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Court-ordered obstetric intervention: Capacity, Consent and Compulsion

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2022

[This thesis is up to date until 1st March 2022.]

List of Abbreviations

LSMT – Life-saving medical treatment

MCA – Mental Capacity Act

MHA – Mental Health Act

SMI – Serious mental illness

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Introduction

Overview

In *Re MB* [1997],[1] Lady Butler-Sloss stated that:

> *'The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, chose not to have medical intervention, even though… the consequence may be the death or serious handicap of the child she bears or her own death.'*[2]

However, over 20 years has passed since this 'ground-breaking' judgment and case after case calls into question how effectively this right is protected in practice. There has not yet been a case in which a pregnant woman has been found to have the requisite capacity to refuse a caesarean section where this has been recommended by her clinician. I therefore agree with Pattinson's contention that there 'is room for cynicism about whether the courts are truly acting according to their declared principles…'[3]

Throughout this thesis, patient autonomy and choice are heralded as important values that should be respected and upheld in medical decisions. The term 'autonomy' will be used to refer to the 'right to hold views to make choices and to take actions based on [your] personal values and beliefs.'[4] In obstetric cases I argue that pregnant women's autonomy is insufficiently respected and unfairly restricted. The obstetric case law paints a picture of control as opposed to empowerment. Thomson argues that while judges claim to be upholding pregnant women's autonomy, 'in reality they are seeking to find a way to rule in favour of protecting the foetus…'[5] Case law evidence supports this suggestion, as judgments are riddled with reference to the wellbeing of the unborn child, which I shall argue infiltrates the judges reasoning and endorsement of treatment.[6] In order for this situation to improve the underlying issues of protection and paternalism need to be tackled. The aim of this change is to reach the point where pregnant women are allowed to make decisions that are perceived as 'wrong' like any other patient.[7]

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[1] *Re MB (Caesarean Section)* [1997] 2 FLR 426.
[2] Ibid, [60].
[3] Shaun Pattinson, *Medical Law and Ethics* (5th edn, Sweet & Maxwell 2017) 154.
[4] TL Beauchamp and JF Childress, *Principles of biomedical ethics* (6th edn, OUP 2009) 99.
[5] Ruth Thomson, 'The Right to Refuse a Caesarean Section: Is the Law Abiding by Its Own Rules' (2015) 2 *Edinburgh Student Law Review* 15, 19.
[6] *Re AA (Mental Capacity: Enforced Caesarean)* [2012] EWHC 4378.
[7] Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (1st edn, Routledge 2016) 220.

The main purpose of this thesis is to progress knowledge and understanding of the problems that continue to exist in obstetric cases. The delivery of this thesis will mostly be explanatory in nature. The structure of the thesis is three-fold and as follows; firstly, to demonstrate that notwithstanding dicta to the contrary, a 'problem' exists in obstetric cases, secondly to explain the current manifestations of this 'problem' in judgments and finally to suggest solutions to tackle this broad-ranging 'problem'. The ideas proposed in chapter IV are introductory in nature, rather solidified solutions to the problem. A further thesis would be required to sufficiently explore and develop these options.

Caesarean Section

A Caesarean section is an operation to deliver a baby through a cut made in the stomach and womb. It is usually either a planned procedure or done in an emergency if it is thought that vaginal birth is too risky.[8] In recent years there has been a move to protect women's choice to opt for a caesarean birth, particularly following the Supreme Court decision of *Montgomery v Lanarkshire* [2015][9] where a woman who was denied the option of caesarean section was recognised as being deprived of her right to an informed decision. However, a caesarean section is an invasive operation and therefore comes with several of its own risks. As Thomson indicates, caesarean sections can 'dramatically increase the risk and incidence of maternal death.'[10] Michalowski identifies specific statistics that support this statement. She notes studies that have demonstrated that '9 to 15 per cent of Caesarean sections result in serious maternal morbidity…'[11] and that 'the risk of maternal mortality is between 2 and 11 times higher with a Caesarean section than it is with vaginal delivery.'[12] This demonstrates that there can be a high degree of risk attached to a caesarean section and thus 'makes unquestioning judicial acceptance of medical calls of necessity especially unsuitable.'[13]

[8] NHS, 'Caesarean Section' (27 June 2019) <https://www.nhs.uk/conditions/caesarean-section/> accessed 6 June 2020.
[9] *Montgomery v Lanarkshire* [2015] UUKSC 11.
[10] Michael Thomson, 'After Re S' (1994) 2 *Medical Law Review* 127, 135.
[11] Sabine Michalowski, 'Court-Authorised Caesarean Sections. The End of a Trend?' (1999) 1(62) *The Modern Law Review* 115, 123.
[12] Ibid.
[13] n10, 135.

Legally valid consent or refusal

Under the UK common law every person 'has the right to have his/her bodily integrity protected against invasion by others.'[14] This is to prevent any interference with an individual's body where it is unwanted and there is no legal consent to justify it. As Feldman argues 'being subjected to treatment… without one's consent is calculated to threaten one's sense of one's own worth and the feeling of being valued by others.'[15] The concept of legal consent was created to safeguard an individual's bodily integrity and autonomy. In chapter I, I will explore in further detail *why* respect for individual autonomy is an important value in medical ethics and note the potential consequences of degradation and feelings of disregard should it not be sufficiently observed.

A legally valid consent or refusal requires the patient to have capacity. The terms competence and capacity will be used interchangeably to describe the 'mental (cognitive-functional) ability to make a particular decision.'[16] Where a patient has the capacity to make a particular decision the clinician must 'first obtain the patient's consent'[17] before they are able 'to legally, carry out any form of medical treatment…'[18]

The Mental Capacity Act 2005 (MCA) 'covers people in England and Wales who can't make some or all decisions for themselves…'[19] and sets out the two-part capacity test for adults under sections 2 and 3. Section 1(2) of the MCA sets out the principle that capacity should be assumed but where this is rebutted then the individual falls under the protection of the MCA. Any decision made on their behalf must be made in their best interests by considering the factors contained under section 4, including 'the beliefs and values that would be likely to influence his decisions if he had capacity…'[20]

Where an adult has capacity, the common law has long acknowledged their right to make their own medical decisions even where they may appear contrary to their best interests. In *Re T* [1992],[21] Lord Donaldson stated that adults with capacity have 'an absolute right to choose whether to consent to

[14] Tina Lanning, 'The Caesarean Section and The Pregnant Woman's Right to Refuse Treatment' (2004) 8(2) *Mountbatten Journal of Legal Studies* 36, 48.
[15] David Feldman, 'Human Dignity as a Legal Value: Part II' (2000) *Public Law* 61, 61.
[16] n3, 136.
[17] n14, 48.
[18] Ibid.
[19] Office of the Public Guardian, 'Mental Capacity Act: making decisions' (*Crime, Justice and Law*, 22 October 2014) < https://www.gov.uk/government/collections/mental-capacity-act-making-decisions> accessed 17 July 2022.
[20] Mental Capacity Act, section 4(6)(b).
[21] *Re T (Adult: Refusal of medical treatment)* [1992] 4 All ER 649.

medical treatment [or] to refuse it…'[22] Subsequently, this principle was confirmed as applying in obstetric cases where pregnant women with mental capacity wish to refuse medical intervention by Lady Butler-Sloss in *Re MB* [1997][23] and by Judge LJ in *St George's Healthcare NHS Trust v S* [1998].[24] As a result, where a hospital trust wishes to perform a caesarean section but the pregnant woman refuses, they must respect her wishes if she has the mental capacity to make that decision. However, if the pregnant woman is found to lack the requisite capacity then the hospital trust must act in her best interests.

Hayden J has set out interim directions for when a hospital trust needs to bring an application to court pending an update to the guidance in the MCA Code of Practice. [25] Paragraph 4 of the guidance identifies section 5 of the MCA as the starting point for making decisions regarding those who lack capacity. Section 5 makes it lawful for an individual to treat a patient if they first 'take reasonable steps to establish whether the patient lacks capacity in relation to the matter in question…'[26] and therefore provides a defence against liability for the medical professional. In some obstetric cases involving women who lack capacity, section 5 might be relied upon; particularly if there is agreement between the parties as to how to proceed. However, there are certain circumstances in which section 5 may not provide a defence and an application to the court of protection is required instead.[27] The guidance also outlines the 'situations where consideration should be given to bringing an application to court...'[28] including where the proposed treatment requires 'a degree of force to restrain the person concerned…'[29] A court needs to state that this restraint is lawful otherwise it would constitute a deprivation of liberty. Altogether, this information presents the legal principles and rules that are relevant to the discussion around obstetric case law and will be referred to throughout the thesis as the legal foundation. It demonstrates why the focus is on capacity and the Mental Capacity Act 2005 in particular.

The Mental Health Act 1983 (MHA), [30] which contains the law relating to mentally disordered people is also relevant to this discussion but will not be considered in any great depth. Section 63 of the MHA states that the 'consent of a patient shall not be required for any medical treatment given to him for the

[22] Ibid, 653.
[23] n1.
[24] *St George's Healthcare NHS Trust v S* [1998] 3 W.L.R. 936.
[25] ---, 'Applications relating to medical treatment: Guidance authorised by the Honourable Mr Justice Hayden, the Vice President of the Court of Protection' [2020] EWCOP 2.
[26] n20, section 5.
[27] n25, [7].
[28] Ibid, [8].
[29] Ibid, [12].
[30] Mental Health Act 1983.

mental disorder from which he is suffering…' [31] Hoffman LJ expanded upon this principle in *B v Croydon* [1995][32] by clarifying that the treatment must 'be directly linked to the mental disorder'.[33] It is debatable whether a caesarean section could be classified as direct treatment for a woman's mental health. However, this was the reality in *Tameside and Glossop Acute Services Trust v CH* [1996][34] (discussed in section 1.4.1) when Wall J declared that the 'caesarean section could be performed without consent as treatment for mental disorder under the MHA section 63.'[35] In this case, section 63 was used as a tool for ensuring a lawful caesarean section against the wishes of the patient. Halliday describes the courts actions as 'indirectly safeguarding the foetus via the categorisation of a caesarean as a treatment for a mental disorder'.[36] The MHA will be considered in this thesis in relation to section 63 of the MHA and its suggested misapplication in these cases. The main focus of discussion is the MCA rather than the MHA because the crux of the issue is about treating delivery rather than treating mental health.

There are many complex issues interwoven in these cases including human rights within the European Convention on Human Rights and the Human Rights Act 1998. In addition, consideration should be had for the UN Convention on the Rights of Persons with Disabilities which protects those with disabilities including mental health disabilities. However, as there are many different aspects to the issue, the human rights dicta will not be covered in any depth.

The woman's rights and the foetus's interests

The rights of a patient, which includes those of a pregnant woman, have been clearly set out; where they have the requisite mental capacity they may refuse medical treatment subject to the MHA.[37] However, pregnancy is a unique situation in the sense that any medical intervention does not only impact the woman herself, but has the potential to affect the foetus she carries. Therefore, it is important to understand any interests that the foetus has in this unique situation. I will not discuss whether the interests that English Law confers to the foetus requires reform; the current position will be accepted. The focus of this thesis is to discuss whether the court is accurately applying the law in obstetric cases.

The UK adopts a gradualist approach to granting foetal interests. This means that a foetus gradually gains value until it acquires legal personhood at birth. Until a foetus is born it is granted limited status

[31] Ibid, section 63.
[32] *B v Croydon Health Authority* [1995] Fam 133.
[33] n7, 46.
[34] *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762.
[35] n14, 55.
[36] n7, 49.
[37] n1.

and is owed some positive moral duties, but not as many as an adult with legal personhood. It is not a legal person, but 'it is not treated as a valueless thing.'[38] These interests are not explicitly stated, but rather conferred through statutory limitations. Sections 58 and 59 of the Offences Against the Person Act 1861[39] and section 1 of the Infant Life (Preservation) Act 1929[40] make it a crime to procure an abortion or 'wilfully cause a child to die it has an existence independent of its mother'.[41] However, these interests are subject to the limitations under section 1(1) Abortion Act 1967[42] which details the grounds for a legal abortion. If the Act didn't place these limitations, then there would be a 'serious conflict between maternal and foetal rights…'[43] which would otherwise result in the foetus having a right to life that could potentially surpass the right of the pregnant person to determine what happens to their body. However, in the UK, statutory law gives 'precedence to the health of the mother over the unborn child...'[44] and therefore the pregnant woman's rights outweigh the foetus's interests. Ultimately the foetus 'is not (and has never been) a legal personality and is therefore afforded no legal protection'[45] against the unqualified right of a pregnant woman to refuse treatment where she has capacity to decide. At least this is the position in theory; in reality, case evidence would suggest that the foetus plays a large role in the outcome of an obstetric case.

Matthew Thorpe caveats this stance with his belief that regardless of the clarity of the law it is difficult for a high court judge to apply it in the 'heat of the moment.'[46] Indeed, evidence suggests that notwithstanding the emphasis that is placed upon a woman's right to choose treatment the judicial outcome 'will be influenced by the expert evidence as to which treatment affords the best chance of the happy announcement that both mother and baby are doing well.'[47] The 'law may rhetorically adhere to a unitary conception of personhood (which excludes the foetus) …'[48] and promote the absolute right to refuse treatment, even where the foetus may suffer harm or death however I agree with Savell's contention that 'it can nonetheless use other means to deny full personhood to pregnant women.'[49] This is the crux of the issue in obstetric cases. It is submitted that the courts can navigate the law in such a

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[38] n3, 123.
[39] Offences Against the Person Act 1861, sections 58 and 59.
[40] Infant Life (Preservation) Act 1929, section 1.
[41] Ibid.
[42] Abortion Act 1967, section 1(1).
[43] D Isaacs, 'Moral status of the foetus: Fetal rights or maternal autonomy?' (2003) *Journal of Paediatrics and Child* Health 58, 58.
[44] n1, 441.
[45] Lisa Miller, 'Two patients or one? Problems of consent in obstetrics' (1993) *Medical Law International 97, 103.*
[46] Matthew Thorpe, 'The Caesarean Section Debate' (1997) 27 *Family Law* 663, 663.
[47] Ibid, 664.
[48] Kristin Savell, 'The Mother of the Legal Person' in S James and S Palmer, *Visible Women* (Hart Publishing 2002) 51.
[49] Ibid, 56.

manner to achieve their desired outcome (the preservation of life) and thus in certain circumstances deny autonomy to the pregnant women, rather than protecting the autonomy of pregnant woman 'as their ratios proclaim, [they] operate, through their subtexts to expose the pregnant woman to covert non-legal mechanisms of disciplinary control…'[50] This is currently achieved through convenient findings of incapacity and subsequent endorsement of medical intervention through assumed best interests' determinations.

The problem

In her book 'Policing Pregnancy' published in 2005, Meredith stated that 'it is clear that although UK law ostensibly upholds pregnant women's rights to make their own decisions about medical care, provided they are judged competent, there remain serious questions about whether this theoretical support is likely to hold firm in practice.'[51] Over 10 years have passed and I argue that Meredith was right to raise concerns about whether this right to refuse would be realised in practice. As highlighted at the beginning of this thesis, there is yet to be an obstetric case in which a pregnant woman is found to have capacity to refuse a medically recommended caesarean before it takes place.[52]

I will argue that in theory the legal principles in *Re MB* are sound as the 'courts have recognised that a woman's autonomy is not diminished by pregnancy…'[53] however in practice the promotion of autonomy in pregnant women is nullified as the courts 'consistently [find] women to lack the necessary capacity to give a valid refusal…'[54] I believe that the main problem therefore lies in the judiciary's application and interpretation of the capacity test and best interests determination under the MCA. There appears to be a keen judicial desire to find an unwanted caesarean section to be lawful, stemming from the need to protect the life of the foetus. Fovargue shares this concern that 'there will only ever be one answer to questions about the mode of childbirth framed around best interests: that women must deliver in the way deemed medically "best", *regardless* of their wishes.'[55] Instead of conceding that the interests of the foetus influenced their decision, the courts find ways of proving that the pregnant woman lacks capacity and then finding that her best interests are served by ensuring the foetus's safety.

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[50] Jane Bryan, 'Reading Beyond the *Ratio*: Searching for the Subtext in the "Enforced Caesarean" Cases' in Daniela Carpi, *Bioethics and Biolaw through Literature* (De Gruyter 2011) 116.
[51] Sheena Meredith, *Policing Pregnancy* (Routledge 2005) 207.
[52] Shaun Pattinson, *Revisiting Landmark Cases In Medical Law* (1st edn, Routledge 2019) 54.
[53] n7, 93.
[54] Ibid.
[55] Sara Fovargue, 'In whose best interests? Childbirth choices and other health decisions' (2021) 137 *Law Quarterly Review* 604, 604.

A notable aspect of the case law today is the focus on pregnant women with a serious mental illness (SMI). In the obstetric cases discussed throughout this thesis there is particular attention paid to the mental health of the patients in the judgments and reasoning. For example, the patients in both *Re AA* [2012][56] and *The NHS Acute Trust v C* [2016][57] were described as suffering from bipolar affective disorder and the patient in *X NHS Foundation Trust & Anor v Ms A* [2021][58] was described as suffering from paranoid schizophrenia. The attention that pregnant women's SMIs receive has been problematic as it has influenced judgments about their capacity and best interests in unwarranted ways. An SMI does not equate to incapacity yet there is evidence of incapacity being assumed before a thorough capacity assessment has been undertaken. I also suggest that there is insufficient effort made to enable these pregnant patients to either maintain or regain their capacity so that they can take control of their own decision or at least participate in conversations. These issues will be explored further in chapters II and III.

Breakdown of Chapters

The purpose of this thesis is to explain the problems that currently exist in obstetric cases and then suggest potential reforms that could work to solve the issue. Chapter I will begin by identifying that an issue does indeed still exist within this set of case law. Subsequently, chapter's II and III will focus on how this problem manifests through the court's application of the law through flexible interpretation of both the capacity test and best interests' determination. Finally, chapter IV will suggest several ways of dealing with the issues including hard law reform, soft law reform and medical solutions.

Chapter I will begin by highlighting the new dominance of autonomy in Western medical ethics and make the case for why respect for a patient's autonomy is so important. The principle of autonomy and what I mean by its 'new dominance' will be explained in more depth in Chapter I. Discussion will then move to the case law pre-dating *Re MB* [1997] to explain the origins and emergence of the problem in obstetric case law. Subsequently I will consider the impact of Lady Butler-Sloss's judgment from *Re MB* [1997] and whether the judgment has achieved it's intended aim of not reducing the autonomy of a female patient by the fact of her pregnancy.[59] Ultimately, I will argue that the judgment has not sufficiently encouraged further empowerment of pregnant women in obstetric decisions.

[56] *Re AA (Mental Capacity: Enforced Caesarean)* [2012] EWHC 4378.
[57] *The NHS Acute Trust & The NHS Mental Health Trust v C* [2016] EWCOP 17.
[58] *X NHS Foundation Trust & Anor v Ms A* [2021] EWCOP 17.
[59] n11, 115.

