, as we shall see later, risks inviting inappropriate responses, directed towards the individual who has been abused rather than the abuser. In a more recent decision, *Re DM* (*Re DM* [2014] EWHC 3119 (Fam)), Hayden J in fact stresses the separateness of the two concepts; 'I emphasise that “vulnerable” is not to be conflated with the concept of incapacitous' (*Re DM* at para. 5), and later (*Re DM* at para. 10) is keen to keep separate the remedies available under the Mental Capacity Act 2005, from the remedies available under the declaratory jurisdiction for those who are vulnerable.

How does the characterisation of the relationship between capacity (or incapacity) and vulnerability presented in *DL, London Borough of Redbridge v G and PB* support the argument presented here, namely that the courts still view vulnerability in relation to older people as being derived from an inherent characteristic? As noted earlier, in light of the Mental Capacity Act, ‘lacking capacity’ in one sense is now to be understood legally as stemming from a disturbance in the functioning of the mind or brain according to s. 2(1) of the Act. Clear examples of such things as will be considered sufficient to fulfil this criterion are given in the Code of Practice to the Act, and include medical conditions such as dementia (Department for Constitutional Affairs, 2007, para. 4.12). It is clear, then, that lacking capacity in its most common legal usage is now linked to a medical condition or cognitive impairment, something that, as noted earlier, recent vulnerability literature seeks to move away from. Characterising vulnerability as being incapacitated, as the courts do here, is reminiscent of the Mental Capacity Act approach, and risks linking an individual’s vulnerability to an internal, often medical characteristic (i.e. his or her dementia, for example) – or reflects a ‘defect’ in an older individual’s ability to resist external undue influence. Indeed, such an approach was clearly articulated in the recent Singaporean case of *Re BKR* (*Re BKR* [2015] SGCA 26), involving the capacity of an older woman to make decisions over her property and affairs, and who was alleged to have both a mental impairment and have been subjected to undue influence. The Singapore Court of Appeal held that only where there was no material question of the mental impairment causing the incapacity that the court would have no jurisdiction under the Singaporean Mental Capacity Act (*Re BKR* [2015] SGCA 26 at para. 124). In other words, wherever there is any suspicion that the mental impairment was just one of the causes of the incapacity then the issue will be determined under the Act. As I shall argue in the next section, this approach may invite inappropriate responses by the courts to perceived vulnerability.

**Inappropriate remedies for older adults**

In order to assess the implications for older people if the courts are committed to retaining an inherent characteristic, or status-based approach to vulnerability, it is important to contextualise the courts’ responses within the critiques and approaches to remedies derived from the theoretical literature. Recent theoretical stances on vulnerability do not assert that interventions or responses by the state or other individuals are unwanted; they in fact seek to move away from a non-interventionist stance (Fineman, 2004). Indeed, the recent House of Lords post-legislative scrutiny report on the Mental Capacity Act notes on several occasions that a lack of response can entrench the experience of vulnerability just as much as improper responses. What the recent vulnerability literature does seek to achieve, however, is to highlight the role that others, and, particularly for Fineman (2008, 2012) the role that the state plays in reducing the effects of external sources of vulnerability for older
people – the so-called ‘responsive state’. Mackenzie (2014) and Kohn (2014), however, go further than Fineman, and draw attention to the fact that in being ‘responsive’, the state can in itself constitute an additional source of vulnerability or further entrench an older person’s experiences of vulnerability. It has the potential for creating what Mackenzie terms a ‘pathogenic’ (Mackenzie, 2014, p. 39) source of vulnerability. This refers to the idea that socio-political or legal responses to the perceived ‘vulnerability’ of older adults may exacerbate them, or add an additional layer of vulnerability to an individual’s experience. It is this feature of vulnerability that Clough (2014) notes is especially important, ‘as it invites a deeper analysis of the impact of laws and policies – their ability to achieve their stated aims and, more importantly, to foster resilience in those rendered vulnerable’ (Clough, 2014, p. 373). In the context of this paper, these two aspects of the more recent vulnerability literature (the responsive state, and being circumspect of pathogenic vulnerability) are especially important as they indicate a need to consider the types of remedies imposed in these particular cases, and an analysis of whether such responses constitute pathogenic sources of vulnerability in themselves – in other words, do they entrench the older person’s vulnerability more than no response or an alternative response? This is especially pertinent to explore, in light of other recent inherent jurisdiction decisions which envisage its task as being ‘facilitative’ rather than ‘dictatorial’, an approach that may perhaps be more in line with recent conceptualisations of how best to respond to vulnerability in older adults and mitigating ‘pathogenic’ vulnerability.

First, as argued earlier, the courts’ current approach attributes an older adult’s vulnerability to an inherent characteristic, and suggests that the inherent jurisdiction retains a role for those who suffer from psychiatric conditions but where the condition does not mean they lack capacity under the Mental Capacity Act (see also An NHS Trust v Dr. A [2013] EWHC 2442 (COP)). A review of the statistics concerning the presence of psychiatric conditions in old age reveals why the implications of this position may be extensive for older adults. It is well recorded that the number of older adults with cognitive or mental impairments is increasing in England and Wales; the number of adults with dementia in the UK currently stands at around 800,000 and is expected to rise to over 1 million in 2025, and nearly 2 million in 2051 (Alzheimer’s Society, 2014a, p. viii). Furthermore, it is predicted that in those over the age of 85, one in five will be diagnosed with dementia (Alzheimer’s Society, 2014b). Although perhaps the most obvious, dementia is not the only psychiatric condition that affects older adults. Recent studies indicate that severe depression, anxiety disorders and lifetime alcohol disorders are also common in those over the age of 65 (Büchtemann, Luppa, Bramesfeld, & Riedel-Heller, 2012; Skoog, 2011; Volkert, Schulz, Härter, Wlodarczyk, & Andreas, 2013). As a result of this we can expect increased legal activity as to their decision-making over the coming years, and as has been noted recently in Deprivation of Liberty Safeguard applications (Gordon, Goldberg, & Harwood, 2015; Health and Social Care Information Centre, 2014). Whilst the majority of this activity may well, at present, be dealt with under the Mental Capacity Act, the approach of the courts in these cases indicates that even if those with psychiatric conditions are not necessarily found to lack capacity under the Mental Capacity Act, they still remain ‘vulnerable’ based on the presence of a psychiatric condition and could be subject to orders under the inherent jurisdiction regardless of the fact that they legally still have capacity. From a purely statistical perspective, attributing vulnerability for the purposes of the inherent jurisdiction to an internal characteristic such as a psychiatric condition has potentially significant implications for older adults – and may
mean that, if they are at risk of harm, their decision-making may be more readily and easily scrutinised by the courts, a position already advanced by Munby J.23

Secondly, in A Local Authority v A, which involved the decision-making ability as to contraception of a woman with serious learning difficulties who was also in a seemingly overbearing marriage, as well as in LBL v RYJ, the courts held that the purpose of the inherent jurisdiction was ‘to facilitate the process of unencumbered decision-making’ (LBL v RYJ at para. 62), and to ‘create a situation where … she can receive outside help free of coercion to enable … her to weigh things up and decide freely what … she wishes to do’ (A Local Authority v A at para. 79). However, the result of the reasoning by Parker J, outlined above, is to the effect of stating that a residence order could still have been placed on PB by virtue of the fact that she had a psychiatric condition, even if she had not lacked capacity under the Mental Capacity Act:24

In my view the inherent jurisdiction does extend to orders for residence at a particular place … Assuming that it would not constitute an unlawful deprivation of liberty in my view I would be entitled to make an order for placement against her will pursuant to the inherent jurisdiction. There are serious risks to PB if she is not properly cared for or if she is not protected against TB. (NCC v PB and TB at paras 121–122)