Chapter II will focus on the first of the two problems that will be discussed: the capacity test. I will agree with MacLean's contention that competence is 'used as a sword by doctors and the courts instead of a shield by the pregnant woman.'[60] Instead of the court harnessing the principles of the MCA to empower women the case law is indicative of control and compulsion. Keene describes a finding of incapacity as the 'cliff-edge off which one falls into the clinging embrace of paternalism.'[61] Overall, I will suggest that the courts use the flexible provisions of the MCA to endorse findings of incapacity. '*Obstetric incapacity'* will be introduced as a concept to describe the much lower threshold that pregnant women are assessed at compared to other patients.

Chapter III will cover the second of the two problems: the best interests' determinations. I will suggest that the courts do not take the patient's wishes into sufficient consideration and instead determinations appear to be driven by the action that would best ensure the wellbeing of the foetus, masked behind justifications of ensuring the pregnant woman's mental and emotional wellbeing.

The final chapter, chapter IV, will consider a wide range of solutions that could work to improve the situation in obstetric cases. I will not advocate for one 'magic' solution, but rather for multiple changes at various levels to help address the overarching paternalism. It will not be possible to cover every potential solution, but a mixture of hard law reform, soft law reform and practicable medical solutions will be proposed in relation to the problems raised in chapter II and III.

[60] A Maclean, 'Caesarean Sections, Competence and the illusion of autonomy' (1999) 1 *Web Journal of Current Legal Issues* 4, 11.
[61] Alex Ruck-Keene, 'Capacity is not an off-switch' (2015) https://www.mentalcapacitylawandpolicy.org.uk/capacity-is-not-an-off-switch/ accessed 13 September 2020.

Chapter I: Promoting obstetric autonomy: The contribution of *Re MB* [1997]

1.0 Introduction

Halliday contends that 'nothing has changed since the end of the twentieth century… the golden principle of medical law (patient autonomy) is just as compromised as it ever has been.'[62] I agree with Halliday's contention and will attempt to confirm this assertion throughout this thesis. *Re MB* [1997][63] might have ostensibly resolved the question of exceptionalism that applied to pregnant women in obstetric situations, however, notwithstanding this judgment I will demonstrate in chapter's II and III that alternative mechanisms have been found to protect the foetus. I will contend that a problem does still exist in obstetric case law and that as a result, pregnant women's autonomy is not being sufficiently championed.

In this chapter the background and origins of the problem will be set out. The obstetric case law in the 1990s will be discussed to demonstrate the manner in which pregnant women's autonomy and choice was often overridden. I will not attempt to refer to all relevant cases, but instead will pull out examples to demonstrate emerging themes. Throughout this discussion, I will highlight recurring themes such as underlying motives of paternalism, which I refer to as the 'the interference with people's liberties or autonomy "for their own good" or to "prevent their harm"'[64] regardless of the individual's preferences. I suggest that this paternalism manifests particularly as protection for the foetus in obstetric cases. Ultimately I will argue that these themes continue to persist in present obstetric case law, causing the continual curtailment of pregnant women's autonomy. I will begin with a discussion surrounding patient autonomy and the social and legal developments that have enhanced its importance in medicine. In *Re T (Adult: Refusal of Medical Treatment)* [1992][65] the court set out the absolute right of a competent adult to refuse medical treatment, even if it results in their death. *Re T* has since been reiterated and developed through cases such as *Ms B v An NHS Hospital Trust* [2002][66] and *Montgomery v Lanarkshire Health Board* [2015].[67] I will therefore question, why, after promoting the importance of

[62] Samantha Halliday, 'Court-authorised obstetric intervention: insight and capacity, a tale of loss' in Camilla Pickles and Jonathan Herring *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (Routledge 2019) 198.
[63] n1.
[64] Loretta Kopelman, 'On Distinguishing Justifiable from Unjustifiable Paternalism' (2004) 6(2) *AMA Journal of Ethics* 75, 75.
[65] n19.
[66] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).
[67] n9.

patient choice and autonomy Lord Donaldson suggested this could be limited in instances where a decision would lead to the death of the foetus. I will also consider why Sir Brown P in *Re S (Adult: Refusal of Medical Treatment)* [1993][68] decided to rely upon these obiter comments, rather than promoting an equal stance where all adults have the right to self-determination in medical decisions.

Following Sir Brown P's judgment, I consider the subsequent cases of *Tameside and Glossop Acute Services v CH* [1999],[69] *Norfolk and Norwich Healthcare Trust v W* [1996][70] and *Rochdale NHS Trust v C* [1997].[71] In *Norfolk* and *Rochdale*, I suggest that the findings of incapacity were unconvincing and motivated by a desire to justify obstetric intervention and note that findings of incapacity are still a feature of today's case law. I suggest these cases are indicative of the attitudes of paternalism that still impact judges reasoning today. In *Tameside* I argue that the utilisation of section 63 MHA[72] was inappropriate because a caesarean section could not reasonably be viewed as treatment for the pregnant woman's paranoid schizophrenia; again, demonstrating a creative use of legal tools to ensure a judgment whereby medical treatment was legally endorsed. Discussion will then turn to *Re MB (Caesarean Section)* [1997],[73] the case that ostensibly settled the issue. Butler-Sloss LJ confirmed the right that every pregnant woman with capacity has the right to refuse treatment. I will identify what the theoretical wins of the case were in promoting women's autonomy in obstetric cases. However, I will advocate that this change has not been reflected in practice and that notwithstanding dicta to the contrary, the respect afforded to pregnant women's autonomy has not been significantly advanced from the cases pre- *Re MB*.

1.1 Respect for autonomy

Social and legal protections have grown exponentially with a focus on individual autonomy. However, where obstetric cases are concerned, I argue that there is insufficient respect for autonomy of pregnant women. The new dominance of autonomy will be explored and criticisms to this strengthened principle will be highlighted including arguments about why it needs to be more carefully balanced against other values. I will argue that notwithstanding the arguments that there is now an 'excessive emphasis'[74] on

[68] *Re S (Adult: Refusal of Medical Treatment*) [1993] Fam 123.
[69] n34.
[70] *Norfolk & Norwich Healthcare Trust v W* [1996] 2 FLR 613.
[71] *Rochdale NHS Trust v C* [1997] 1 FCR 274.
[72] n30, section 63.
[73] n1.
[74] Toni Saad, 'The history of autonomy in medicine from antiquity to principlism' (2018) 21(1) *Medicine Health Care and Philosophy* 125, 126.

upholding patient autonomy, that the current level of importance attached to championing individual autonomy is correct and justified.

1.1.1 What is autonomy?

The word autonomy derives from the Greek words 'autos' and 'nomos' which mean 'self' and 'rule or governance', respectively.[75] Simply put, autonomy can be described as self-rule or self-governance.[76] The precise definition and meaning of the term autonomy is disputed by academics.[77] Autonomy is, as Switankowsky puts it 'a philosophical concept that is riddled with psychological complexities and individual peculiarities.'[78] Dunstan describes autonomy as a 'right to act on one's own judgment about matters affecting one's life, without interference by others.'[79] Entwistle states that respect for autonomy 'is most strongly associated with the idea that patients should be allowed or enabled to make autonomous decisions about their health care.'[80] Beauchamp and Childress purport that 'to respect autonomous agents is to acknowledge their right to hold views to make choices and to take actions based on their personal values and beliefs.'[81] Overall, I propose that autonomy refers. very generally, to 'self-governance'. Therefore, respect for autonomy summarises the notion that an individual has the right to make their own choices and decisions in life, free from interference.

1.1.2 The new dominance of autonomy

Autonomy underwent a growth in significance to become the premier principle in Western medical ethics.[82] This progression is identified with the intention of highlighting the slower appreciation of autonomy in obstetric cases, thus, drawing attention to obstetric cases as a particular group of patients whose treatment has been divergent from the norm. The principle of autonomy did not always hold pride of place in healthcare decisions. The Hippocratic Oath, written nearly 2500 years ago,[83] is indicative of the foundations of medical ethics and details the conduct by which physicians should be

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[75] n4, 99.
[76] Jukka Varelius, 'The value of autonomy in medical ethics' (2006) 9(3) *Medicine Health Care and Philosophy* 377.
[77] n4, 99.
[78] IS Switankowsky, *A New Paradigm for Informed Consent* (University Press of America 1998) xvii.
[79] G Dunstan, 'Should philosophy and medical ethics be left to the experts?' In S Bewley and RH Ward, *Ethics in Obstetrics & Gynaecology* (RCOG Press 2002) 3.
[80] V Entwistle, S Carter, A Cribb and K McCaffrey, 'Supporting Patient Autonomy: The Importance of Clinician-patient relationships' (2010) 25(7) *Journal of General Internal Medicine* 741, 741.
[81] n4, 99.
[82] Jonathan Herring, *Medical Law and Ethics* (8th edn, OUP 2020) 25.
[83] Kathy Oxtoby, 'Is the Hippocratic oath still relevant to practising doctors today' (*British Medical,* 2016) <https://www.bmj.com/content/355/bmj.i6629> accessed 23 February 2022.

held accountable. Its early formulations can be described as paternalistic in nature, with a heavy focus on a physician's duty to treat patients, with no reference to the importance of including the patient in the decision. That is not to say that patient choice was entirely ignored, but it is indicative of the 'major imbalance of power'[84] that used to exist within the doctor-patient relationship. As Sherwin points out, until the end of the 20th century, 'physicians were actually trained to act paternalistically toward their patients… with little regard for each patient's own perspectives…'[85] This demonstrates how decisions regarding medical treatment were characterised by paternalism and protection, rather than autonomy.

Over the last century there has 'been a shift from a paternalistic model of medical decision-making… towards an autonomy-based model…'[86] In reaction to the 'horrifying experimentation in concentration camps'[87] that occurred during WWII - highlighted in the Nuremberg trials - consent and autonomy have grown to the forefront of biomedical ethics. The extreme violations of bodily integrity that occurred in the Nuremberg trials highlighted the importance of patient consent in not just medical trials but all medical procedures. The creation of the European Convention on Human Rights in 1959 further cemented the importance of autonomy through its creation of rights; notably Article 8, the right to respect for private and family life which encompasses the 'right to personal autonomy and physical and psychological integrity…'[88] It was created with the intent 'to ensure that governments would never again be allowed to dehumanise and abuse people's rights with impunity…'[89] Furthermore, the introduction of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006 added to this accumulating picture of human rights. The purpose of the UNCRPD is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities…'[90]

In addition, the notion that 'doctor knows best'[91] began to be questioned in the early 1960s. This emerged following WWII where 'a new world of consumerism was on offer for the working majority.'[92]

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[84] Michael Jones, 'Informed Consent and Other Fairy Stories' (1999) 7 *Medical Law Review* 103, 129.

[85] Susan Sherwin, *The Politics of Women's Health: Exploring Agency and Autonomy* (Temple University Press 1998) 21.

[86] Emily Jackson, *Medical Law*: *Text, Cases and Materials* (5th edn, OUP 2009) 34.

[87] n4, 117.

[88] ---, 'European Convention on Human Rights' <https://www.echr.coe.int/documents/convention_eng.pdf> accessed 6 August 2022.

[89] ---, 'What is the European Convention on Human Rights?' (2018) <https://www.amnesty.org.uk/what-is-the-european-convention-on-human-rights> accessed 8 August 2021.

[90] ---, 'United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)' <https://humanrights.gov.au/our-work/disability-rights/united-nations-convention-rights-persons-disabilities-uncrpd> accessed 2 December 2021.

[91] n86, 34.

[92] David Sturgeon, 'The business of the NHS: The rise and rise of consumer culture and commodification in the provision of healthcare services' (2014) 34(3) *Critical Social Policy* 405, 406.

Through the NHS, clinicians' decisions no longer had to be 'silently complied with by the patient.'[93] With the expansion of internet resources patients began to question decisions and requested information so they might better understand procedures. Gerda Cohen remarked on this in 1964, describing how 'patients [were] becoming impatient: of being treated like chipped flowerpots in for repair… of being kept in ignorance.'[94] As a result, over this last century we have moved away from a system 'governed by largely unchecked paternalism'[95] to self-determination being 'widely regarded as the cornerstone of clinical ethics.'[96]

This evolution was cemented in case law. In *Re T (Adult: Refusal of Medical Treatment)* [1994][97] Lord Donaldson held that an adult patient 'has an absolute right to choose whether to consent to medical treatment [or] to refuse it…' [98] so long as they 'suffer from no mental incapacity.'[99] This addressed the question; when does an adult patient have the right to refuse medical treatment? Lord Donaldson confirmed that the right endures even 'if a refusal may risk permanent injury to his health or even lead to premature death.'[100] It is important to quickly note that Donaldson did highlight one possible exception to this rule, where 'the choice may lead to the death of a viable foetus…' [101] however this will be discussed in more detail later in section 1.2. The judgment was significant because it heralded the importance of patient autonomy taking precedence over medical paternalism. It encapsulates the 'shift from a paternalistic model of medical decision-making, based upon the idea that "doctor knows best" towards an autonomy-based model which assumes that adults with capacity have an almost absolute right to refuse medical treatment'[102] It established that even where the consequences of a patient's decision could result in serious harm or death, that so long as they have mental capacity respect for their autonomy prevails. This *ratio decidendi* decision is the foundation upon which modern day capacity and consent law has been built.

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[93] Kaba and Sooriakumaran, 'The evolution of the doctor-patient relationship' (2007) 5(1) *International Journal of Surgery* 57, 57.
[94] Alex Mold, 'Repositioning the patient: patient organizations, consumerism, and autonomy in Britain during the 1960s and 1970s' (2013) 87(2) *Bull Hist Med* 225, 226.
[95] Coggon and Miola, 'Autonomy, Liberty and Medical Decision-Making' (2013) 70(3) *Cambridge Law Journal* 523, 523.
[96] Brostrom, Johansson and Lindberg, 'Temporising and respect for patient self-determination' (2019) 45(3) *Journal of Medical Ethics* 161, 161.
[97] n21, 653.
[98] Ibid.
[99] Ibid.
[100] Ibid, 664.
[101] Ibid, 653.
[102] n86, 34.

1.1.3 Criticisms of autonomy

However, autonomy is not the only significant principle in medical ethics. Beauchamp and Childress suggest that there are four basic principles: autonomy, beneficence, non-maleficence, and justice. In certain scenarios, moral principles may clash and thus it is important to decide what should prevail in any given situation. Academics can take very different approaches to the same situation. This can be attributed to the differentiating moral theories that academics maintain. Every 'moral theory will recognise different types of moral interest and weigh them differently.'[103] For instance, virtue theorists focus on conduct, looking at whether a person's motive is virtuous. They do not believe the consequence in a particular situation is important. The 'central feature of virtue ethics is its rejection of the idea that patient autonomy is an absolute or overriding virtue.'[104] This is because virtue theorists do not believe acting out of self-interest is virtuous. In contrast, libertarians believe that 'actions are right if, and only if, they respect a person's autonomy.'[105]

Saad condemns the heavy shift to autonomy that has recently occurred in medical ethics. He describes the focus on autonomy as an 'excessive emphasis'[106] that 'jeopardises necessary elements of medical practice.'[107] Other academics agree with this sentiment. Academics such as Stirrat, Gill and Entwistle highlight their worries that the increasing emphasis on autonomy is having a negative impact on the doctor-patient relationship. Stirrat and Gill purport that 'the dominance of the individual autonomy paradigm'[108] has harmed the patient-doctor relationship 'in which each fully respects the autonomy of the other…'[109] O'Neill attributes this to the idea that the 'interpretation of autonomy has become too individualistic.'[110] In short, their worries pertain to the idea that autonomy is dominating medical ethics to such an extent that clinicians feel obliged to 'tell patients about health care options then stand back and abide by their choices.'[111]

I disagree with this description of what it means to respect autonomy in practice. Doctors are still essential in medical decision-making, and it is important that they work with the patient to discuss all

[103] Ibid, 35.
[104] Ibid, 16.
[105] Ibid, 18.
[106] n74, 126.
[107] Ibid.
[108] GM Stirrat and R Gill, 'Autonomy in medical ethics after O'Neill' (2005) *Journal of Medical Ethics* 127, 127.
[109] Ibid, 127.
[110] Ibid.
[111] Ibid, 741.

the relevant information. The Supreme Court in *Montgomery v Lanarkshire Health Board* [2015][112] emphasised the importance of dialogue between doctors and patients and reaching decisions in partnership. They referenced documents in force at the time that guided doctors to 'work in partnership with patients. Listen to, and respond to, their concerns and preferences.'[113] However, ultimately the decision of whether or not to accept treatment should be the patients' and theirs alone. This view should not be considered as an attack on the expertise of the doctor but rather a confirmation that they are enabling their patients to make their own medical choices.

However, Davies and Glynn think it is a worrying predicament to hand over complete control to a patient with capacity because for those who only just pass the threshold of capacity they 'may feel abandoned rather than autonomous.'[114] However there is a flaw in this argument insofar as respecting an individual's autonomy does not mean that clinicians are not permitted to provide any support in making their decision. Some academics also condemn the supposedly individualistic nature of autonomy because it neglects to consider the importance of social relationships. Thus, some academics would seek to limit the scope of autonomy to ensure that other people are considered in medical decisions. As Jackson points out, some commentators are critical of the priority given to autonomy because 'respecting a patient's right to reject life-saving medical treatment ignores the impact that this might have upon other people such as her dependent children.'[115] However, this is a controversial approach to medical ethics as it would suggest that a person's autonomy could be limited by another's interests. In obstetric cases, the law is such that pregnancy should not dimmish the woman's right to autonomy.

That is not to state that autonomy should prevail in every scenario. As Beauchamp and Childress stress, autonomy should not override all other moral considerations: 'construing respect for autonomy as a principle with priority over all other moral principles… is indefensible.'[116] The best example of this is where a patient lacks capacity. In such a scenario, it is appropriate that decisions be made in a patient's best interests that might contradict the individual's desired approach. This encapsulates the principle of beneficence forming part of the decision made, which can be characterised as the 'moral obligation to

[112] n9.
[113] General Medical Council, 'Good Medical Practice' (2013) <https://medvle.buckingham.ac.uk/pluginfile.php/24/course/section/13/GMP_2013.pdf_51447599.pdf.> accessed 29 October 2021.
[114] M Davies and G Elwyn, 'Advocating mandatory patient "autonomy" in healthcare: adverse reactions and side effects.' (2008) 16 *Health Care Analysis* 315, 315.
[115] n86, 241.
[116] n4, 140.

help other people'.[117] This obligation to help and protect a patient who lacks capacity permits judges to act with intentions of protection and paternalism. Autonomy is therefore not absolute in this situation as the welfare of the individual forms part of their best interest's determination. Autonomy is not completely dismissed though as it does form part of the assessment of their best interests through the consideration of their 'wills and preferences' as required under section 4(6) MCA. This demonstrates that although autonomy is important, it might be appropriate to allow paternalism to take precedence and construe a best interests determination that contradicts the patient's wishes where a patient lacks capacity.