Given the confusion the courts have between vulnerability and incapacity demonstrated above, this approach (stating that a decision made in PB's best interests under the Mental Capacity Act could also be authorised by invoking the inherent jurisdiction) is perhaps unsurprising. Ethically, however, it is problematic as a remedy imposed on PB does little to highlight and respond to the external features that may compromise her decision-making – preferring to respond to a threat that is based on her perceived inherent vulnerability, i.e. her cognitive impairment. This is, again, not only at odds with remedies provided in cases such as DL, where injunctions were granted against the son (as opposed to the parents), but even London Borough of Redbridge v G, where injunctions were granted against C and F, not G, but it is even incompatible with previous cases such as A Local Authority v A, where undertakings were directed towards enabling Mrs A to make a decision as to contraception away from the influence of her husband. Authorising PB’s detention in a care home based on her ‘inherent’ source of vulnerability may in fact render her susceptible to other (pathogenic) sources of vulnerability. Given the value she places on her marriage, she may feel disempowered or exposed based on not being able to reside with her husband, or in her own home – an aspect of moving to care homes that is frequently reported by older people in empirical research (Biedenharn & Normoyle, 1991; Gott, Seymour, Bellamy, Clark, & Ahmedzai, 2004; Lee, 1997; Lloyd, Calnan, Cameron, Seymour, & Smith, 2014) or she may even develop negative relationships with staff in the care home, even more likely given her original reluctance to live there.

Finally, and as touched upon earlier, the approach taken by Parker J may also be seen as envisaging a ‘best interests’ approach for the inherent jurisdiction. Apart from being paternalistic, a criticism often levied at any ‘best interests’ standard (Dunn, Clare, Holland, & Gunn, 2007; Fennell, 2008; Szerletics, 2012),25 this type of approach is problematic both legally,26 and theoretically, in light of the aims of the recent vulnerability literature on a number of counts, particularly for older people. If A Local Authority v A and LBL v RYJ are correct, then ‘the goal of the jurisdiction is to safeguard decision-making, rather than to safeguard well-being per se’ (Keywood, 2011, p. 331). If this is indeed the case, then the proper remit of the jurisdiction is to facilitate maximally autonomous decision-making
for older adults and a ‘best interests approach’ does not necessarily sit comfortably with the aims of vulnerability theory for older people, which emphasise empowerment and self-development, and therefore recognising effective ways in which we can promote such responses among the older population, as opposed to taking decision-making out of their hands (Fineman, 2012; Hall, 2014). A more nuanced vulnerability approach for older individuals focuses our attention on the ‘conditions necessary for developing and maintaining [a specific set of] capacities’ (Dodds, 2007, p. 504).

The decision in PB, however, arguably fails to recognise this in a way that is empowering for PB herself, by stating that whilst the inherent jurisdiction ‘exists to protect, liberate and enhance personal autonomy … [t]o be maintained in optimum health, safe, warm, free from physical indignity and cared for is in itself an enhancement of autonomy’ (NCC v PB and TB at para. 113). While it may be argued that this is correct from an objective standpoint, the way someone should want to make a decision objectively is irrelevant, the relevant issue framed by more nuanced accounts of vulnerability is how PB herself wants to make a decision, and calls for a legal response that supports this decision-making process. In particular, the approach demonstrated by the courts explicitly derides the value she places on her marriage and her ability to reside with her husband, notwithstanding his controlling behaviour, and arguable lack of understanding of her medical needs. At paragraph 63, cited earlier, for example, Parker suggests that she is uncertain as ‘to what extent TB’s influence leads her to be incapacitous all the time’ (emphasis added), and at other points indicates that she needs ‘protection’ from her husband because she is at risk (NCC v PB at para. 71).

In the context of the inherent jurisdiction, a responsive vulnerability theory requires a consideration of the subjective experiences of the older adult – it does not necessarily seek to escape value judgments or interference, but recommends that legal responses make such judgments from the subjective point of view of the older adult at the heart of the proceedings, rather than from an objective stance. This point becomes particularly salient when we reflect upon the multiplicity and diversity of factors that older people take into consideration when making decisions about their care (Brown, 2011; Cicirelli, 1998; Fried & Bradley, 2004; Pritchard-Jones, 2014). Comparing these three cases highlights this particular point well. In PB, PB is an individual who clearly values her interdependence and marriage to her husband over and above many other factors. In contrast, G, in London Borough of Redbridge v G, values her independence – as well as her interdependence from the relationship with her fellow churchgoers. In DL it was uncertain, even doubtful, that any of the three parties concerned wanted the litigation. ML at the very least did not want proceedings brought in respect of her relationship with her son, and whilst it was not so certain that this was the case for her husband, GRL, it was uncertain how much he would want to go against his wife’s wishes.