However, the problem in obstetric cases lies in the fact that paternalism too frequently takes precedence over autonomy. Thorpe demonstrates this point when he identifies that 'whatever emphasis legal principle may place upon adult autonomy… at some level the judicial outcome will be influenced by the expert evidence as to which treatment affords the best chance of the happy announcement that both mother and baby are doing well.'[118] He goes even further, highlighting that 'it is simply unrealistic to suppose that the preservation of each life will not be a matter of equal concern…'[119] This attitude is the root of the problems in obstetric cases. Pregnant women are not being enabled to exercise their autonomy. Instead, paternalistic attitudes are infiltrating cases to a disconcerting extent, demonstrating the exceptionalism of these cases.

1.1.4 The importance of respect for autonomy

As Sartre states, '… it is necessary that we make ourselves what we are.'[120] By making decisions based on our own personal beliefs, we have the freedom to shape an individual identity that brings us happiness and comfort. Autonomy is 'an indispensable component of individual wellbeing...'[121] Immanuel Kant believes that 'respect for autonomy flows from the recognition that all persons have unconditional worth…'[122] and therefore individuals should be allowed to 'determine his or her own moral destiny.'[123] As Judge Martens stated in *Cossey v The United Kingdom* (1990),[124] 'man should be

[117] Katie Page, 'The four principles: Can they be measured and do they predict ethical decision making?' (2012) *BMC Medical Ethics* 1, 3.
[118] n46, 663.
[119] Ibid, 664.
[120] JP Sartre, *Being and nothingness* (Routledge 1993) 59.
[121] Elizabeth Romanis, 'Why the Elective Caesarean Lottery is Ethically Impermissible' (2019) 27(4) *Health Care Analysis* 249, 255.
[122] n4, 63.
[123] Ibid, 64.
[124] *Cossey v The United Kingdom* [1990] ECHR 21.

free to shape himself…'[125] as this allows individuals to make their own decisions and 'pursue their conception of the good life.'[126] In the context of medical decision-making, Romanis states that 'patient autonomy and an individual's right to bodily integrity are usually seen as paramount…'[127] Entwistle purports that it is important that 'patients should be *offered* options and *allowed to make* voluntary choices about potentially life-changing health care interventions…'[128] If an individual is not allowed to exercise their autonomy, there can be degrading consequences. Herring suggests that where the right to self-government is restricted, we fail to respect an individual's humanity.[129] This is harmful because it 'involves attitudes and actions that ignore, insult [and] demean'[130] a person's wishes.

The American case of *Re AC* (1990)[131] demonstrates a particularly disturbing example of the consequences of denying self-determination in medical decisions. Angela Carder was forced to undergo an unwanted caesarean section instead of receiving treatment for her terminal cancer. She was described as physically thrashing and twisting on her bed in an attempt to fight off the doctors. However, as Pattinson explains, they 'quite literally silenced' her screams of 'no' by jamming a tube down her throat to pump her with sedatives.[132] Carder died in an obvious state of distress, spending the last minutes of her conscious life feeling violated, disrespected and in pain. This example highlights the potentially dire consequences of overriding an individual's wishes.

Beauchamp and Childress note that by violating a person's autonomy you 'treat that person merely as a means; that is, in accordance with other's goals without regard to that person's own goals.'[133] This results in an individual losing control over their own life and destiny. This outcome is undesirable because 'most people think it is preferable to somehow be their own person and shape their own lives than to live under the control of others.'[134] This demonstrates just how important it is to respect an individual's autonomy. It is admitted that 'although personal liberty has been cherished and prized… so too is the veneration and preservation of human life.'[135] Autonomy is not ultimate, but it is very important and it is time that it was sufficiently respected in obstetric cases.

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[125] Ibid.
[126] Daniel Callahan, 'When self-determinations run amok' (1992) 22(2) *The Hasting Center Report* 51, 52.
[127] n121, 255.
[128] n80, 741.
[129] n82, 25.
[130] n4, 103.
[131] *Re AC* (1990) 573 A.2d 1235.
[132] n3, 55.
[133] n4, 103.
[134] n80, 741.
[135] Lord Justice Thorpe, 'Consent for Caesarean section: Part 2 – autonomy, capacity, best interests, reasonable force and procedural guidelines.' (1999) *Clinical Risk* 209, 210.

1.2 Obstetric cases as an exception to the rule?

The balance between autonomy and paternalism set out above consolidates the importance of respecting a patient's autonomy, whilst also placing checks on this absolute right through the threshold of mental capacity. Whilst autonomy is extremely important, it is not always king in the medical system. In *Re T* [1992][136] Lord Donaldson cements autonomy as the cornerstone of medical ethics and sets out the acceptable levels of paternalistic intervention. However, following this statement Lord Donaldson suggests one possible qualification to the rule: 'in which the choice may lead to the death of a viable foetus.'[137] By adding this line in the judgment, the progressive statement of autonomy was questioned in relation to pregnant women whose medical decisions impact their foetus. As this statement was only *obiter dictum* it did not become precedent. However, it did pose the opportunity for the courts to discuss this potential exception to the rule in future cases and it is therefore important to consider *why* Lord Donaldson distinguished this circumstance? Why was the protection of the foetus seen as a possible justification for non-consensual treatment? What other 'recognised right or interest is considered sufficiently important to justify'[138] the idea that a 'competent woman's refusal is capable of being overridden'?[139] It is important to try to understand Lord Donaldson's judgment and rationale because it could help to provide insight into the underlying issue with obstetric cases. This will be informative when considering present day cases because it will help to suggest why obstetric cases are still a differentiated category in practice. Lord Donaldson presented this potential limitation to the rule but 'gave no indication as to the legal foundation on which the exception was based.'[140] I suggest there are two potential reasons why Lord Donaldson singled this particular scenario out; public policy concerns and his individual principles of morality.

Lanning suggests that the reason Lord Donaldson differentiated obstetric cases as a category can be inferred from his conclusion when he stated 'though an individual had a right to self-determination, this was to be balanced against society's interest of preserving the sanctity of life; and that any doubt should fall in favour of society's interest.'[141] In this statement, Lord Donaldson is indicating that although a woman's autonomy is important, so too is the life of the foetus. This suggests that there is a potential conflict in principles that can occur when a pregnant woman refuses to consent to treatment that is for the benefit of the foetus. Such situations can be highly emotive, and Lord Donaldson appears to be

[136] n21.
[137] Ibid, 653.
[138] n7, 42.
[139] Ibid.
[140] n14, 53.
[141] Ibid, 37.

recognising this moral dilemma through his obiter comment. Lanning refers to this struggle, stating that the moral pressure to act to save or protect life is great…'[142]

Even though a foetus 'is owed some positive moral duties'[143] under English law (as outlined in the Introduction), it is not and never has had the status of 'legal personhood'. Therefore, it is safe to presume that Lord Donaldson was not attempting to base his suggested limitation on any legal foundations of substantive 'foetal rights'. Indeed, when he referred to the 'legal and ethical complexity'[144] in these scenarios he made no reference to the specific interests of the foetus against those of the pregnant woman. Instead, he refers to the conflict as being between the 'interests of the patient and that of the society in which he lives.'[145] I suggest that Lord Donaldson's language could imply that this is a 'public policy' or 'public interest' issue that requires discussion. I refer to public policy as the 'principles, often unwritten, on which social laws are based'[146] and use this phrase to also refer to public interest considerations. This is evidenced by the fact that Lord Donaldson refers to the conflict that *society* would have with such an outcome. The concept of 'public policy' has been employed in other scenarios to quash an otherwise valid consent or refusal. In *R v Brown* [1993][147] for example, a group of homosexual men consensually took part in sadomasochistic activities. The men were found to have mental capacity, however their consent did not waive the crime of assault and GBH inflicted. It was found that irrespective of the consent of the participants their actions were inconsistent with public policy. Similarly, I suggest that Lord Donaldson could be implying in his judgment that medical decisions regarding the life of a foetus are a potential cause for public policy concerns. The circumstances in *R v Brown* [1993][148] contradicted public policy because the harm endured was deemed unnecessary. Equally, the death of an otherwise viable foetus could be construed as socially immoral. Lord Donaldson however does not articulate the potential relevance of public policy considerations outright. The absolute right of an adult to refuse treatment is framed in terms of capacity alone. However, by suggesting this potential qualification I propose that Lord Donaldson was attempting to open the potential for the rule to become more elaborate than only framing it around the stipulation of capacity. He is providing the potential for future courts to decide whether other factors, such as public interest, could quash a valid refusal, regardless of the patient's capacity.

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[142] Ibid, 69.
[143] n52, 123.
[144] n21, 653.
[145] Ibid, 661.
[146] Oxford Dictionary, 'Public Policy' <https://www.lexico.com/definition/public_policy> accessed 23 January 2021.
[147] *R v Brown* [1993] 2 All ER 75.
[148] Ibid.

Alternatively, it might not have been Lord Donaldson's intention to imply that public policy concerns were a potentially valid consideration in obstetric cases. In fact, it is a possibility that he made this statement without inference to another valid legal principle. Instead, I suggest that his decision might have been influenced by his personal moral and religious beliefs that consciously or subconsciously prejudiced his statement and judgment in *Re T*.

Either way, Lord Donaldson is drawing attention to this scenario because he believes it might be an exception to the rule. Deshpande states 'obstetrics is the only field in medicine in which decisions made in the care of one person immediately affect the outcome of another.'[149] When a non-pregnant adult refuses to consent to medical treatment only they are directly affected. Whereas in obstetrics, the courts and medical team are faced with the dilemma that 'the pregnant woman's refusal to undergo treatment has major implications for the foetus.'[150] There was no Parliamentary statute for Lord Donaldson to refer to that would provide guidance as to whether the woman's rights should always trump the foetus's interests and there still isn't any explicitly statutory guidance on this. However, the Court of Appeal did state in *Re F (In Utero)* [1988][151] that:

> *"If the law is to be extended in this manner, so as to impose control over the mother of an unborn child where such control may be necessary for the benefit of that child, then under our system of Parliamentary democracy* ***it is for Parliament to decide (emphasis added)*** *whether such controls can be imposed and, if so, subject to what limitations or conditions."*[152]

This judgment made it clear that the possibility of ordering a caesarean section against the will of a woman with capacity was a decision to be made by Parliament, not the courts. Therefore, Lord Donaldson highlighting this scenario is particularly surprising as the Court of Appeal made it clear that this issue falls outside of their jurisdiction. On the other hand, he might have highlighted the obstetric scenario as way of signalling that this area needs proper deliberation before falling under the general rule. There are other academics who have called for Parliamentary intervention to settle this moral dilemma to create certainty for courts. For instance, Lanning questioned 'is it not time, as many have argued, for Parliament to step in and put an end to the maternal rights-foetal rights debate?'[153]

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[149] N Desphande and M Corrina, 'Management of Pregnant Patients Who Refuse Medically Indicated Caesarean Delivery' (2012) 5(3/4) *Medical Reviews in Obstetrics & Gynecology* 144, 150.
[150] Ibid, 145.
[151] *Re F (In Utero)* [1988] Fam 122.
[152] Ibid, 144.
[153] n14, 69.

In the preceding discussion I have outlined two potential reasons why Lord Donaldson singled out this area of obstetrics as a potential exception to the general rule: public interest concerns and personal subconscious bias. Overall, these reasons are indicative that this is a unique situation that has many moral implications and controversies. It demonstrates an underlying hesitancy to permit full autonomy to a woman should her decision cause the death of the foetus she carries. This is important to raise at this point in the case law, because even though Lady Butler-Sloss in *Re MB (Caesarean Section)* [1997][154] later settled the issue, I argue that the courts are still not comfortable with this outcome. Pregnant women's autonomy continues to be limited, albeit through seemingly lawful procedures. However, the same caution that Lord Donaldson expresses in *Re T* towards permitting the same level of autonomy for pregnant women who wish to refuse medical treatment is synonymous with judges' attitudes in current case law.

1.3 Express limitation of a competent woman's autonomy

Following Lord Donaldson's judgment in *Re T* [1992][155] was the case of *Re S (Adult: Refusal of Medical Treatment)* [1994][156] which saw Sir Brown P override the wishes of a mentally competent pregnant woman to ensure obstetric intervention. This is the only case in which this has openly occurred. This case came before the Family Division of the High Court a few months after the judgment of *Re T*. This means that the 'potential limit to self-determination of pregnant women, mooted by Lord Donaldson, was soon put under the spotlight…'[157] The President, Sir Brown P granted the declaration sought. The caesarean section was lawfully performed notwithstanding the refusal of the competent pregnant woman, Mrs S, therefore implying that the protection of the foetus was a valid justification for non-consensual treatment. He had the opportunity to consolidate the absolute right of *all* people with capacity to refuse any treatment. Instead, he decided in favour of preserving S's life 'and also I emphasise the life of her unborn child'[158] over the progression of pregnant women's autonomy. However, it is also important to be aware that this was an emergency ruling in which Sir Brown P had little time to come to a decision and Lord Donaldson's judgment in *Re T* was an influential dictum.

[154] n1.
[155] n21.
[156] n68.
[157] n14, 53.
[158] n68, 124.

1.3.1 *Re S* [1994] Judgment

This case concerned a pregnant woman, S, who was 30 years old. She was admitted to hospital with ruptured membranes and was in labour for more than two days. S and her husband both refused the advised caesarean section on religious grounds, describing themselves as 'Born Again Christians'. The foetus was in a transverse lie position, with its elbow projecting through the cervix and its head on the right side. This meant there was a grave risk of a rupture of the uterus if natural labour was permitted to continue. To save both their lives it was deemed necessary by the surgeon to perform a caesarean section on S. Sir Brown P accepted this medical evidence and stressed that this was a matter of 'life and death'[159] for both S and the foetus.

Irrespective of S's competent refusal to the caesarean section, Brown made the declaration sought by the Hospital 'in the knowledge that the fundamental question… was left open by Lord Donaldson in *Re T*.'[160] The fundamental question being whether a pregnant woman should be able to refuse treatment where her 'choice may lead to the death of a viable foetus.'[161] By answering in the affirmative, Sir Brown P suggests that the state of pregnancy could differentiate competent women from other adult patients with capacity who are able to validly refuse any treatment. It is the only judgment in which a competent woman has had her refusal overridden. However, it presented a worrying attack on the autonomy of pregnant women and seemed to transfer them to a 'category of patient with a much more limited ability to determine their own treatment.'[162]

1.3.2 Misapplication of American case law

In *Re T*, Lord Donaldson founded an individual's absolute right to make a decision regarding their own medical treatment dependent upon the threshold of capacity. In comparison, the formulation of Sir Brown P's judgment in *Re S* is important to note as he does not frame his decision in terms of capacity or incapacity. As Harrington argues 'it is evident from Sir Brown P's brief judgment that capacity was not required to resolve the matter in any case.'[163] Indeed, S's capacity was not considered at all, therefore falling out of line with the general rule presented by Lord Donaldson in *Re T*. This demonstrates that Sir Brown P was indeed reinforcing the idea that pregnant women could be an exception to the rule.

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[159] Ibid.
[160] Ibid.
[161] n21, 653.
[162] n7, 42.
[163] John A Harrington, 'Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment' (1996) 16 *Legal Stud* 348, 360.

Since Sir Brown P did not judge this case in-keeping with the ratio of *Re T*, it is important to discuss how he came to this judgment instead. What legal basis did Sir Brown P rely upon to justify his conclusion? It seems that Sir Brown P relied upon Lord Donaldson's possible exception from *Re T*, in combination with American case law to justify his decision. As there was no direct English authority, Sir Brown P defends his legal position through reference of *Re AC* (1990).[164] He purports that 'if this case were being heard in the American courts the answer would be likely to be in favour of granting a declaration in these circumstances.'[165] Reference to comparative law is not unusual in judgments. In fact, the Practice Direction on the Citation of Authorities states that 'cases decided in other jurisdictions can, if properly used, be a valuable source of law in this jurisdiction.'[166] However, reference to American case law should go no further than 'a comparative aid to the interpretation of English law'.[167] It is not usual for it be adhered to as a pseudo precedent. Therefore, I argue that Sir Brown P's reliance on *Re AC* to justify his decision was a questionable application of law and his actions in this case implied a deliberate utilisation of fitting legal authority to ensure a particular outcome rather than a thorough consideration of the relevant rules and laws to produce the most fitting decision. For instance, Sir Brown P did not consider the case of *Re F (In Utero)* [1988][168] which confirmed a foetus has no legal rights to be upheld.

Furthermore, Sir Brown P's decision has been 'strongly condemned… because of its misapplication of a recent American case…'[169] At first instance in *Re AC* (1990),[170] it was held that the refusal of the patient, Ms Carder, could be overridden in favour of preserving the life of the foetus. She was subsequently forced to undergo a caesarean section, a major surgery, even though it was accepted that it would not guarantee the life of the 26-week-old foetus and would probably shorten Ms Carder's life. Following Ms Carders and the foetus's death, the District of Columbia Court of Appeals subsequently found that the judge had failed to properly balance the rights of Carder against the interests of the state.[171] The court stated that 'some may doubt that there could ever be a situation compelling enough to justify a massive intrusion into a person's body, such as a caesarean section, against that person's

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164 n131.
165 n68.
166 The Law Library of Congress, 'The Impact of Foreign Law on Domestic Judgments: England and Wales' (2010) 31 <https://tile.loc.gov/storage-services/service/ll/llglrd/2013417620/2013417620.pdf> accessed 2 January 2021.
167 Ibid.
168 n151.
169 n163, 360.
170 n131.
171 Aurora Plomer, 'Judicially Enforced Caesareans and the Sanctity of Life' (1997) *Anglo-American Law Review* 26.

will.'[172] This statement demonstrates a strong affirmation of women's autonomy. Thomson heralded this case 'as a landmark and a victory which marked a turning point in the US in the struggle for reproductive autonomy.'[173] Following this interpretation of the judgment, it is reasonable to make the case that Sir Brown P was mistaken in his application of *Re AC* as supporting a judgment of overriding S's decision. However, it did not say that a woman's decision should be final in all cases, rather it said that 'we do not quite foreclose the possibility that a conflicting State interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional.'[174] Arguably AC's case was rare and exceptional as the foetus had been deprived of oxygen and at 26 weeks was unlikely to survive.

I suggest that Sir Brown P's employment of American case law was questionable and that it is indicative of a desire to justify and enable the safe delivery of the foetus. I will demonstrate in the following section that preservation of the life of the foetus was central to Sir Brown P's decision. Furthermore, I believe that Sir Brown P's judgment is indicative of underlying attitudes and concerns in obstetric cases and these are still relevant to this day and influence the outcomes of cases.

1.3.3 Commentary, Criticisms and Queries

Overall, this case is an example of a judge struggling with the emotive considerations that can be found in these types of obstetric cases. Alongside Lord Donaldson's hesitation in *Re T* [1992],[175] it is reasonable to assume that where the life of a foetus is involved, judges struggle with permitting a pregnant woman to exercise their full autonomy if their decision would harm the foetus. The law is very clearly set out in *Re MB* [1997],[176] however it is reasonable to assume that judges still struggle with these emotive situations as any decision they make will have irrevocable and life-altering impacts. I condemn Sir Brown P's judgment in *Re S* [1993][177] in principle as it showed a complete disregard for pregnant women's autonomy. As stated in the RCOG Ethics Committee Guidelines, the judgment was 'out of step in elevating the status of the foetus in law to such an extent that its supposed rights become more important than its mother's.'[178] However, I appreciate the difficulties that Sir Brown P faced when adjudicating, including the time pressures and lack of specific English common law to draw upon.