So what types of remedies would a responsive vulnerability analysis have envisaged? How could the courts have reacted more appropriately in the cases critiqued in this article? To put this question bluntly, how could the courts have responded to the situations encountered by GRL and ML, G and PB, in a more ‘vulnerability-friendly’ manner? One suggestion that emerges from this analysis would be to simply remove the requirement under the Mental Capacity Act that incapacity must be because of an impairment or disturbance in the functioning of the mind or the brain (Mental Capacity Act s. 2(1)). This would have the benefit of retaining the safeguards contained in the Act itself for such cases, and the aspects of the
Act that the House of Lords' post-legislative scrutiny were in favour of, but removing the association between incapacity and impairment, thereby making the Act itself applicable to situations where an individual's decision-making is threatened by elder abuse. This would mean that cases such as these could be decided under the Act, but without the artificiality of having to establish the causal nexus between the diagnostic element and the functional element of lacking capacity – thereby potentially encompassing DL-type facts.

Even at first glance, however, there are potentially a number of problems with this suggestion. First, removing this requirement from the Act does not itself automatically render the Act relevant to instances of elder abuse – the question remains ‘at what point does the state intervene in such cases’? Removing this aspect of the Act simply requires us to establish an alternative threshold over and above which the state will consider it necessary to intervene. As such, if this is a viable option, then more work must be done on how to establish what would then be the necessary boundaries of the Mental Capacity Act, or even whether such boundaries are legally realisable. Neither does such an approach conquer the problems that are encountered when faced with ‘best interests’ decision-making – it would continue to take decision-making out of an older person's hands and place it in the hands of the state – an approach rejected by the recent vulnerability literature. Moreover, neither does such an approach adequately address the concerns raised earlier regarding the ethical implications of conflating external threats to decision-making such as abuse, with perceived internal ‘failures’, such as impaired functional capabilities.

Finally, given that the Mental Capacity Act ‘is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further … the court has no greater powers than the patient would have if he were of full capacity’ (Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67 at para. 18), an alternative suggestion would be to retain the inherent jurisdiction for cases such as these, but make greater use of the breadth of remedies available under the jurisdiction. In London Borough of Redbridge v G, it is welcoming to note the local authority's assurances of home-care for G, given her fears about moving to a care home (London Borough of Redbridge v G [2014] EWCOP 17 at para. 43), and the Court's emphasis on re-integrating G with her church community (London Borough of Redbridge v G [2014] EWCOP 17 at para. 83), as well as the removal of C and F from G's home. However, given the clearly detrimental effect both C's conduct and the legal proceedings had on G, and the court's rejection of her consistently expressed wishes for C and F to remain in her home, perhaps the court could also have explicitly considered the possibility of offering ongoing emotional support and advice, such as counselling, to the extent that G would have been willing and able to accept such offers, and to the extent that these are not already provided within the care package available to G. Similarly, in PB, rather than simply authorising her residence in a care home with limited supervised contact with her husband (NCC v PB at para. 123), the court could potentially have explored alternative options such as providing secure community living arrangements and an appropriate care package, as well as less restricted contact with TB.

These suggestions may be, in principle, more sensitive to the ‘responsive state’ envisaged by Fineman. In light of the recent decision in Re MN (Re MN [2015] EWCA Civ 411), however, where the Court of Appeal held that the Court of Protection ‘… has no more power, just because it is acting on behalf of an adult who lacks capacity, to obtain resources or facilities from a third party … than the adult if he had capacity would be able to obtain himself’ (Re MN [2015] EWCA Civ 411 at para. 80), it may be that the courts are progressively moving
in the opposite direction, at least where an individual lacks capacity under the Mental Capacity Act. It remains to be seen whether the court would take this line if faced with a similar case under the inherent jurisdiction, and if it did, then this would also indicate that the jurisdiction’s remedies are not ‘theoretically limitless’, after all.

**Concluding remarks**

’Society must guard against excesses that might ironically deny the elderly their autonomy by forcing it upon them’ (Kapp, 1989, p. 5). This was the warning issued by Marshall Kapp in 1989. Following DL, there does seem to be a clear commitment to retain the inherent jurisdiction to safeguard the decision-making of older adults, particularly for those who have been the victims of ‘elder abuse’, but the argument presented in this paper is that the court’s approach to the vulnerable older adult is confused, and remains grounded in historical and outdated ideas of what it means to be ‘vulnerable’. Moving forwards in developing the jurisdiction for the vulnerable older adult who may be the victim of ‘elder abuse’, the courts may be wise to heed Kapp’s warning. In turn, this paper suggests that the retention of the jurisdiction is not necessarily unwelcome and may well be more flexible than the Mental Capacity Act in responding to compromised decision-making for older adults who experience abuse, but in order to be that responsive a more nuanced understanding of what it means to be vulnerable, and in particular what it means to be a vulnerable older person is required. Given the fledgling nature of the post-Mental Capacity Act cases on the scope of the inherent jurisdiction, the arguments put forward here are tentative, but in turn serve to highlight broader ethical and legal issues for further research. What is the interplay between the jurisdiction, vulnerability and human rights principles? Can the inherent jurisdiction provide a better, more appropriate way of thinking about cases of ‘fluctuating capacity’, such as dementia? Unfortunately only when the courts begin to engage the jurisdiction rather than forcing such cases under the Mental Capacity Act will these areas open up for discussion, and will we be able to envisage a more responsive judiciary. At present, however, we will have to wait and see just how ‘responsive’, and in what way, the courts are willing to become.

**Notes**

1. The Serious Crime Act 2015 has also recently received Royal Assent, and criminalises coercive or controlling behaviour in intimate or family relationships (s. 76 Serious Crime Act 2015). Given that this is yet to be enacted, it remains to be seen to what extent this provision will also support the obligations incumbent on local authorities by virtue of the Care Act.

2. It is worth noting at the outset that only DL was in fact decided using the jurisdiction. London Borough of Redbridge v G and PB were decided under the Mental Capacity Act, but, nevertheless, PB contained lengthy discussion of the jurisdiction before its ultimate rejection, and London Borough of Redbridge v G provided interesting comments on vulnerability. This point, and the difficulty it presents in blurring the legal boundaries of ‘capacity’ and ‘vulnerability’, will also be discussed further in this paper.

3. Whilst the aim of the paper is to examine the construction of the ‘vulnerable older adult’ in these cases, and examine the broader legal implications of this for the development of the inherent jurisdiction more generally, the arguments presented may apply to other ‘groups’ traditionally considered vulnerable, and how these particular cases interplay with other inherent jurisdiction cases will form a key feature of the analysis.
4. Hale J held that the declaratory jurisdiction could only be invoked to protect a legal right and not to limit an individual’s freedom of association. To this effect, Hale J explains a legal right in the context of this particular case by stating that, ‘It is access, or freedom of association, rather than harassment, or freedom from association, which is protected under English law’ (emphasis in original): Cambridgeshire County Council v R (An Adult) ([1995] 1 FLR 50 at p. 52). She goes on to say that ‘[i]t is clear … from the troubling circumstances of this case that there exists no wholly appropriate legal mechanism for examining whether or not W should be free to make her own decisions in the vital matter of her relationship with her family … it is a sad state of affairs that the law is unable to provide suitable protection in such a situation’: Cambridgeshire County Council v R (An Adult) ([1995] 1 FLR 50 at p. 56).

5. R v Bournewood Community and Mental Health NHS Trust, ex parte L ([1999] 1 AC 458) was subsequently ruled unlawful by the European Court of Human Rights in HL v UK ([2004] ECHR 471), which led to the Deprivation of Liberty Safeguards being inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007. More recently, however, see An NHS Trust v Dr A [2013] EWHC 2442 (COP).

6. This approach was endorsed by the Court of Appeal in DL. It is also important to note the broad brush approach that Munby J takes to this idea of vulnerability, though. Despite this definition, he also states that it is difficult to delineate the group he considers vulnerable (Re SA at para. 77), and that the definition he has given is ‘descriptive, not definitive; indicative rather than prescriptive’ (Re SA at para. 82). The particular wording used by Munby J also mirrors the statutory approach under s. 29(1) of the National Assistance Act 1948, although the Act does not use the term ‘vulnerability’ explicitly, s. 29(1) states that ‘[a] local authority shall have power to make arrangements for promoting the welfare of persons … who are blind, deaf or dumb, and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.’ I would like to thank Kirsty Keywood for bringing this point to my attention.