[172] n131.
[173] n10, 136.
[174] n131.
[175] n21.
[176] n1.
[177] n68.
[178] Royal College of Obstetricians and Gynaecologists, 'Law and ethics in relation to court-authorised obstetric intervention' (2006) http://aogm.org.mo/assets/Uploads/aogm/Guidelines/RCOG---UK/No-1-RCOG-Law-and-Ethics-in-Relation-to-Court-Authorised-Obsetric-Intervention.pdf accessed 22nd July 2021.

Academics such as Thomson became concerned that Sir Brown P's judgment threatened 'to lead English law down the road towards greater recognition of the foetus as a legal person.'[179] This would have had severe consequences for the woman. As Savell purports, if foetal interests had been allowed to take precedence over the woman's autonomy it would 'suggest that pregnancy may transfer a woman from that category of patient who has the right to consent or refuse consent to any treatment… to the category of patient with a much more limited ability to determine their own treatment…'[180] This would differentiate pregnant women from every other mentally competent adult patient. It is reasonable to assume that had S not been pregnant 'her refusal of consent to LSMT would have been upheld.'[181] It was the status of her being pregnant and the potential result of her decision impacting the wellbeing of the foetus that led to reservations regarding her refusal. Correa summarises the wrongness of the situation, utilising the analogy that 'increasingly it is the contents of the container that matter, not the container herself.'[182] Indeed, Sir Brown P's judgment would indicate that the foetus is a more important consideration than the woman, although I do acknowledge that he emphasised that the caesarean would save both lives.

On the other hand, there were other academics following *Re S* who 'suggested that such fears [were] unfounded.'[183] Katherine De Gama argued that *Re S* was such 'an obvious aberration that it could not possibly be followed or used as authority for any further foetal protection policies.'[184] This was indeed the reality. Sir Brown P's judgment received such a backlash (as outlined below) that it is the only case to date in which a Judge has not considered capacity at all and granted the declaration sought whilst unapologetically disregarding capacity considerations. Following this case, no judge has attempted to override the refusal of a pregnant woman where incapacity has not yet been established. Instead, I suggest that they have sought other means to ensure the life of the foetus is preserved and these are discussed in detail in chapter's II and III.

Sir Brown P's judgment received a lot of criticism from academics and the public alike. As Lanning contends, the case became a '*cause celebre'*;[185] a controversial issue that attracted a great deal of public attention. It provoked a lot of debate 'about the rights and wrongs of forcing pregnant women to undergo

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[179] n10, 132.
[180] n48, 57.
[181] n7, 43.
[182] Gena Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* (Women's Press 1985) 299.
[183] n10, 132.
[184] Katherine De Gama, 'A Brave New World? Rights Discourse and the Politics of Reproductive Autonomy' in *A Bottomley and J Conaghan (eds) Feminist Theory and Legal* Strategy (Blackwell 1993) 114, 122.
[185] n14, 54.

surgical operations against their wishes.'[186] In response to all the interest and criticism, the Royal College of Obstetricians and Gynaecologists (RCOG) issued 'guidelines which suggested that doctors should respect the competent mother's wishes.'[187] Furthermore, the Cumberledge Report, *Changing Childbirth* published in 1993 placed great emphasis on a woman's right to choose. The 'main thrust of the recommendations were patients' choice and patient's autonomy…'[188] therefore reinforcing the idea that Sir Brown P's declaration was unfounded and that S's refusal to consent to the caesarean section should have been upheld.

This strong, autonomy-centred response appears to condemn and dissuade any future judges from following Sir Brown P down a road where the foetus's interests are elevated above the pregnant woman. Instead, the guidance published post-*Re S* seems to consolidate that the formulation of all these cases should remain solely on capacity, therefore discounting any public policy concern arguments that would otherwise suggest that obstetric cases could be an exception to the general rule in *Re T*. Of course, this guidance was not legally-binding and thus in common law, the issue was still unsettled following *Re S*. However, no judge following *Re S* overruled a competent pregnant woman's refusal. In *Tameside & Glossop Acute Services Trust v CH* [1996],[189] *Norfolk & Norwich Healthcare Trust v W* [1996][190] and *Rochdale NHS Trust v C* [1997],[191] the judges looked at the cases purely in terms of capacity. All of these pregnant women were found to lack capacity and therefore the judges found that their refusals were capable of being overridden lawfully. The framing of the issue remained solely as a capacity threshold, with no public interest considerations being hinted at.

This begs the question of whether the backlash and criticism from *Re S* was successful in the pursuit of respect for pregnant women's autonomy? There are some academics that would say not. Academics, such as Stern believed that Sir Brown P's direct acknowledgement of the foetus's wellbeing in the judgment was actually a welcome introduction into this strain of case law. This was not because she necessarily thought that the foetus's interests should supersede the woman's autonomy, but because it presented the opportunity to acknowledge these moral issues head on and trigger a meaningful discussion. Stern made the argument that it 'would be a welcome development in the law as it would require explicit consideration of the demands of public policy in each case.'[192] If these issues are

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[186] Ibid.

[187] Royal College of Obstetricians and Gynaecologists, 'A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Intervention' (1996).

[188] n14, 37.

[189] n34.

[190] n70.

[191] n71.

[192] K Stern, 'Court-Ordered Caesarean Sections: In Whose Interests?' [1993] 56 *The Modern Law Review* 238, 242.

explicitly acknowledged and addressed there is more opportunity to convince courts of the severe harm that unwanted invasive surgery can cause. However, the backlash to *Re S* effectively silenced the issue instead of openly addressing it. I suggest that this contributes to the persistence of problems in obstetric cases today. The moral dilemma persists, even if legally the issue is settled. Even though the formulation of obstetric cases is now different (every competent pregnant woman may refuse any treatment), the result is the same. This is because no pregnant woman wishing to refuse the recommended treatment has been found to have capacity. The issues and underlying themes of *Re S* are therefore an important part of understanding why the problem still exists today and why autonomy is still being restricted.

1.4 Setting the tone for future obstetric judgments

Following *Re S* 'there was a spate of cases which came before the English courts requiring declarations authorising caesarean section.'[193] These cases were *Tameside & Glossop Acute Services Trust v CH* [1996],[194] *Norfolk & Norwich Healthcare Trust v W* [1996][195] and *Rochdale NHS Trust v C* [1997].[196] In each of these cases, the women's refusals were overruled. This was on the basis that the women all lacked capacity and a caesarean section was in their best interests.

1.4.1 *Tameside and Glossop Acute Services Trust v CH* [1996]

In *Tameside*, Wall J 'declared that a caesarean section could be performed without consent as treatment for mental disorder under the MHA section 63.'[197] This was a controversial judgment because in utilising section 63, Wall J 'manipulated the statute construing induction of labour and caesarean section as treatment for mental disorder.'[198]

This case concerned a pregnant woman, CH, aged 41 who suffered from paranoid schizophrenia. Upon examination, two obstetricians agreed that the foetus was suffering from intra-uterine growth retardation, meaning that the foetus was smaller than it should be. They voiced concerns that should the pregnancy be allowed to continue, the foetus might die in the womb and therefore advised that CH should undergo an induced labour so a caesarean section might be performed. CH wanted her child to be born healthy and alive. However, at this point in the pregnancy, CH was no longer taking her mental

[193] n34, 55.
[194] n34.
[195] n70.
[196] n71.
[197] n14, 55.
[198] Ibid, 56.

health medication. As a result, her mental health continued to deteriorate. She believed that the consultant obstetrician and psychiatrist were treating her in such a way that was harmful to her child. Nevertheless, CH agreed to undergo an induced labour. The Trust were worried however that at the point of doing so, she would refuse and therefore sought a declaration that they would be able to legally restrain CH should she withhold consent, in order to perform the caesarean section.

This was a pre-emptive application as CH was not yet in labour. Thus, Wall J could not declare that she lacked capacity at the point in time of refusing the caesarean section, because it had not yet come to pass. It is important to note that although CH suffered from paranoid schizophrenia and was detained under the Mental Health Act 1983, that this did not automatically forfeit her capacity and autonomy. There is, however, section 63 of the Mental Health Act 1983 that states that 'the consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering…'[199] This means that if the caesarean section can be characterised as treatment for CH's paranoid schizophrenia, then the hospital do not require her consent to perform the operation. There was evidence that section 63 had been employed successfully in preceding cases, such as *B v Croydon Health Authority* [1995].[200] In this case, nasogastric feeding was found to be ancillary treatment for B's psychopathic disorder. They interpreted 'medical treatment' to include supplementary treatment, that alleviate symptoms of the disorder, such as 'nursing and care concurrent with the core treatment or as a necessary prerequisite to such treatment…'[201] Thus, even though nasogastric feeding did not treat B's mental disorder directly, it was deemed within the definition of 'medical treatment' under section 63. However, Hoffman LJ stressed that this treatment must be directly linked to the mental disorder.

The limits of section 63 were demonstrated in *Re C (Adult: Refusal of Medical Treatment)* [1994].[202] Hoffmann LJ also judged this case, but here he held that the amputation of C's leg could not be considered medical treatment for his paranoid schizophrenia. Thus, the hospital still required his consent to perform the operation as he was found to have capacity. If this type of invasive surgery was not found to be 'medical treatment' for C's paranoid schizophrenia in *Re C*, then it is debatable that another form of invasive surgery, such as a caesarean section, could be categorised as so. However, this is exactly what Wall J found. He argued that if the foetus was to die, then CH would blame the medical staff. This would impact her cooperation with them in the future and potentially disrupt treatment of her paranoid schizophrenia following the birth of her child. Thus, he held that the caesarean section was in effect, treatment for CH's mental health. This was a very stretched interpretation of section 63 in

[199] n30, section 63.
[200] n32.
[201] Ibid, 138.
[202] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

comparison to cases such as *B v Croydon* and *Re C*. Wall J gives very presumptuous reasons, including the potential for her trust in the psychiatric services to be undermined.[203] These unconvincing links suggest he has overemphasised the need of a caesarean section for the purposes of treating CH's paranoid schizophrenia. This makes the judgment a very controversial decision as the 'interpretation of treatment for a mental disorder has been unduly stretched.'[204]

I contend that Wall J's utilisation of section 63 MHA was simply a convenient means of ensuring a lawful caesarean section for CH, without requiring her consent. Halliday aptly summarises this case as 'indirectly safeguarding the foetus via the categorisation of a caesarean as a treatment for a mental disorder'.[205] Indeed, this is case is a prime example of judges working through their subtext 'to disable the autonomy of pregnant women, entrench the power of the medical profession and protect the foetus in a way denied by the simple rhetoric of the ratio.'[206]

1.4.2 *Norfolk & Norwich Healthcare Trust v W* [1996] and *Rochdale NHS Trust v C* [1997]

Following *Tameside* were two cases; *Norfolk & Norwich Healthcare Trust v W* [1997][207] and *Rochdale NHS Trust v C* [1997],[208] heard on the same day, by the same Judge Johnson J. In fact, Johnson J stopped midway through the *Norfolk* judgment to deliver the *Rochdale* decision. In both cases, the women were found to lack capacity and obstetric intervention was held to be in their best interests. Johnson J based both these findings of incapacity on the fact that the women were 'in the throes of labour with all that is involved in terms of pain and emotional stress'[209] and therefore unable to weigh information relevant to the medical decision.

These judgments received a lot of academic criticism. By justifying incapacity based on symptoms 'in the ordinary course of labour…'[210] Johnson J effectively opened the floodgates for any pregnant woman in labour to be found incompetent. As Lanning questions, did Johnson J mean 'that all [women who are in labour] are all incapable of making decisions?'[211] I argue that such a conclusion is indicative of the underlying motives of the judges. Johnson J utilised the flexible assessment of capacity to guarantee

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[203] n7, 49.
[204] Ash Samanta & Jo Samanta, *Medical Law* (2nd edn, Macmillan Law Masters 2015) 155.
[205] n7, 49.
[206] n70, 115.
[207] n70.
[208] n71.
[209] Ibid, 275.
[210] n70, 616.
[211] n14, 56.

findings of incapacity in both women. He effectively manipulated the law to ensure the protection of the foetus's life. This demonstrates the inherent problems in obstetric cases, which persist today.

In *Norfolk and Norwich Healthcare Trust v W* [1996],[212] W was in a state of arrested labour in Hospital, even though she insisted she was not pregnant. Her obstetrician was concerned about the safety of W and her foetus. It was advised that without a forceps delivery or caesarean section there was the potential for W's caesarean scars to reopen and the foetus to suffocate. The Trust sought a declaration to perform either a forceps delivery, or if essential, a caesarean section and to permit the use of necessary force and restraint if required. In determining W's capacity, Johnson J referred to the *Re C* capacity test. This test later became the foundation on which the Mental Capacity Act 2005 test was based. Johnson J found that she failed the third part of the test, 'weighing the information [relevant to the decision in question] in the balance to arrive at a choice'.[213] This was due to the fact that 'she was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour…'[214] This was a very concerning justification for a finding of incapacity because every pregnant woman in labour is generally in a state of emotional stress and physical pain. Thus, Johnson J's reasoning would suggest that no woman in labour is capable of weighing information relevant to a decision to refuse medical treatment, rendering them automatically lacking capacity.

In *Rochdale NHS Trust v C* [1997],[215] the consultant obstetrician advised that a caesarean section was needed to save the life of the foetus and prevent some harm to the patient, C. However, C was strongly opposed to the surgery, stating that 'she would rather die than have [a caesarean section] again.'[216] Johnson J found C to lack capacity based on similar reasoning to *Norfolk*. He stated that she was unable to weigh information properly because she was 'in the throes of labour with all that is involved in terms of pain and emotional stress.'[217] He went even further, claiming she was unable 'to make any valid decision about anything of even the most trivial kind.'[218]

1.4.3 Behind a veil of incompetence

These cases demonstrate that Sir Brown P's controversial approach in *Re S* was not repeated. The judges in these cases, Wall J and Johnson J, did not attempt to overrule any decision made by a woman with

[212] n70.
[213] Ibid, 616.
[214] Ibid.
[215] n62.
[216] Ibid.
[217] Ibid.
[218] Ibid.

capacity. However, they were never faced with that dilemma as they decided that all three women lacked the capacity to refuse treatment anyway. Technically, these cases can be viewed as falling under the general rule of *Re T* because the pregnant women's right to decide was appropriately limited due to their lack of capacity. However, these findings of incapacity were questionable. However, these findings of incapacity were questionable. I contend that these findings are suggestive of the fact that consideration for the wellbeing of the foetus was still very much part of the judges' thinking, even if not outwardly expressed. However, to avoid the controversy that followed the *Re S* judgment, I argue that the judges gave tenuous reasons to justify findings of incapacity so that they could lawfully grant the declarations sought. This way they were able to stay in line with the common law rule under *Re T* and avoid controversial public policy discussions that would follow a finding of capacity.

Instead of women's autonomy being adequately respected, I suggest that it has been conveniently discounted through findings of incapacity. Harrington argues that part of the repugnance that commentators felt toward the *Re S* decision was that 'it represented an open endorsement of medically sanctioned standards of behaviours… though behind a veil of incompetence.'[219] The cases that followed *Re S* are perfect examples of this. Non-consensual treatment was still a feature of all of the three cases discussed above. The only difference to the *Re S* judgment was that these happened 'behind a veil of incompetence',[220] therefore technically falling in line with the *Re T* rule. I therefore suggest that these three cases should not be celebrated as a 'move away' from the disregard of pregnant women's autonomy featured in *Re S*. Instead, these cases should be cautioned as setting the tone for future obstetric cases.

These three cases demonstrate that the issue was firmly framed as one of capacity (in line with *Re T* judgment). The pregnant women's right to self-determination was based purely on the condition of their capacity. However, 'a literary analysis of the subtext of the "enforced caesarean" cases expose the disingenuousness at their heart.'[221] I agree with Bryan's contention that 'rather than being protective of the autonomy of the pregnant woman, as their ratios proclaim, [they] operate, through their subtexts…'[222] This means that although these judgments might appear reasoned on the surface, I propose that there was more emotive influence than a simple and objective analysis of these women's capacity.

[219] n164, 360.
[220] Ibid.
[221] n50, 117.
[222] Ibid, 116.

1.5 *Re MB (Caesarean Section) [1997]*: The turning point?

Five years after Lord Donaldson's obiter comments in *Re T*, the question of pregnant women's right to refuse treatment was finally resolved. Lady Justice Butler-Sloss was praised for confirming the absolute right to pregnant women with capacity, even where their decision might result in the death of a viable foetus. The issue was ostensibly settled; women's right to self-determination would prevail over the interests of the foetus. This was an obiter statement, but it was later confirmed in *St George's Healthcare NHS Trust v S* [1998].[223] However, in this thesis I will argue that the spirit and ethos of the *Re MB* judgment has not been fully realised because the empowerment of pregnant women is still lacking in following case law. I will work to prove this in Chapter's II and III.

The case of *Re MB* concerned a woman, Miss MB, who was 40 weeks pregnant. After examination from a doctor, Mr N, the foetus was found to be in breech position. This posed potentially serious consequences for the foetus if delivered through a vaginal birth. MB herself was at little risk of physical danger. However, Mr N recommended that a caesarean section should be performed due to the assessed 50% risk to the foetus and hospital policy that footling breach presentations be delivered by caesarean section. Initially, MB agreed to have the caesarean section, however she later refused after the anaesthetist arrived to insert the veneflon (a cannula inserted through the skin into one of your veins). She stated that she did not want blood samples to be taken or to undergo anaesthesia by way of injection. She also refused to consent to anaesthesia by mask after being explained the potential danger of regurgitating and inhaling her stomach contents. The hospital sought a court order to perform the caesarean section, which Hollis J granted. MB instructed her lawyer Mr Francis to appeal and the case was heard the same night in the Court of Appeal by Lady Justice Butler-Sloss and Lord Justices Saville and Ward.

Butler-Sloss stated in her judgment that:

> *'The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, chose not to have medical intervention, even though, as we have already stated, the consequence may be the death or serious handicap of the child she bears or her own death.'*[224]

In short, a woman who has capacity may refuse medical intervention, even where it may result in the death or harm of the foetus. However on the facts, MB was determined to lack capacity at the moment

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[223] n24.
[224] n1, 60.

of refusing the caesarean section due to her needle phobia and therefore her refusal was not legally valid. Butler-Sloss LJ found that it would be in MB's best interests to see her child born alive and healthy. Therefore, the Court of Appeal dismissed the appeal and sanctioned the caesarean section. Ultimately MB ended up signing the consent form and co-operated fully in the operation and the induction of anaesthesia.

1.5.1 The theoretical benefits

The judgment *Re MB* was praised because the case clarified the legal principles of consent. It established that the same principles govern *all* adult patients with capacity and therefore as Michalowski commends, the courts confirmed that in theory 'the autonomy of the female patient is not reduced by the fact of her pregnancy…'[225]

In *Re MB* Butler-Sloss LJ also questioned the validity of the findings of incapacity in *Norfolk* and *Rochdale*. Johnson J's findings of incapacity in both cases are based on his perceptions of labour and assumptions of their pain and emotional stress rendering them unable to make a decision. However, such a presumption will no longer stand following *Re MB*. Instead, when assessing a woman's capacity using the *Re C* capacity test (now under the Mental Capacity Act 2005), the judge 'will have to be satisfied on the facts of the individual case that the labour pain is indeed so severe as to exclude decision-making capacity.'[226] Consequently, women can no longer be automatically labelled as lacking capacity on account of their being in labour.

Furthermore, it was stated that irrationality does not amount to incompetence, 'but they (irrationality, panic and indecisiveness) may be symptoms or evidence of incompetence.'[227] This endorsed Lord Donaldson's rule in *Re T* as being applicable to pregnant people as well. This means that 'a mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all…'[228] Thus, even where a court may find a woman's decision to withhold consent from a caesarean section unwise, so long as she has capacity, her autonomy remains protected.

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[225] n11, 115.
[226] Ibid.
[227] n1.
[228] *Sidaway Appellant v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and other Respondents* [1985] AC 871, 904.

Sir Brown P's judgment in *Re S* and reliance upon American case law was expressly criticised. In doing so, Butler-Sloss settled the issue of how to frame the debate surrounding refusals to caesarean sections. By expanding the *Re T* judgment to cover all adults, including pregnant people, the debate is framed just around the question of capacity. This means the public interest in the life of the unborn child, as alluded to in *Re S*, is not referred to in future case law.

1.5.2 *St George's Healthcare NHS Trust v S* [1998][229]

Lady Butler-Sloss LJ's approach was further confirmed a year later in *St George's Healthcare NHS Trust v S* [1998][230] where the Court of Appeal overrode the first instance High Court decision. S was 36 weeks pregnant when she was diagnosed with severe pre-eclampsia, a life-threatening condition. Her doctors advised that she should undergo an induced labour to reduce the risk of harm to herself and the foetus. However, S refused stating that she wished to undergo a natural delivery. Nevertheless, the High Court judge, Hogg J, granted the declaration sought by the Hospital that performing a caesarean section on S would be lawful. Her capacity was not considered in this judgment, but it should be noted that this High Court decision pre-dated the *Re MB* judgment.

S underwent the caesarean section and delivered a healthy baby, however she appealed against the High Court decision, believing the decision to be a direct infringement of her autonomy. The Court of Appeal agreed with this contention and in doing so endorsed the judgment of *Re MB*, which had been delivered since the first instance judgment. It is commendable that the Court of Appeal supported the notion that a mentally competent woman need not 'consent to medical treatment for the benefit of the foetus.'[231] They rejected the High Court's judgment and thus held that S's wish to reject the caesarean section should have been upheld as she had capacity to make the decision herself. However, the usefulness of this judgment in the pursuit of women's autonomy is questionable. The Court of Appeal viewed the situation retrospectively. S had already delivered a healthy baby at this point and was herself in good health, therefore it was arguably easier for the Court to state that the woman's wishes should have been respected. Their judgment, unlike the High Court's, had no direct consequences for S. Additionally, they had unlimited time to analyse the case law and arrive at a fair outcome. I suggest that it is easier to reach this decision retrospectively than it is to approach it whilst the situation is ongoing. This case may appear to represent a positive step towards the protection of women that 'robustly asserts the primacy of patient autonomy'.[232] However, this progressive statement of rights for pregnant women

[229] n24.
[230] Ibid.
[231] n7, 58.
[232] n41, 664.

needs to be supported by judges who are willing to uphold these rights in the face of potentially harming consequences for the foetus. The Court of Appeal's support in this judgment did not prevent the violation of bodily integrity that S had to experience; the damage was already done.

1.6 Has *Re MB* [1997] triggered the empowerment of women?

Butler-Sloss LJ established that the interests of the foetus should not outweigh the right a competent pregnant woman has to decide what happens to her body, therefore rejecting Lord Donaldson's suggestion that autonomy may be limited in circumstances where a foetus is at risk of harm or death. Theoretically it did offer pregnant women the equivalent protection to that of any other adult with capacity. However, this praise seems unjustified when in practice there is yet to be a case in which a woman's decision to refuse a caesarean section has actually been accepted. In this thesis I suggest that although Butler-Sloss LJ intended to protect and uphold the autonomy of pregnant women, in reality, her judgment had a limited impact.

This begs the question of why? The Court of Appeal has strongly endorsed the right of a competent adult to refuse medical treatment, twice. The law is clear, yet there appears to be continual reluctance to defend this autonomy and right to self-determination. As Pattinson contends, 'there seems to be a keen judicial desire to find an unwanted caesarean to be lawful.'[233] I suggest that this is because there is a subconscious learning towards foetal protection.

At the beginning of this chapter, I considered case law prior to the *Re MB* judgment to demonstrate underlying attitudes of paternalism in obstetrics. I suggest that the emotive considerations surrounding foetal wellbeing are still prevalent in obstetric case law following *Re MB*. However, instead of being considered outright, as Sir Brown P did in *Re S*, clinicians and judges alike have been subtly ensuring the wellbeing of the foetus through convenient utilisation of the provisions of the MCA. This advantageous application of the statute will be explained further in Chapter's II and III. Fovargue makes the point that while considerations surrounding foetal protection are not unwelcome 'when it occurs without an open and honest discussion, there is an uneasy feeling that a hidden agenda is being pursued, with the regulation and policing of pregnant women the ultimate goal'.[234] This might not necessarily be calculated manipulation, but rather subconscious considerations that influence the judgments. As a result, I believe that some pregnant people are found to lack capacity when arguably they do not and caesarean sections found to be in their best interests, when evidence would otherwise suggest that non-

[233] n52, 128.
[234] n55, 619.

intervention would be more appropriate for her wellbeing. From case law evidence and analysis, I suggest that the reason for this subconscious leaning towards foetal protection stems from the desire to safeguard the soon-to-born baby. When judges are presented with the option to save both the life of the baby and the pregnant woman, I argue that they struggle to consider the alternative choice; to accept that the pregnant person does have the capacity to refuse the caesarean section and risk the wellbeing of the foetus.

The law is clear that a foetus has no legal rights that override those of a pregnant woman.[235] However, I believe this does not equate with how judges view the life of the foetus in obstetric cases. This sentiment is aptly demonstrated by Judge LJ in *St George's* - the Court of Appeal judgment that supposedly consolidated the importance of pregnant women's autonomy. Judge LJ acknowledged that whilst a foetus may not have legal interests it 'is not nothing: if viable it is not lifeless and it is certainly human.'[236] Judge LJ accepts that a foetus's limited interests should not override a competent woman's autonomy, but he is still expressing his uneasiness with dismissing the foetus so entirely. This adds to the picture of understanding why there appears to be a subconscious leaning towards foetal protection.

Furthermore, Judge LJ clearly disapproved of S's wishes to refuse a caesarean section. He stated that 'no normal mother-to-be could possibly think like that…'[237] His condemnation goes further as he describes her thinking as 'bizarre'[238] and that the decision to refuse treatment that would save the life of her unborn child as 'morally repugnant'.[239] Bryan contends that by using these particular words, a narrative and image is created whereby the 'law exerts a powerful influence over how the issues are perceived, conditioning pregnant women and society at large, not to refuse treatment but to submit to the power of the medical profession.'[240] This acts in opposition to the principles they are supposedly promoting, thereby creating a hidden subtext to their judgments. The 'narratives are all the more potent because they are buried within the supposedly objective, impartial court judgment: fiction masquerading as fact.'[241] Although the courts are upholding the precedence of competent women's autonomy, the particular wording selected would suggest that they in fact struggle with endorsing treatment that does not ensure the safety of the unborn baby. I argue that this attitude continues to impact the judgments of obstetric cases.

[235] n1, 60.
[236] n24, 952.
[237] Ibid, 957.
[238] Ibid.
[239] Ibid.
[240] n50, 122.
[241] Ibid.

Judge LJ's language portrays a narrative about what the 'right-thinking' pregnant woman would do. He appears to associate capacity with choosing the treatment that ensures the safety of the foetus. This implies a connection between irrationality and a finding of incapacity. This will be discussed in more detail in chapter II. It is particularly likely that pregnant women will have their capacity questioned if they make a decision that conflicts with foetal welfare. This is despite the consistently affirmed principle that 'irrationality does not equate to incapacity.'[242] However these biases as to what a woman 'should want' are seemingly ingrained in clinicians and judges due to presumptions that a woman with capacity would consent to treatment for the benefit of her foetus. Women who disagree are more readily found to have their capacity questioned.[243] I think this mindset about the 'right-thinking' pregnant woman feeds into the paternalistic tendencies in obstetric cases. This is because judges might feel a duty to protect the foetus from the pregnant person's seemingly irrational decision.

Matthew Thorpe writing extra-judicially stated that it is 'easier for an appellate court to discern principle'[244] than it is for a high court judge to apply it in the 'heat of the moment'.[245] Indeed, it appears that whatever emphasis is placed upon a woman's right to choose treatment, the judicial outcome 'will be influenced by the expert evidence as to which treatment affords the best chance of the happy announcement that both mother and baby are doing well.'[246] Despite two Court of Appeal endorsements of women's superseding autonomy, her right to decide is practically void if it threatens the life of the unborn baby. *Re MB* has only equalised patient autonomy in principle and not in practice. In chapter IV I will re-visit my contention that paternalism is the main underlying issue to be resolved in obstetric cases before women's autonomy can be better respected. I will discuss varying soft and hard law reforms that might work to address this problem.

1.7 The issue now

In this chapter I identified the original issue in obstetric case law; whether a pregnant woman's autonomy could be limited when her decision would otherwise harm her foetus. Ultimately though, Lady Justice Butler-Sloss in *Re MB*, affirmed by Judge LJ in *St George's*, settled the issue. The law is now clear and direct: where a pregnant woman has capacity, she may refuse any treatment even when it may cause harm to her foetus. However, I argue that this judgment has had a very limited impact in practice and suggest that women's autonomy is still being unduly restricted in obstetric cases.

[242] n21.
[243] n51.
[244] n135, 211.
[245] Ibid.
[246] Ibid, 664.

Underlying paternalism still exists in these cases and works to restrict the full extent of pregnant women's autonomy. Now that I have outlined that there is still an 'issue' in obstetric cases, the next two chapters will focus on how this issue currently manifests in case law. There are two main ways in which I believe the issue expresses in post-*Re MB* obstetric case law; through capacity assessments (chapter II) and best interests' determinations (chapter III).

In chapter II I look at the issues present in the judicial assessments of pregnant women's capacity. Bryan contends that 'the law is served by the narrative of incompetency: it provides a convenient, palpable story to explain the disregarding of the pregnant woman's treatment refusal.'[247] I agree with this contention and argue that Judges utilise the flexible capacity test under the Mental Capacity Act 2005 to ensure findings of incapacity. In chapter III I consider best interests' determinations. Through analysis of the case law, I suggest that the best interests determination appears predetermined. The declaration sought by the hospital trust is endorsed to ensure the safety of the foetus. Halliday suggests that the courts consider what 'a prudent patient who fulfils the maternal ideological role would do, concluding that she would be willing to accept any intervention necessary to ensure the safe delivery of the foetus.'[248] I agree with the suggestion that presumptions and expectations about motherhood influence judicial determinations.

Chapter IV concludes this thesis with a discussion about what needs to change for pregnant women's autonomy to be adequately respected. Overall, I argue that for there to be any real progress for pregnant women, it is the underlying paternalistic attitudes that need to be addressed. Otherwise, any type of reform will not work to address the route of the problem. Instead, the protection of the foetus at the detriment of the woman's autonomy will continue to manifest through new avenues.

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[247] n50, 120.
[248] n7, 189.

Chapter II: Obstetric Incapacity

2.0 Introduction

In *Re MB* [1997],[249] Lady Butler-Sloss stated that a 'woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention…'[250] even though, as we have already stated, 'the consequence may be the death or serious handicap of the child she bears or her own death.'[251] However, over 20 years has passed since this 'ground-breaking' judgment and there is yet to be a case in which this right has been engaged in practice. Therefore, as Halliday contends, 'it seems a rather hollow victory to say that a woman with capacity may refuse treatment…'[252] when the courts have never found a woman to have the capacity to refuse the treatment. It is, of course, possible that in all these obstetric cases, the women truly have lacked capacity to refuse obstetric intervention. However, I argue that the relevant evidence points towards an underlying issue instead.

It is contended that the courts use the concepts of capacity and best interests under the Mental Capacity Act 2005 (MCA)[253] as tools to justify obstetric intervention when the life of the foetus is at risk. This chapter will focus on the issue of capacity assessments and discuss how the courts are applying the MCA capacity test and section 1 statutory principles. This argument is supported by other academics. Meredith proposes that since the right to refuse has been repeatedly stated in UK law, 'questioning the capacity to give valid refusal has become a major feature of obstetric conflict in this jurisdiction.'[254] MacLean argues that competence is 'used as a sword by doctors and the courts instead of a shield by the pregnant woman.'[255] It is agreed that the concept of capacity should be used to either empower or protect women, but instead it is exploited to manage and control them. Bryan also argues that 'the law is served by the narrative of incompetency: it provides a convenient, palpable story to explain the disregarding of the pregnant woman's treatment refusal.'[256] Analysis of case judgments support the notion that capacity appears to be utilised as a means to ensuring the desired outcome is achieved. Thus, creating a 'win-win situation: the law maintains its apparent respect for the woman's autonomy and the

[249] n1.
[250] Ibid, 60.
[251] Ibid.
[252] n62, 181.
[253] n20.
[254] n51, 104.
[255] n60, 11.
[256] n50, 115.

foetus is saved.'[257] By ensuring a finding of incapacity, the courts can then legally endorse obstetric intervention through the process of best interests under section 4 MCA.[258] As Ruck-Keene describes it, a finding of incapacity creates a 'cliff-edge off which one falls into the clinging embrace of paternalism.'[259]

Overall, I suggest that in obstetric cases, the courts manipulate the concept of capacity in order to ensure findings of incapacity. The purpose of this chapter is not to contend that all these women actually had capacity. Although in certain cases, the findings of incapacity will be questioned. Instead, the main argument is that the courts rarely, if ever, conduct proper and impartial assessments of capacity. Therefore, I propose that the threshold against which pregnant women are assessed is set at a much lower threshold from other patients. As such, this chapter puts forward the idea that a separate type of capacity exists in obstetric cases. This will be coined '*obstetric incapacity*'; to call out the unacceptable but observable exceptionalism that applies. I will use this as a tool to identify something that is not supposed to be happening; that this is a de facto category that should not exist but, which I argue is in fact apparent.

In the UK, the 'law adopts a combination of the status and the functional approaches to capacity.'[260] The functional approach looks at an individual's capabilities, whereas the status approach describes the categorisation of assumed incapacity based on a characteristic. In English law, this is age, the status of being under 18 years old. In this chapter, I put forward the suggestion that pregnant women who refuse obstetric intervention necessary for the foetus's life are a category of patients that in practice also fall under this 'status approach'. There has been no instance to suggest that they are capable of being found to have capacity when they wish to refuse the clinicians recommended treatment. Until there is a case that negates this argument, it is reasonable to suggest this de facto category exists, notwithstanding judicial dicta to the contrary.

This chapter will explore the numerous ways in which the courts are conveniently concluding that a sub-category of women whose decisions could harm a viable foetus lack capacity to decide, notwithstanding provisions of the MCA that mitigate against such conclusions. Not every point discussed below is valid in every case. Instead, the value of the points is cumulative; together they build a case for the differential treatment of pregnant women that supports the notion of 'obstetric incapacity'. When all the factors are added together it presents a worrying picture.

[257] Ibid, 121.
[258] n20, section 4.
[259] n61.
[260] n86, 243.

In this chapter I refer to the current wishes and feelings of the pregnant woman regarding the decision about her delivery. By this, I am referring to the patient's wishes and feelings in that moment, rather than the presumed wishes and feelings of the individual if they were not incapacitated. I will begin this chapter by looking at the capacity test, contained in sections 2 and 3 of the MCA and discuss the problems that exist with the application of both of these limbs. I will then suggest that the core principles that form the foundation of the MCA are not sufficiently embodied in obstetric cases. This discussion will include analysis of sections 1(3) and 1(4) of the MCA. These principles specify that an individual should not be treated as unable to make a decision unless all practical steps have been taken to help them to do so and that they should not be treated as unable to make a decision merely because they make an unwise decision. Following this discussion, I will analyse the references made to 'insight' in obstetric cases. I contend that insight does not equate to incapacity and yet in practice, courts often make reference to insight as indicative evidence of a finding of incapacity. To conclude, the inherent malleability of the definition of capacity will be summarised. Cumulatively, all of the points that will be discussed feed into the suggestion that there is a de facto special category that exists, and this will be referenced as '*obstetric incapacity*'.

2.1 Two-part test: The Diagnostic Test

The capacity test is a two-stage test found under sections 2(1) and 3(1) of the MCA. It is framed in terms of 'incapacity'. This means that a patient can only be found to lack capacity if they satisfy both the diagnostic test (section 2(1)) and the functional test (section 3(1)). The diagnostic test 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.'[261] This is explained in the Code of Practice, which clarifies that a person 'lacks capacity if they have an impairment or disturbance that affects the way their mind or brain works, and the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.'[262] This first stage is the 'diagnostic' element because it determines the presence of an 'impairment of, or disturbance in the functioning of, the mind or brain.' The Code of Practice provides examples, including conditions associated with significant learning difficulties and some forms of mental illnesses including paranoid schizophrenia and bipolar disorder.[263]

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[261] n20, section 2(1).
[262] Department for Constitutional Affairs, 'Mental Capacity Act 2005: Code of Practice' (2007) 42 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf> accessed 21 May 2021.
[263] Ibid, 44.