7. Adopting the language of the Wolfenden Report; (Committee on Homosexual Offences & Prostitution, 1957) cited by Munby J in Local Authority X v MM and KM [2007] EWHC 2003 (Fam) at [128].

8. The language used by the Court is adopted from the Jolley (2003) Report.

9. This approach itself was adopted from Who Decides (Lord Chancellor’s Department’s, 1997), the green paper on decision-making for mentally incapacitated adults, which ultimately led to the enactment of the Mental Capacity Act 2005.

10. What exactly the Act means by ‘enquiries’, however, is left unexplained; the guidance for implementation simply refers to ‘whatever enquiries [the local authority] thinks necessary to decide what if any action needs to be taken and by whom’ (Department of Health, 2014, para. 14.57), and explains that ‘enquiry’ could mean any number of things from an informal chat with the individual in question, right through to a ‘much more formal multi-agency plan or course of action’ (Department of Health, 2014, para. 14.64). Secondy, the Act repeals s. 47 of the National Assistance Act 1948, which provided local authorities with a power of removal of a vulnerable adult, but does not replace this with any other provisions such as a power of entry. In this respect the Care Act arguably falls short in comparison with the provisions in both the Scottish (Adult Support and Protection (Scotland) Act 2007) and Welsh (Social Services and Well-being (Wales) Act 2014) legislation (Fitzgerald & Ruck Keene, 2014).

11. The approach to vulnerability based on the presence of internal characteristics is not one that is peculiar to social welfare law and policy, though. For example, the current offences of willful neglect or ill-treatment found in s. 44 of the Mental Capacity Act and s. 127 of the Mental Health Act 1983 are ones that apply when a person lacks capacity, or the perpetrator reasonably believed that person lacked capacity (i.e. because of an impairment of, or a disturbance in the functioning of, the mind or brain according to s. 2(1)), or when an individual is being treated for a mental health disorder. This remains the legal position until ss 20 and 21 of the Criminal Justice and Courts Act 2015, which provide for general offences of willful neglect or ill-treatment by health care workers or health care providers, enter in to force. For a critique of the scope of the current offences, as well as their utility, see Alghrani, Brazier, Farrell,
Griffiths, and Allen (2011); House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013–14 (2014) at paras 301–309; Hansard, HL Deb 10 March 2015, Vol. 760, Col. 631. Similarly, the offence of causing or allowing the death of a vulnerable adult under s. 5 of the Domestic Violence Crime and Victims Act 2004 applies only to an adult who is ‘vulnerable’ under its terms; ‘a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise’ (s. 5(6)). Likewise a similar definition is to be found in the Safeguarding Vulnerable Groups Act 2006 s. 56(9) which states that an individual may be vulnerable if, inter alia, he has ‘particular needs because of his age,’ ‘has any form of disability’ or ‘has a physical or mental health problem’ (s. 56(9)(a)–(c)). Dunn et al. (2008) also note the use of this characterisation of vulnerability not only in relation to the inherent jurisdiction but also to ‘vulnerable witnesses’ in the criminal justice system.

12. The use of the phrase ‘experience vulnerability’ as opposed to ‘be vulnerable’ is important. On the account of vulnerability presented here, it is important to distinguish between the two. More recent vulnerability theory, which emphasises the role of external factors, align more to an understanding of vulnerability as being experienced, however an account of vulnerability that looks at an internal characteristic (which more recent accounts, including the one advanced here) gives the overwhelming impression that vulnerable is something an individual can ‘be’. It is the former understanding of vulnerability that this article adheres to and as such the term ‘experience vulnerability’ is deliberately used here.

13. There was also a question over PB’s refusal of an endoscopy, however this was not ultimately an issue to be decided by the court as PB voluntarily underwent the procedure (NCC v PB and TB at para. 124).

14. See in particular the judgment of Munby J in Local Authority X v MM and KM at para. 120: ‘The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with.’

15. If this is the case, then we could question whether it is accurate, from an administrative point of view, as counsel for DL did on appeal (DL v A Local Authority (2012) EWCA Civ 253 at paras 36–39), but which was rejected by the Lord Justices (DL v A Local Authority (2012) EWCA Civ 253 at para. 57–63).