In obstetric cases, I argue that this test is not always properly applied. The 'diagnostic test' is generally satisfied in serious mental illness (SMI) obstetric cases. Although in some cases, such as *Re AA* [2012][264] and *A University Hospital NHS Trust v CA* [2016],[265] the categorisation of the pregnant woman's mental impairment is based on insufficient evidence. At the *Re AA* [2012][266] hearing, AA was described as having schizophrenic disorder. This is an SMI that categorically satisfies the 'impairment of, or a disturbance in the functioning of, the mind or brain' requirement under section 2(1). However, in the subsequent adoption proceedings, AA is instead described as suffering from bipolar affective disorder. Bipolar affective disorder is a materially different SMI to paranoid schizophrenia. The uncertainty surrounding the categorisation of AA's SMI diagnosis raises a question as to whether the diagnosis was clear and, if so, whether an uncertain diagnosis was too readily accepted in order to justify overriding her wishes.[267] In turn, this position does not sit comfortably within the underlying ethos of the MCA; to provide patients with every opportunity to facilitate or prove capacity so that they may make their own decisions.[268]

University Hospitals NHS Trust v CA [2016][269] is another example of an obstetric case where the categorisation of the woman's mental impairment is based on insufficient evidence. In this case, the patient CA was labelled as having autism and a learning disability. However, in coming to the conclusion that CA had a learning disability the psychiatrist, Dr I, simply estimated that she had an IQ between 60 and 70. He made assumptions based on her previous and current level of functioning rather than carrying out the formal IQ testing. By failing to complete the formal IQ testing we cannot be sure that CA had a genuine learning disability as Dr I's assessment could have been influenced by prejudgments made based on prior information about her level of functioning. In addition, Dr I also concluded that CA was autistic without carrying out a full assessment. The Official Solicitor, Ms Gollop, highlighted this failing, submitting that there was no clear evidence of any formal diagnosis. Mr Justice Baker gave a worrying response to this contention. He acknowledged that 'the evidence [was] not as comprehensive as is usually adduced in cases of this sort…'[270] but regardless of this failing, was happy to 'accept Dr I's expert diagnosis of CA's mental state and functioning.'[271] In this statement, Mr Justice Baker alludes to the point that in other similar cases he would have expected more

[264] n6.
[265] *A University Hospital NHS Trust v CA* [2016] EWCOP 51.
[266] n6.
[267] Emma Walmsley, 'Mama Mia! Serious Shortcomings with another '(En) Forced' Caesarean Section Case *Re AA* [2012] EWHC 4378 (COP)' (2015) 23(1) *Medical Law Review* 135.
[268] n20, section 1(3).
[269] n265.
[270] Ibid, 28.
[271] Ibid, 24.

comprehensive evidence before accepting the labels of autism and a learning disability. Again, this attitude suggests divergent treatment of pregnant women. The handling of CA's case indicates that there is a lower threshold to satisfy a finding of incapacity in obstetric cases. In her opening statement, Ms Gollop had raised doubt as to whether either element was established on the evidence. It is concerning that Mr Justice Baker did not demand that formal testing be completed before proceeding with the case. It is even more disturbing that he acknowledged this was a different attitude taken than in other similar cases. Overall, this evidence suggests an inclination to establish a SMI in obstetric cases, regardless of whether the evidence is thorough or clear enough to do so. This attitude needs to change if pregnant women are to be treated equally with other adult patients.

2.2 Two-part test: The Functional Test

Problems also lie in the court's engagement with the second limb of the two-stage test; the functional test. In *Re AA* [2012],[272] for example, the court's analysis of this second limb is arguably deficient. The finding of incapacity is based upon insufficient consideration of section 3. A declaration of incapacity should only be made once the diagnostic and functional criteria are both sufficiently satisfied. This second stage is the 'functional' element because it questions the person's ability to make a decision. It is a legal question rather than a medical diagnosis. It explains the circumstances under which 'a person is unable to make a decision for himself…'[273] There are four ways in which this might manifest, 'if he is unable to (a) understand the information relevant to the decision (b) retain that information (c) use or weigh that information as part of the process of making the decision or (d) to communicate his decision…'

The original iteration of the capacity test that is now endorsed in statute came from the common law in the case of *Re C* [1994],[274] where it was coined the '*Re C'* capacity test. As well as setting out the original capacity test, it is a great example of how the two-stage capacity test should be applied in practice. The patient, C, had a gangrenous leg which was likely to cause his imminent death. However, C continued to refuse the recommended amputation even though it was predicted there was only a 15% chance he would survive without it. C also suffered from paranoid schizophrenia, a serious mental illness that would satisfy the diagnostic test under the MCA. However, when discussing C's capacity, Thorpe J found that he 'understood and retained the relevant information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.'[275] C was found to have the

[272] n6.
[273] n20, section 3(1).
[274] n202.
[275] Ibid, 295.

requisite capacity to refuse life-saving treatment, regardless of his serious mental illness. This case demonstrates that having a serious mental illness does not equate to incapacity. As Holman J stressed in *Re SB* [2013],[276] satisfying the diagnostic test 'is the beginning not the end of the enquiry…'[277] and therefore after 'unreservedly accept[ing]'[278] that the patient in this case suffered from a mental illness he proceeded to assess her capacity without expectations of incapacity. This reinforces the fact that *both* the diagnostic and functional criteria need to be satisfied before any finding of incapacity is declared. It demonstrates how a patient with a SMI can retain capacity and that a thorough analysis of the functional limb is required to establish incapacity. Whereas in obstetric cases, I argue that the courts often fail to adhere to this structure. The shortcomings of the courts are highlighted when assessed against the court's treatment of C in *Re C* [1994].[279]

The case of *Re AA* [2012][280] concerned a pregnant Italian woman, AA, who was detained under the Mental Health Act with paranoid schizophrenia. AA's obstetricians wanted her to undergo a caesarean section rather than a natural delivery. The NHS Trust applied to the Court of Protection for a declaration that a planned caesarean section would be in her best interests. When considering AA's capacity, Mostyn J stated that he was 'struggling to envisage a circumstance where a patient detained under section 3 as an inpatient with a diagnosed mental illness has got capacity.'[281] This statement presents a presumptuous attitude towards determining capacity that does not correspond with the position that 'detention under the Mental Health Act is not proof in itself of incapacity.'[282] By highlighting his perception of symmetry between incapacity and ill-mental health, I believe he is inadequately appreciating the importance of the second stage of the capacity test under section 3(1). Such an attitude sits in stark contrast to that taken by Mr Justice Thorpe in *Re C* [1994].[283] The patient, C's, paranoid schizophrenia was acknowledged in this case, but not considered determinative of his capacity. A thorough investigation into his ability to make the decision, to refuse a leg amputation, was conducted and his capacity found intact. This demonstrates an evident divergence in attitudes between pregnant women and other adult patients. Mostyn J did acknowledge in the *Re AA* judgment that 'the fact of detention under section 3 of the Mental Health Act does not ineluctably mean that she lacks capacity…'[284] However, this was stated in the context that Mr Lock QC explained this to him first. I propose that this differentiation in approach and attitude demonstrates an unwillingness on Mostyn J's

[276] *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417.
[277] n7, 61.
[278] Ibid.
[279] n202.
[280] n6.
[281] Ibid, 9.
[282] n202, 295.
[283] Ibid, 290.
[284] n6, 2.

part to find AA capable of making decisions about her delivery. Whereas Mr Justice Thorpe, in *Re C* [1994],[285] appeared more methodical and unbiased in his application of the capacity test with an acceptance that the declarations sought by NHS Trust to act in the patient's best interests should not always be granted. As Meredith sustains, 'many of the cases that have come to court suggest that women are being treated differently from other competent adults merely because of the fact of pregnancy.'[286] In obstetric cases, incapacity is almost always established and obstetric intervention then judged to be in the pregnant woman's best interests. I argue that not accurately applying the capacity test demonstrates a rudimentary lack of respect that is suggestive of a biased response. When dealing with obstetric cases, the courts need to employ the same impartial and thorough application of the capacity test as they do with other adult patients. A finding of incapacity should only be declared once the pregnant woman has been shown to satisfy both the diagnostic threshold *and* the functional threshold.

2.3 Enabling patients to make their own decisions

One of the five statutory principles set out under section 1 of the MCA states that 'a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.'[287] This reflects the underlying ethos of the MCA; that the patient should be 'at the very heart of the decision-making process'[288] and empowered 'to make decisions for themselves wherever possible…'[289] The MCA is not intended to confer all decision-making powers to medical staff and judges. The patient should not be a 'thing' to be managed. They are human beings that deserve every opportunity to decide their own treatment. Thus, the section 1(3) principle also helps to 'prevent unnecessary interventions in their lives.'[290] In obstetric cases, I suggest that little, if any support is provided to enable women to make their own medical decisions. Instead, there appears to be an almost ready acceptance that she lacks capacity. In most of the recent cases, the women concerned have SMI's that inhibit their ability to make decisions. I believe that that not enough is done to enable these women to regain capacity or maintain it.

In *NHS Acute Trust & NHS Mental Trust v C* [2016],[291] the patient C was detained under section 2 of the MHA because she was suffering a 'manic episode with psychotic symptoms.'[292] The consultant

[285] Ibid.
[286] n51, 206.
[287] n20, section 1(3).
[288] n262.
[289] Ibid.
[290] Ibid, 22.
[291] n57.
[292] Ibid, 3.

obstetrician believed that C required a caesarean section performed under general anaesthetic due to her 'inability to remain still and her unpredictable behaviour.'[293] However, C consistently expressed a wish to undergo a vaginal delivery instead. In response, the trust applied to the court for a declaration that it would be lawful to perform a caesarean section against C's wishes. The case was taken before court a few weeks before C was due to give birth. Halliday argues the remaining weeks of C's pregnancy could 'have made a key difference in stabilising her mental health and enabling her to participate in the decision about how to give birth.'[294] If they had utilised that time to help C regain capacity, then there would be no need to decide on her behalf. The goal should have been to support C to make her own decision, rather than making it for her. Admittedly, there were time-limiting issues in this case because her relapse in mental condition was triggered by the late stages of her pregnancy. There was not a lot of time left to work with her, nonetheless there was still *some* time which could have been used but was not.

Admittedly, it was a proactive decision by the trust to identify a potential problem in advance of her delivery. This is commendable because it follows the procedural safeguards set out by Lady Butler-Sloss in *Re MB* [1997][295] where she states that steps should be taken to bring a problem 'before the court, before it becomes an emergency…'[296] However, this is not the only way in which the Trust could have been organised. Instead of only using the time to apply to Court, they could have also been utilising it to treat C's mental health. Instead, the Trust seemed readily acquiescent to accept her state of incapacity and ensure the lawfulness of an unwanted caesarean section. When really, the emphasis should have been on C and helping to treat her psychotic symptoms so that she could regain capacity. By failing to capitalise on the remaining weeks of C's pregnancy, I argue that her obstetrician did not take all practicable steps to help C make a decision herself and therefore failed to realise the patient-central and empowering focus of the MCA. This is particularly unfortunate considering the fact that C's wishes (vaginal delivery) were opposite to the declaration sought. Had they supported her, then her preference might have become legally indisputable. However, maybe that is where the problem stems from; the judges did not want her wishes to become valid (whether consciously or subconsciously) and therefore did not feel compelled to help her regain capacity and decide against their advice. I argue that this reluctance to enable pregnant women to make their own decision where it clashes with the clinician's recommendation is a further indication of the paternalistic attitudes in obstetric case law. It fortifies the suggestion that obstetric cases are a separate category to the norm as they feature insufficient application of the core underlying principles of the MCA.

[293] Ibid, 9.
[294] n62, 192.
[295] n1.
[296] Ibid, 62.

2.4 Unwise decisions

Another underlying principle of the MCA is that a patient cannot be found to lack capacity because they are perceived to make a foolish, silly or unwise decision. This is contained in section 1(4) which states that 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision.'[297] This principle was a feature of common law long before the Mental Capacity Act 2005 was enacted. In *Sidaway v Bethlem Royal Hospital Governors* [1985][298] Lord Scarman stated that 'the patient is entitled to reject that advice for reasons which are rational or irrational or for no reason.'[299] This case example is not directly related to capacity, but it demonstrates that the principle was rooted in early case law. Lord Donaldson further confirmed this principle in *Re T* [1992][300] when he stated that 'the right of choice is not limited to decisions which others might regard as sensible.'[301]

The purpose of this principle is to prevent assumptions that a patient lacks capacity based on the decision they wish to make. It recognises that people are unique and make decisions that not everyone will agree with. Fundamentally, it prevents judges and clinicians who disagree with a patient's wishes from automatically pathologising their seemingly 'unwise' decision as indicative of their inability to decide. It forces courts to make the distinction between patients who make seemingly unwise decisions from patients who are genuinely unable to make decisions. As Sarah-Louise Bingham explains, the 'assessment of capacity must be decision-specific.'[302] That is because when determining capacity, it is not the content of the decision that matters, but the decision-making process. An unwise decision does not equate to incapacity. However, a doctor is not likely to question a patient's capacity unless they believe their decision to be 'seriously misguided or irrational.'[303] As Jackson contends it is 'probably inevitable that doctors are more likely to question a patient's capacity when she refuses treatment…'[304] This means that unwise decisions or rather, treatment refusals in obstetric cases essentially 'act as a trigger for capacity assessments.'[305] Subconsciously, this could cause courts to form associations between unwise decisions and incapacity. Regardless I suggest that generally, with non-obstetric patients, the courts manage to maintain the distinction between unwise decisions and legal incapacity.

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[297] n20, section 1(4).
[298] n228.
[299] Ibid, 666.
[300] n21.
[301] Ibid, 653.
[302] Sarah-Louise Bingham, 'Refusal of treatment and decision-making capacity' (2012) 19(1) *Nursing Ethics* 167, 169.
[303] n86, 243.
[304] Ibid.
[305] n62, 187.

Whereas in obstetric cases ‘there is an expectation that women will choose the “right” option for their foetus…’;[306] failure to adhere to this standard indicates a lack of capacity.

In obstetric cases, I suggest that women are still being found to lack capacity because they wish to make a decision that impacts the wellbeing of the foetus, rather than the fact that they are genuinely unable of making a decision. In the majority of obstetric cases, a finding of incapacity is justified on the basis that the woman’s inability to ‘use or weigh the information (relevant to the decision) as part of the process of making the decision…’[307] However, I question the reasons provided for why these pregnant women are found unable to ‘use or weigh’ the information because the judgments often lack substantive explanation as to why this is the case. Miller argues that a pregnant woman’s wishes are only respected ‘on condition that they do not endanger the life of the child she is carrying.’[308] Indeed, it appears to be a feature of these cases that these pregnant women are found unable to properly appreciate the risks of a natural delivery because they do not agree with the obstetricians recommended caesarean section. This essentially implies that a woman is unable to make a decision about her obstetric care if she chooses to disregard the obstetrician’s proposed treatment. As a result, where a pregnant woman wishes to make a risky or unwise decision that deviates from the medically recommended option are pathologized and assumed to be an indicator of incapacity.

In *Re DD* [2014][309] Cobb J said that the patient, a 36-year-old woman DD did not have capacity to decide how to give birth to her child. This finding is interesting, considering that earlier that year she had been found to have the requisite capacity to make other medical decisions. I believe it is therefore questionable whether she genuinely lacked the capacity to refuse a caesarean section and instead suggest that the content of the decision influenced the courts finding of incapacity. Of course, it should be noted that capacity is decision specific. It could simply be that for the other decisions she was genuinely able to ‘use and weigh the information’ in relation to the decision in a way she wasn’t able to with a caesarean section. However, this is doubtful as no evidence was provided to explain why she had the capacity to make other medical decisions, but not the one regarding the method of delivery. It is important to caveat this statement with the acknowledgment that we only know of what is in a judgment based on what is reported. Therefore, other salient evidence could have been provided that categorically explained why she did lack capacity in this particular instance.

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[306] n48, 57.
[307] n20, section 3(1)(c).
[308] n45, 103.
[309] *The Mental Health Trust v DD* [2014] EWCOP 11.

DD was able to understand, retain and communicate information relevant to the decision, but was found unable to use or weigh the information. The ability to use and weigh information relates to understanding the implications and consequences of a decision, including its risks and benefits. By stating DD was unable to use or weigh the relevant information, the court was claiming that DD was not able to weigh the 'risks associated with a caesarean section'[310] against its proposed benefits. However, there is no information presented that explains why she was supposedly unable to weigh the consequences of her decision. Instead, I suggest that her refusal was pathologized and used as an indicator that she was unable to make the decision. By not coming to the obvious conclusion that the courts would expect of a pregnant woman, I believe that they must have assumed her unable to weigh the risks and benefits when in reality, DD might have used and weighed the information before coming to the conclusion that made the most sense to her.

Similarly, in *A University NHS Trust v CA* [2016],[311] the woman, a Nigerian who wanted a natural birth at home was found to lack capacity due to her inability to 'use and weigh information'. As a child, CA had been physically restrained and subjected to female genital mutilation (FGM). In these circumstances, the judge did recognise that a caesarean could be traumatic. However, he swiftly moved on from this point and arguably did not place enough emphasis on how this might influence the way in which she 'weighs information'. When weighing her options, CA might have placed more importance on feeling safe at home and not suffering the associated trauma that could come with surgical intervention. Whereas I suggest that the courts had expectations of what a pregnant woman with capacity *should want* in that scenario and projected these expectations onto the assessment of her capacity; that she should want to prioritise the safety of her foetus over all other factors. However, this should not be the reality of the situation; a pregnant woman should not be deemed unable to use and weigh the relevant information simply because she does not reach the conclusion the courts expect of her.

In contrast, the courts have shown their ability in non-obstetric cases to identify where patients are truly unable to make decisions. As Pattinson states, 'a patient who makes a decision that is based upon a misperception of reality stemming from a mental disorder will lack capacity.'[312] In *Trust A and Another v H* [2006],[313] the 45-year-old female patient H, had an ovarian cyst that appeared to be cancerous and required surgical intervention. However, H maintained that her stomach swelling was 'just food'. She also believed that she was married and had no children when she was actually divorced with two

[310] Ibid, 116.
[311] n265.
[312] n3, 142.
[313] *Trust A and Another v H (An Adult Patient)* [2006] EWHC 1230.

children. H expressing these thoughts showed evidently delusional beliefs and a misperception of reality. When assessing her capacity, Sir Mark Potter found that her schizophrenia 'prevented her from understanding that the surgery would remove her pain and that she had cancer.'[314] She was unable to 'use or weigh that information as part of the process of making the decision.'[315] Therefore H was found to lack capacity to refuse the surgery to remove her ovarian cyst.

Another example of truly delusional belief in a non-obstetric case is *NHS Trust v T* [2004],[316] where the patient, Ms T had a history of self-harming which was causing dangerously low haemoglobin levels. There was a risk she would die and thus required a blood transfusion. However, she continually refused the treatment on the basis that she believed her blood to be evil and that any healthy blood given to her would become contaminated, consequently producing more 'evil blood' in her body. Charles J found that 'Ms T was unable to use and weigh the relevant information and thus the competing factors in the process of arriving at her decision to refuse a blood transfusion…'[317] and therefore lacked capacity.

In both of these cases, incapacity was based on misperceptions of reality. It was not the beliefs themselves that were judged, but the delusional mind that fabricated them. These examples are provided to demonstrate the difference between seemingly 'foolish' decisions and patients that are simply unable to make decisions. When assessing capacity, the critical question is whether 'someone can make a decision not whether she can make a sensible or responsible decision.'[318] In *A University NHS Trust v CA* [2016],[319] I argue that there was not enough consideration given to CA's trauma and the strength of this reason for CA to avoid a caesarean section. This was not a delusional belief, but a 'truth' for CA. As such, I believe the reasons given for why CA was 'unable to use or weigh' information were lacking in the judgment.

2.4.1 Decision pathologized as evidence of incapacity

From the evidence presented, I contend that pregnant women are being found unable 'to use or weigh' information because they do not reach the outcome (obstetric intervention) that the obstetricians purport to be the most logical and sensible option. It is almost as if the courts think that when completing the process of making the decision about obstetric care, there is only one acceptable conclusion. As Fovargue purports, it is pointless to apply the provisions of the MCA, 'if doing so will only lead to one

[314] n3, 143.
[315] n20, section 3(1)(c).
[316] *NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2004] EWHC 1279 (Fam).
[317] Ibid, 63.
[318] n86, 251.
[319] n265.

conclusion…'[320] Failure to come to this conclusion is then used as evidence that the woman was unable to complete the process of making the decision and thus lacks capacity. It is like comparing the decision to an unambiguous mathematical equation, for example, 1 + 2, and since she failed to arrive at the summation of 3 she lacks capacity, when really there is no specific sum to be completed. Different women will attach different weight to the risks and benefits of treatment and then conclude that they wish to refuse to consent to a caesarean section. It does not mean that they were unable to 'use or weigh' the information though. So long as they are capable of completing that balancing act, it does not matter whether their reasons appear rational or not. I am not stating that these women actually had capacity. From the judgments themselves it is difficult to determine whether these two women were actually unable to 'use and weigh' information. The issue is that by conflating unwise decisions with lacking capacity we cannot be sure whether these women did actually have capacity. Their decisions are pathologized without a thorough analysis of their ability to make a decision.

As Jackson states 'it is sometimes difficult to distinguish between a person's bizarre wishes, which must nevertheless be respected and a person's inability to use and weigh information, which may mean that she fails section 3(1)(c) of the test for capacity.'[321] I purport that this is what is happening in many obstetric cases. As shown already, there is a definite sentiment in courts that any decision that does not ensure the best interests of the foetus is seen as 'bizarre' and either consciously or subconsciously, this leads to a determination that she is unable to make a decision. Halliday suggests that there is a particularly clear danger that in obstetric intervention cases, 'treatment refusals or non-compliance are pathologized, seen as evidence of the woman's inability to make the decision…'[322] and that is why there has not been a single case in which a woman who wishes to refuse caesarean section has been found to have the requisite capacity. In *North Somerset Council v LW and others* [2014][323] a woman was deemed to have capacity. However, this was only after she accepted the medical advice and consented to a caesarean section. It is questionable whether she would have still been found to have capacity had she not made the decision endorsed by her obstetricians.

Savell suggests that pregnant women are in a very unique position, there is 'a bounded, unitary model of selfhood [that] places the mother and foetus in an antagonistic relationship.'[324] When other adult patients make their own decisions these are seen as 'appropriate qualities of self-sufficiency and self-direction'[325] in a legal person. However, in the case of the pregnant woman, they are registered as

[320] n55, 617.
[321] n86, 250.
[322] n62, 187.
[323] *North Somerset Council v LW and others* [2014] EWHC 1670 (Fam).
[324] n48, 64.
[325] Ibid, 31.

abnormal 'and may signal legal incompetence.'[326] As a result, altruistic expectations are placed upon the pregnant woman and this unique relationship works against the position of section 1(4). By virtue of this unique relationship, even if legally negated by section 1(4), the 'normal' pregnant woman is presented as someone who follows their doctor's advice and will consent to medical interventions. She is expected to be 'compliant, nurturing and self-sacrificial.'[327] Therefore when she strays from this ideal, she is pathologized as lacking capacity to make a decision. Whereas, because LW eventually agreed with the proposed treatment she was found to have capacity in *North Somerset Council v LW and others* [2014].[328] This essentially suggests that if a woman does not agree with her clinicians, this triggers the assumption that she is not able to weigh the information in making the decision about her treatment delivery and is consequently unable to make the decision and thus, lacks capacity.

Obstetric cases are not the only scenario in which this type of dilemma appears. Cave and Tan identify a similar 'catch-22' situation in anorexia nervosa cases where an individual's capacity to refuse food is being assessed.[329] In these anorexic nervosa cases they identify how patients are found to lack capacity to make decisions in relation to their treatment by virtue of their condition, anorexia. In these cases, the anorexic patient's capacity is denied on the basis 'that the (apparent) irrationality itself indicates a lack of autonomy, and thus incapacity.'[330] This statement suggests that 'some systems of reasoning are themselves determinative of incapacity…'[331] Cave and Tan criticise this stance and argue that 'capacity should be decision and not disease specific'[332] and the courts 'should adopt a patient-centred rather than clinician-centred approach to framing the decision.'[333] Similarly in obstetric cases, it is contended that the pregnant woman's ability to make a decision should be the focus of her capacity assessment rather than considerations surrounding the wellbeing of the foetus. This demonstrates that there are parallels with other conditions and similar criticisms arising in terms of the assessment of capacity based on the content of the decision, rather than the patient making the decision. The cases discussed demonstrate the courts acting in a manner that is not in-keeping with section 1(4), one of the core principles of the MCA and thus adds to the building picture of obstetric incapacity.

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[326] Ibid, 61.
[327] Ibid, 32.
[328] n323.
[329] Emma Cave and Jacinta Tan, 'Severe and Enduring Anorexia Nervosa in the Court of Protection in England and Wales' [2017] *International Journal of Mental Health and Capacity Law* 4, 24.
[330] John Coggon, 'Mental Capacity Law, Autonomy and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection' (2016) 24(3) *Medical Law Review* 396, 401.
[331] Ibid.
[332] n329, 24.
[333] Ibid, 4.

2.5 Lack of insight

As this section will demonstrate, a trend has emerged in obstetric cases, whereby pregnant women are described as having a 'lack of insight' into their condition.[334] This has been used as indicative and conclusive evidence that the woman lacks capacity, even though insight forms no part of the capacity test under section 2 and 3 MCA. But as we shall see, judges are often seen to justify a finding of incapacity on the basis of a lack of insight. For example, in *X NHS Foundation Trust & Anor v Ms A* [2021],[335] Ms A was found lack capacity on the basis of her lack of insight.

Jackson explains, 'lack of insight' is not the same as 'lacking capacity.'[336] To possess capacity, you only need a 'broad, general understanding'[337] of the benefits and risks of the treatment, whereas insight refers to a deeper understanding. There are circumstances where a patient may lack insight into their condition but have the capacity to make a decision regarding their treatment. As Allen explains 'the two concepts are like quibbling siblings… often both siblings attend to a person's decision. Occasionally one of them may decide to turn up without the other. Sometimes both siblings are absent.'[338] They describe similar situations, but they are not identical. Therefore, it is not justifiable for judges to use a lack of insight as evidence of a woman's incapacity. This observation adds further substance to the argument that pregnant women's actions and desires are often pathologized as an indication of incapacity.

The use of 'insight' as evidence of incapacity is another indicator that the judging of obstetric cases is not totally in-keeping with the principles of the MCA and adds to the cumulative case that the threshold for capacity in obstetric cases is set at a different standard. In the following discussion I will consider what insight means and analyse obstetric cases where it has been used to indicate capacity. I will then explain why insight and capacity are distinct concepts and by conflating the two, the idea of 'obstetric incapacity' is again reinforced.

2.5.1 Differentiating insight and capacity

[334] n58, 6.
[335] Ibid.
[336] n86, 251.
[337] *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342, [26].
[338] Neil Allen, 'Is Capacity "In Sight"?' (2009) *Journal of Mental Health Law* 165, 169.

As Hotopf states, ‘insight is not a legal concept’[339] and yet in case law judgments you sometimes see it doing ‘legal “work”.’[340] Insight is instead, a clinical construct that derives from a psychiatric background.[341] There are numerous definitions of insight. Halliday summarises it as an ‘awareness of one’s own condition and behaviour.’[342] It refers to the ability to have an understanding of what you, as a patient are suffering from; a sort of self-awareness. A patient will be described as ‘having insight’ if they are ‘aware that they are suffering from a mental disorder and [are] able to articulate their condition in the language of symptoms.’[343] Whereas a ‘patient who is unwell but [also] unaware of their own illness may be described as “lacking insight” …’[344]

The connection between insight and incapacity is not an issue that is unique to obstetric cases. As Cairns points out ‘insight [is] the aspect of psychopathology most strongly associated with lack of capacity…’[345] This highlights the connection and overlap between insight and capacity. In past cases, insight has ‘sometimes [been] used as a proxy for decision-making capacity (DMC) and a lack of insight is sometimes taken as sufficient evidence of lack of DMC.’[346] What is unusual in obstetric cases however, is that the courts are still readily applying this connection, regardless of the literature that strongly refutes this. This discussion will now focus on why insight should not be used as an indicator of capacity. I argue that these concepts cannot be used interchangeably and that it is important for courts to not fall into the trap of assuming incapacity based on a psychiatrist’s assertion that the patient lacks insight.

Firstly, there is no mention of insight in the MCA or the Codes of Practice. It is not an aspect of the capacity test found in section 2(1) and 3(1). In ‘England and Wales, insight is not included in the legal definition of capacity…’[347] and therefore, the judicial use of the term is dubious considering that the only language they should be considering is that contained under the MCA. Furthermore, the 2018 NICE guidelines expressly state that ‘a person may have decision-making capacity even if they are

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[339] Matthew Hotopf, ‘Mental Capacity, diagnosis and insight’ (2008) British Medical Journal <https://www.bmj.com/rapid-response/2011/11/02/mental-capacity-diagnosis-and-insight> accessed 10 December 2021.
[340] Ibid.
[341] n55, 184.
[342] Ibid, 184.
[343] Mental Health and Justice, ‘Insight’ <https://mhj.org.uk/4-insight/> accessed 22 April 2022.
[344] Ibid.
[345] Ruth Cairns, ‘Prevalence and predictors of mental incapacity in psychiatric in-patients’ (2005) 187 *British Journal of Psychiatry* 379, 384.
[346] n343.
[347] Ibid.

described as lacking 'insight' into their condition. Capacity and insight are two distinct concepts.'[348] The NICE guidelines are not legally enforceable; however, they are the official recommendations for health and care professionals in England and it is therefore noteworthy that NICE are expressly condemning any assumptions of incapacity based on a lack of insight. This assertion should encourage healthcare professionals and the courts alike not to conflate the two concepts when completing capacity assessments. It is also important to note that capacity is a legal construct whereas insight is a psychiatric term and as Halliday states, 'a psychiatric term of art has no place in the legal test of capacity…'[349] When insight is allowed to infiltrate the capacity assessment it changes the nature of the test from legal to medical. As Diesfeld and Sjostrom argue, the use of insight medicalises arguments, 'framing the person's self-perceptions and choices as evidence of pathology.'[350] However, the MCA was not designed to conduct purely medical evaluations and to place the decision-making power in the hands of psychiatrists is to ignore the underlying purpose of the statutory test.

There is a material difference between the concepts of capacity and insight. It is important that the distinction is maintained. The capacity test requires the patient to 'understand the information relevant to the decision…'[351] under section 3(1) of the MCA. In *Heart of England NHS Foundation Trust v JB* [2014],[352] Peter Jackson J explained what was required of the patient under section 3(1). He stated that all that was necessary of JB was that he had a 'broad, general understanding'[353] of the benefits and risks of amputation rather than a more detailed understanding of the relative risks of different types of amputation. What is not required is for the patient 'to understand every last piece of information about her situation and her options…'[354] This means that pregnant women do not need to understand every medical detail related to a vaginal delivery or caesarean section, they just need to understand the key benefits and risks that are material when making the decision. As Peter Jackson J explained further, 'what is required is an understanding of the nature, purpose and effects of the proposed treatment.'[355]

In contrast, 'insight might be understood to signify a deeper understanding of the issue…'[356] The Cambridge dictionary describes insight as 'the ability to have a clear… [and] deep understanding of a

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[348] National Institute for Health and Care Excellence, 'Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance' (National Collaborating Centre for Mental Health, 2018) <www.nice.org.uk/guidance/cg192/evidence/full-guideline-pdf-4840896925> accessed 2 August 2022.
[349] n62, 198.
[350] Kate Diesfeld and Stefan Sjostrom, 'Interpretive Flexibility: Why Doesn't Insight Incite Controversy in Mental Health Law?' (2007) 25 *Behav Sci Law* 85, 98.
[351] n20, section 3(1).
[352] n337.
[353] Ibid, 26.
[354] n86.
[355] Ibid, 247.
[356] n62, 192.

complicated problem or situation…'[357] This deeper understanding of medical treatment is not what is required by the MCA. It is not necessary for a pregnant woman to understand every detail of the proposed treatment. So long as she can 'understand and weigh the salient details relevant to the decision at hand'[358] then she can still be found to have capacity. Case explains the importance of not conflating insight with capacity. She says that requiring a deeper understanding would 'conflict with judicial insistence that the threshold for capacity should not be set too high.'[359] Therefore, when the courts use insight as evidence of incapacity, they set a low threshold for incapacity. Reference to the term in a number of obstetric cases (as explored in the section below) suggests that this is likely to be particularly problematic for pregnant women refusing obstetric intervention.

2.5.2 Insight in Obstetric cases

I will now highlight obstetric cases in comparison to non-obstetric cases to demonstrate that the courts are still failing to make this distinction when assessing the capacity of pregnant women. This evidence will demonstrate that obstetric cases have not caught up with the current status quo, which again supports the notion that obstetric cases are an outlying category.

Halliday identifies the issue of insight and incapacity in obstetric cases in 'Insight and capacity, a tale of loss.'[360] She specifically draws on two case examples - *The NHS Acute Trust v C* [2016][361] and *A University Hospital NHS Trust v CA* [2016][362] - to show evidence of the problem. She does this by highlighting how these women's 'non-compliant behaviour was seen as a result of her lack of insight.'[363] Over five years later and insight is still being used as an indicator of incapacity, regardless of the NICE Guidelines published in 2018 and the extensive literature that expressly condemns this approach. For example, in *X NHS Foundation Trust & Anor v Ms A* [2021][364] Ms A was found to 'lack capacity with regard to her mental health care and treatment as she was demonstrating no insight into her previous illness…'[365] This judgment illustrates the point that insight is still being wrongly employed in obstetric cases and that this particular issue has not yet been resolved.

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[357] Cambridge Dictionary, 'Insight' <https://dictionary.cambridge.org/dictionary/english/insight> accessed 21 September 2022.
[358] *LBL v RYJ and VJ* [2010] EWHC 2664 (Fam) [58].
[359] Paula Case, 'Dangerous Liaisons? Psychiatry and Law in the Court of Protection – Expert Discourses of "Insight" (and "Compliance")' (2016) 24 *Med Law Rev* 360, 375.
[360] n62, 178.
[361] n57.
[362] n265.
[363] n62, 198.
[364] n58.
[365] Ibid, 4.

In *The NHS Acute Trust v C* [2016][366] the consultant psychiatrist claimed that C had no insight into her mental state and that she lacked capacity to make a decision about her obstetric treatment. The patient C, 'had a history of bipolar affective disorder, but her condition had been generally well controlled by psychotropic medicine…'[367] but in late pregnancy she was detained under section 2 MHA suffering a manic episode with psychotic symptoms. Whilst determining C's ability to make a decision about her medical treatment, I suggest that the distinct concepts of insight and incapacity were unfairly connected. Her consultant obstetrician stated that 'she lacked capacity to decide on her obstetric care because her inability to concentrate for long periods prevented her from understanding the whole context…'[368] However, the capacity test should not have assessed C's ability to understand the whole context of delivery. All that was required of C was to have a 'broad, general understanding'[369] of the benefits and risks of a natural delivery as opposed to a caesarean section. However, she was assessed against a tougher threshold that is associated with insight rather than capacity. The judge said that she had 'no insight into her mental state'[370] and this fed into her assessment of incapacity. Furthermore, because she was compared against the criteria for insight we do not know whether C actually had capacity or not. There is not enough information presented to demonstrate whether she would have surpassed a lower threshold. This demonstrates the dangers of inserting the medical term 'insight' into the functional limb of the capacity test. It prevents a genuine capacity assessment from occurring because a deeper understanding from the pregnant woman is demanded instead.

In comparison, there is case evidence of how this distinction should be maintained in cases of non-obstetric patients, such as *R (on the application of B) v Dr SS* [2005].[371] In this case, the patient Mr B was diagnosed with bipolar affective disorder. His medical officer Dr SS,wanted to compulsorily treat Mr B with anti-psychotic medication to which he did not consent. Mr B preferred to believe that he was mentally well or would at most accept that he was one of those 10% of bipolar affective disorder patients who would not relapse.[372] As a result, in the professional opinion of Dr SS and the Second Opinion Appointed Doctor, Mr B lacked insight into his condition. However, Mr B's ability to recall discussions with doctors about treatment was described as 'remarkable'. Judge Charles J found that he was able to understand and retain the information relevant to the decision, both components of capacity irrelevant of insight. Overall, Mr B was found to have the requisite capacity to refuse to consent to the

[366] n57.
[367] n62, 190.
[368] Ibid, 192.
[369] n337, 62.
[370] n57, 38.
[371] *R (on the application of B) v Dr SS* [2005] EWHC 1936.
[372] Ibid.

recommended psychotic medication, therefore presenting a case in which a patient was found to *lack* insight but *retain* capacity.

The previous case shows how the court was able to make the distinction between insight and incapacity in 2005 in relation to a patient outside of the obstetric context. However, in 2021 in obstetric settings a lack of insight was synonymous with a lack of capacity when concerning pregnant women who wish to refuse obstetric intervention. In *X NHS Foundation Trust & Anor v Ms A* [2021][373] Ms A was 38 weeks pregnant when she was detained under section 2 MHA for a period of assessment. It was established that she was experiencing a relapse of her paranoid schizophrenia. Her consultant obstetrician, Dr B 'formed the view that Ms A lacked capacity with regard to her mental health care and treatment as she was demonstrating *no insight* into her previous illness.'[374] This presents another situation where a medical professional has allowed evidence of insight to influence and determine their opinion on capacity. It is fair to note that Mr Justice Cohen did not base his finding of incapacity solely on Ms A's lack of insight. He did discuss her ability to make a decision under the section 3(1) functional criteria finding that she was 'unable to weigh the risks of what she wants, namely birth at home.'[375] Nonetheless, it is concerning that the connection between insight and incapacity was still being maintained. It was another subtle strike against Ms A and unhelpfully aided in building an overarching argument of incapacity.

This presents a concerning discrepancy between obstetric and non-obstetric cases. Where the courts were differentiating incapacity and insight in the non-obstetric case of *R (on the application of B) v Dr SS*[376] in 2005 they were still falling into the trap of unreasonably connecting the two terms in the obstetric case of *X NHS Foundation Trust & Anor v Ms A*[377] in 2021. This implies that obstetric cases are lagging behind the current and up-to-date stance on capacity assessments. This is an unacceptable differentiation in treatment that signals a stagnation in the progression of autonomy of pregnant women compared to other patients. This distinction between pregnant patients and non-pregnant patients solidifies the argument that the incapacity threshold is set lower in obstetric cases enforcing the idea of 'obstetric incapacity'.

2.6 Deference to medical opinion

[373] n58.
[374] Ibid, 4.
[375] Ibid.
[376] n371.
[377] n58.

The concept of 'capacity' under the MCA is a legal construction. It contains medical and psychiatric elements, however 'the assessment is ultimately a matter for the court.'[378] In obstetric cases I suggest that the capacity test is being 'dominated by the medical discourse.'[379] The courts often defer to the psychiatrist and obstetricians' medical opinions and their judgments that the pregnant woman lacks capacity is often accepted as fact. This means that in practice the decision often falls to the obstetrician.