16. This functional approach has also been heavily criticised by the Committee on the Rights of Persons with Disabilities: ‘it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right’: UN Committee on the Rights of Persons with Disabilities, General Comment 1, CRPD/C/GC/1 at para. 15.

17. It is precisely because vulnerability differs from mental incapacity that the courts in both Re G and Re SA felt the need to make the declarations it did; neither G nor SA lacked mental capacity, but both were at risk of harm. In G’s case it was the risk of losing her capacity again should she have unrestricted contact with her father, and for SA it was the risk of harm if she was forced to enter in to a marriage.

18. This is despite earlier references to vulnerability that MacFarlane LJ makes, which align vulnerability to autonomy, rather than capacity: ‘The jurisdiction…is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity …’ (DL v A Local Authority (2012) EWCA Civ 253 at para. 54). This latter conceptualisation of vulnerability as pertaining to autonomy may be more in line with recent theoretical accounts.

19. For example, the decision made must be carried out in the least restrictive way (Mental Capacity Act s. 1(6)), or the list of relevant factors to be considered when making the decision (s. 4(6)).

20. The legal consequences of this approach were argued forcefully by counsel for DL (DL v A Local Authority (2012) EWCA Civ 253 at paras 36–41), although this argument was not accepted by the Lord Justices. See also Hewson (2013).

22. In particular I discuss the difference between the approach of the courts in the cases that form the focus of this paper, in comparison with the approach in LBL v RJY and A Local Authority v A ([2010] EWHC 1549 (Fam)). It is also important to note, however, that the arguments put forward here do not advocate for a non-interventionist approach, i.e. a reinforcement of the public-private divide. What this article seeks to highlight is that intrusion may be welcome, but vulnerability theory has the potential for illustrating more appropriate types of remedies.

23. ‘[A]n adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult is not on the face of it vulnerable’ (Re SA at para. 83).

24. And, furthermore, would still have been compliant with article 5 of the European Convention on Human Rights. Her reference to ‘unsound mind’ is in light of the requirements of article 5(1)(e) of the European Convention, which stipulates that a person may be deprived of their liberty in accordance with a procedure prescribed by law if they are of unsound mind. We can question how wide the court in PB envisages the term ‘unsoundness of mind’ and whether this would, then, extend beyond those who have psychiatric conditions to also include those who have been subjected to coercion or undue influence. An analysis of how broad ‘unsoundness of mind’ may be framed is beyond the scope of this paper, however it is worth noting that the Winterwerp criteria require someone of unsound mind to be suffering from a ‘true medical disorder’ established by ‘objective medical expertise’ (Winterwerp v The Netherlands [1979] 2 EHRR 387 at para. 39).


26. Although outside the scope of this article, it is important to note that without any provision of review for PB’s detention, this approach subverts the current procedural requirements that exist under the Deprivation of Liberty Safeguards and may also therefore be unlawful under the European Court of Human Rights ruling in HL v UK ([2004] ECHR 471). Had this case been decided under the inherent jurisdiction, however, and Parker J had put in place measures for the court to review her detention (as happened in An NHS Trust v Dr A, then this approach, being more stringent procedurally than the review mechanisms found in the Deprivation of Liberty Safeguards, may in fact be more human rights compliant. I would like to thank Beverley Clough for drawing my attention to this last point.

27. I would like to thank Paul Skowron for highlighting this possibility.

28. Indeed abandoning the inherent jurisdiction as a means of safeguarding decision-making for older people could potentially be in violation of state obligations under article 8 of the European Convention, as the Court of Appeal held in DL ([2012] EWCA Civ 253 at para. 66). For an argument that the jurisdiction may certainly be better equipped for dealing with the capacity of adults with mental impairments to consent to sexual relations see Clough (2014).

**Acknowledgements**

I would like to thank the anonymous reviewer for his or her positive comments on this article, as well as Kirsty Keywood and Simona Giordano for their insightful observations on earlier versions. I would also like to thank Beverley Clough and Paul Skowron for their remarks and support in drafting the paper.

**Disclosure statement**

No potential conflict of interest was reported by the author.
References


Lord Chancellor's Department. (2007). *Old age* (or, do we need a critical theory of law and aging?). *Constructing risk and selling death in an ageing society*. Farnham: Ashgate.