In *Re AA* [2012],[380] no independent psychiatrist assessment into AA's capacity was conducted. The assessment was completed by only one psychiatrist, who had been treating AA for 6 weeks and therefore was not impartial. Her treating psychiatrist deemed AA to lack capacity and this was accepted as fact without any scrutiny into her assessment. The Counsel for the Official Solicitor, Mr Lock said 'we have thought carefully as to whether we ought to ask your Lordship to adjourn this so that we can get further into capacity…'[381] but determined that because AA had been treated by this psychiatrist for 6 weeks her finding of incapacity was evidence enough. This statement expressly contravenes the procedural safeguards set out in *St George's NHS Trust v S* [1996].[382] In this case, the court said that 'the issue of capacity should be examined by an independent psychiatrist, ideally one approved under s12(2) MHA 1983…'[383] This recommendation was not heeded in *Re AA*. Mostyn J accepted the psychiatrist's assessment as factual evidence of AA's incapacity. This approach ignores the fact that 'the roles of the court and the expert are distinct…'[384] The medical personnel should present their expert evidence but 'the judge must always remember that he or she is the person who makes the final decision.'[385] The MCA test contains medical elements and requires expert psychiatrist assessments however it is fundamentally a legal concept and as Baker J purports in *CC v KK & STCC* [2012][386] 'the assessment is ultimately a matter for the court.'[387]

Unfortunately, in obstetric cases such as *Re AA* [2012][388] the fact the capacity test is a legal construct is often overlooked. Instead, as Clough notes 'the judges often accept professional's view that the person lacks capacity without necessarily scrutinising the particular requirements outlined in the Act.'[389] This

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[378] *CC v KK & STCC* [2012] EWHC 2136 (COP) [24].
[379] n62, 198.
[380] n6.
[381] n6, [9].
[382] n24.
[383] Ibid, [22].
[384] Ibid, [39].
[385] Ibid, [44].
[386] n378.
[387] Ibid, [24].
[388] n6.
[389] Beverley Clough, 'People Like That: Realising the Social Model in Mental Capacity Jurisprudence' (2014) 22 *Med Law Rev* 53, 56.

demonstrates yet another failing in the court's application of the capacity test in obstetric cases. For pregnant women to be treated as the MCA intends, the courts need to limit their deference to medical expertise. This does not mean that judges should assess capacity without any reliance on or reference to medical opinion. However, ultimately the courts should come to their own conclusion and provide clear justifications for their assessment to avoid what currently appears to be a ready acceptance of medical opinion. At present I believe that the courts do not provide sufficient reasoning for why they have accepted the medical opinion as indicative evidence of the woman's capacity. Currently, I suggest that 'doctors frequently give opinions about capacity which are accepted without further legal intervention.'[390] Whereas the functional test under section 3(1) should 'be subject to stringent assessment in court'[391] before there is any finding of incapacity otherwise the threshold for incapacity would be set much lower.

2.7 Convenient findings of incapacity

Thus far, it has been demonstrated that the courts do not properly engage with the MCA and that it can be manipulated to produce a desired outcome. Pregnant women are treated differently to other patients outside of the obstetric context in a manner that I have argued diverges from the philosophy of the MCA. In an article in 1999, MacLean argued that 'the real problem of the issue is competence being used as a sword by doctors and the courts instead of a shield by the pregnant woman.'[392] Over 20 years later this statement still presents a relevant point as the courts use capacity as a tool to ensure that obstetric intervention is justified. The concept of capacity should be used to empower or protect women but instead it is exploited to manage and control them.

2.7.1 A malleable concept

Discussion has shown that clinicians and courts often fail to properly engage with the MCA in obstetric cases. For example, there is little attempt to support women to regain or achieve capacity as required under section 1(3). However, even with greater adherence to the statutory principles, the definition of capacity is still 'inherently malleable'[393] and thus easy to manipulate. The manner in which 'capacity' is formulated means that a patient's ability to make a decision can be interpreted differently. There is no specific definition of capacity under the MCA because it needs to be applicable in numerous different

[390] British Medical Association, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (2nd edn, Wiley-Blackwell 2004) 86.
[391] n62, 187.
[392] n60, 11.
[393] n7, 86.

case scenarios. However, this means that the courts have broad discretionary powers when considering the criteria under section 3(1). There is slightly more specific guidance under the Code of Practice that expands on what it means to 'understand the information relevant to the decision.'[394] However, this is still not specific enough advice to cover every given scenario. Judges retain some artistic license when determining capacity. Of course, it is not possible to cover *every* given scenario, however I believe that further clarification should be provided than is currently included. It is concerning that the concept of capacity is so malleable because as Jackson explains 'a great deal turns on whether a patient has capacity.'[395] This is a valid statement because where a patient has capacity 'the principle of autonomy dominates, and the patient is entitled to refuse treatment…'[396] whereas a finding of incapacity entitles doctors 'to act paternalistically and treat the patients in their best interests.'[397] This demonstrates just how important the distinction between capacity and incapacity is because it essentially symbolises who has control over the medical decision.

2.7.2 Convenient Findings of Incapacity

In 1997 Brazier argued that by focussing upon capacity 'the way is left open to establish in a great many cases where women and doctors disagree about childbirth that the woman was incompetent so that what others consider her interests and her child's require can lawfully be done.' [398] This claim is indeed supported when analysing the obstetric cases heard in the 1990s. For instance, in *Norfolk and Norwich Healthcare Trust v W* [1997][399] Johnson J said that W was unable to make a decision due to the debilitating effects of the 'acute emotional stress and physical pain in the ordinary course of labour…'[400] This statement essentially suggested that 'any woman in labour may be considered to be incompetent because of the very fact that she is in labour due to the stress and pain involved'[401] therefore implying that every woman will lack capacity when they are in labour. This argument was ultimately discredited by Lady Butler-Sloss in *Re MB* [1997].[402] However, the point remains that because capacity is such a flexible and ambiguous concept the courts are able to justify findings of incapacity from any number of constructed reasons.

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[394] n262.
[395] n86, 299.
[396] Ibid.
[397] Ibid.
[398] M Brazier, 'Hard Cases Make Bad Law' (1997) 23(6) *Journal of Medical Ethics* 341, 343.
[399] n70.
[400] Ibid.
[401] n7, 48.
[402] n1.

Therefore, even though Lady Butler-Sloss's *Re MB* judgment might have condemned certain justifications from being used the courts have simply reimagined ways of validating incapacity. As Halliday contends, over the years 'the legal landscape of court-authorised obstetric intervention has changed little; rather the battle lines have been redrawn to focus upon women who are mentally ill…'[403] No matter how the law is re-designed or confirmed in favour of women's autonomy, there has always been the means to find a woman to lack capacity and thus endorse obstetric intervention. Until there is a genuine tolerance towards the possibility of a foetus suffering harm, I suggest that no pregnant woman will be found to have the requisite capacity to refuse to consent to the recommended obstetric treatment.

In more recent cases, women have been described as lacking insight and their unwise decisions are pathologized as evidence of incapacity. As demonstrated earlier in this chapter, it appears that the courts associate capacity with a certain decision; the treatment recommended by the obstetrician. Any woman who does not come to this conclusion is categorised as unable to make a decision about her treatment. Thus, it appears that courts associate capacity with compliance. Holstein points out that 'patient testimony that contradicts expert opinion is not treated as a countervailing report, but instead is seen as a symptom itself.'[404] Such a stance condemns any woman who refuses to consent to a caesarean section as unable to do so. This essentially creates a 'catch-22'[405] situation in which no woman will be found to have the requisite capacity to disagree with her obstetrician. Hewson explains this situation, stating that 'women may only refuse consent if they are competent, but refusal signifies lack of competence and may therefore be overridden.'[406] This demonstrates an avenue through which the courts can ensure obstetric intervention. I suggest that this reinforces the inevitably of incapacity in these scenarios and confirms the reality of a de-facto obstetric incapacity.

In addition, there is still considerable deference to the medical expertise when determining capacity. As a result, the functional criteria under section 3(1) are not always effectively engaged with and the test has become more medical than legal in nature. Bryan argues that 'it becomes a game: medicine gives judges the means, the evidence of incompetency, by which they can achieve their objective, the protection of the foetus, whilst maintaining the law's position of neutrality and whilst refusing to acknowledge that the woman's right to self-determination has been ignored.'[407] It is agreed that by focussing on the woman's SMI and emphasising her diagnosis as evidence of incapacity the courts are able to maintain their adherence to the *Re MB* common law right to refuse intervention. No matter the

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[403] n7, 87.
[404] James Holstein, *Court-ordered Insanity: Interpretive Practice and Involuntary Commitment* (Aldine Transaction 1993) 102.
[405] Barbara Hewson, 'Could the High Court order you to have an operation?' (1998) 115 *Living Marxism* 24.
[406] Ibid.
[407] n50, 120.

reason or justification employed by the courts the end result is arguably inevitable; the woman with a SMI or a learning disability lacks capacity to refuse treatment, especially if it puts the life of the foetus in danger.[408] Based on evidence to date, it is inevitable that any woman who wishes to disagree with her obstetrician's recommendations will be overruled if her foetus is at risk.

2.8 Exceptionalism in obstetric cases

Overall, this chapter has demonstrated the ways in which incapacity in obstetric cases is treated differently to incapacity in other cases and therefore justifies the use of the term 'obstetric incapacity' as a mechanism to demonstrate exceptionalism. The same issues do not arise in every obstetric case, however by combining the different problems identified, a holistic picture is created of a much lower threshold against which pregnant women's capacity is assessed.

Firstly, it was identified that the two-part test contained in the MCA is not always sufficiently observed. For the diagnostic test in section 2(1), the labelling is not always clear or appropriately evidenced as shown in the case of *Re AA* [2012].[409] Furthermore, the functional test in section 3(1) is liable to subjective interpretations of what it means 'to use or weigh information' as part of the test. It was demonstrated how the application of this phrase in *Re C*, a non-obstetric case, underwent a thorough analysis, whereas in *Re AA*, AA's detention under section 3 MHA was seen as almost determinative of her incapacity.[410]

The statutory principles that underpin the MCA were also identified as being insufficiently observed in obstetric cases. Section 1(3) mandates that individuals should not be 'treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'[411] and yet case evidence suggests that pregnant women are rarely seen to be supported and enabled to make their own decisions about their delivery and treatment. Furthermore, it has been inferred from case law that judges deem a pregnant woman's refusal of a caesarean section (which would benefit the foetus) as unwise and these associations are ultimately projected onto their judgment of her capacity. This does not align with the sentiment of section 1(4) of the MCA which instructs that a 'person [should not] be treated as unable to make a decision merely because he makes an unwise decision'[412]

[408] n55, 611.
[409] n6.
[410] Ibid, [9].
[411] n20, section 1(3).
[412] Ibid, section 1(4).

I also highlighted in this chapter how a pregnant woman's lack of insight has been used to substantiate findings of incapacity even though these are distinct and incongruent terms. This provided another example of how women's actions are pathologized by the courts to justify a finding of incapacity. Finally, I identified the high levels of deference to medical opinion that occurs in obstetric cases when determining capacity. Medical knowledge and expertise are a required and important element of the capacity test; however, the decision should ultimately be constructed by the court. Instead, I have suggested that there is ready acquiescence of the clinician's judgment that essentially results in their opinions dictating the result. I argue that instead, medical expertise should merely be one factor in the judgment and inform rather than determine the judge's outcome.

Combined, these individual arguments add up to create a bigger picture of divergent treatment in obstetric cases. Therefore, the term 'obstetric incapacity' has been used as a tool to highlight this de facto category and draw attention to the fact that it should not exist as a distinguished group, but it does. Overall, this chapter has demonstrated that problems still exist in the judgments of obstetric cases and as a result, the autonomy of pregnant women is still being limited post-*Re MB*. In chapter IV I will suggest a few potential solutions that could work to combat the issues presented in this chapter and encourage more substantiated assessments of capacity to combat the exceptionalism that currently occurs.

This chapter has considered the problems that are present in obstetric cases in relation to assessing pregnant women's capacity who wish to refuse a recommended caesarean section. In the next chapter I will continue to build on the overall argument that problems still exist in the judgments of these obstetric cases. This will be accomplished through a focus on the patient's best interests and the problems that I suggest still exist with these determinations in obstetric cases.

Chapter III: The pregnant woman's best interests

3.0 Introduction

In a paper written in 1999, Thorpe stated that 'it is unnecessary to dwell on best interests in the context of cases involving caesarean section'[413] because where a pregnant woman lacks capacity 'the obstetrician proceeds towards the goal of successful delivery….'[414] It is worrying that Thorpe considered it essentially redundant to investigate the woman's best interests as it should be assumed that the safe delivery of the foetus should be the default action. This statement was made before the Mental Capacity Act 2005 and the statutory test was introduced, however I suggest that the sentiment of Thorpe's words still rings true in the court's judgments to this day.

The Mental Capacity Act 2005 'adopts a participative approach'[415] towards the best interests determination. However, as Halliday argues, the case law demonstrates 'that the central focus… continues to be the woman's physical health and the welfare of the foetus often cloaked in references to the impact that harm suffered by the foetus would have upon her mental health.'[416] This chapter will support this claim by considering obstetric case law that displays the underlying motives of protection for the foetus. It will demonstrate how the courts insufficiently regard the individualistic and subjective considerations that should be integral in the determinations.

The starting point for the best interests determination is section 1(5) of the Mental Capacity Act 2005 (MCA),[417] which is one of the core six principles that underpins the Act. It states that 'an act done, or decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests.'[418] There is no singular definition of best interests contained in the MCA. Instead, section 4 MCA contains numerous factors that must be considered when making the best interests determination. In addition, the Code of Practice[419] gives examples to flesh out these statutory provisions. I will work through a few of these section 4 MCA factors and other influencing MCA principles to demonstrate that the courts are routinely falling short of the standard set out in the MCA.

[413] n135, 210.
[414] Ibid.
[415] n7, 87.
[416] Ibid.
[417] n20, section 1(5).
[418] Ibid.
[419] n262.

The bulk of the discussion will centre around section 4(6) which holds that the patient's 'past and present wishes and feelings'[420] must be considered in their best interests' assessment. I will first set out the direction in which the law has developed (to help honour the will and preferences of patients) but suggest obstetric capacity cases have been slower to conform. This element of the best interests test has been subject to considerable discussion and elaboration. Lady Hale's judgment in *Aintree v James* [2013][421] will be analysed to demonstrate the current position on the patient's wishes in the best interests determination. This will be used as a comparable standard from which obstetric cases will be examined. I will argue that pregnant women's wishes rarely play a significant role in the best interests determinations, unless they are aligned with the clinicians wishes. This will be demonstrated through case examples including *Guys & St Thomas's NHS Foundation Trust v R* [2020], *East Lancashire Hospital NHS Trust v GH* [2021][422] and *Re AA* [2012][423] where R and GH's wishes were set aside and AA's were not even ascertained. In comparison to the standard set in *Aintree v James* [2013], I will demonstrate that women are not the 'centre of the decision'[424] and instead, are 'treated as an object, a recipient of care, a risk to be managed.'[425] I argue that pregnant women are often managed, rather than empowered in obstetric cases and this will be discussed in relation to the best interests determination. Furthermore, I suggest that clinicians and courts make presumptions regarding the woman's best interests based on their expectations of motherhood and the 'right-thinking' pregnant women. This chapter will touch upon other sections within the MCA where the courts are falling short of the standard set. This will include insufficient consideration of; whether the patient will regain capacity (section 4(3)), encouraging the patient to participate in their own best interests' determination (section 4(4)) and using the least restrictive method to treat (section 1(6)).

<u>3.1 The patient's wishes</u>

Section 4(6) Mental Capacity Act 2005 states that the person making the determination 'must consider, so far as is reasonably ascertainable… the person's past and present wishes and feelings…'[426] This principle has been interpreted and developed in cases of non-obstetric intervention.[427] However, in this chapter, evidence will demonstrate that although courts consider a pregnant woman's wishes in her best interests' assessment, they are not given the prominence they deserve when they contradict her doctor's

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[420] n20, section 4(6).
[421] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.
[422] *East Lancashire Hospital NHS Trust v GH* [2021] EWCOP 18.
[423] n6.
[424] n7, 189.
[425] Ibid.
[426] n20, section 4(6).
[427] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, *Wye Valley NHS Trust v B* [2015] EWCOP 60.

recommendation. Instead, the discussion and determination is 'dominated by experts and their views of the safest way forward.'[428] This approach is worrying as it is not in keeping with the ethos of the UNCRPD or the underlying purpose of the MCA that is to provide a 'framework that places individuals at the very heart of the decision-making process.'[429] The UNCRPD is an international treaty that 'protects the right to equal protection before the law'[430] to which the UK is a signatory.

In this section, I will first set out the direction in which the law has developed, to honour the will and preferences of patients. Lady Hale's judgment in *Aintree v James* [2013][431] and the introduction of the UNCRPD were notable milestones that pointed towards greater weight being placed on the patient's wishes in their best interests' determination. The discussion following this will highlight that the cases in the obstetric context have been slower to conform to this development. I will seek to demonstrate the 'second-class' treatment of pregnant women in comparison to the progressive inclusion of other patients wills and preferences in their best interests' determinations. Chapter IV will seek to address this problem and explain what needs to change for pregnant women's wishes to be adequately respected in the determination of their best interests.

3.1.1 Development of the best interests test

As Jackson argues, the 'meaning of "best interests" has changed significantly since the principle was established'[432] over 30 years ago. When determining the best medical treatment for a patient, Lord Goff stated in *Re F* (1988)[433] that 'the test was what other doctors would consider to be in her best interests…'[434] There was no requirement to consult the patient or to take their views into consideration. Instead, it was accepted that 'the doctor was the best person to advise them as to what treatment was in their best interests.'[435] So long as the doctor was not negligent under the *Bolam* test,[436] then their proposed treatment was accepted as acting in the patient's best interests. This was the origin of the best interests' test.

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[428] n7, 199.
[429] n262.
[430] Emma Cave, 'Protecting Patients from their bad decisions: Rebalancing rights, relationships and risk' (2017) 25(4) Medical Law Review 527, 531.
[431] n421.
[432] Emily Jackson, 'From "Doctor Knows Best" to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions about Their Medical Treatment' (2018) 81 MLR 247, 252.
[433] n151.
[434] Ibid.
[435] n14, 36.
[436] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

The best interests concept started to evolve in the late 20th century following widespread criticism that the *Bolam* test was an inadequate measure of best interests. This was recognised in the Law Commission's report on Mental Incapacity 1995,[437] which formed the basis of the Mental Capacity Act 2005. In this report they recommended that the best interests' criterion should encompass 'a strong element of "substituted judgment"'[438] so that in determining the individual's best interests 'regard should be had to the ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider if able to do so.'[439] This recommendation was then expressed in the form of section 4(6) of the MCA, thus endorsing the evolution of the best interests test. The best interests test no longer permits an automatic authorisation of clinician's wishes but requires a holistic assessment with subjective considerations.

However, the question remains: to what extent should a patient's past and present wishes and feelings be considered in their best interests' assessment? As Jackson points out, 'the Act does not specify what weight should be given to the patient's wishes…'[440] The best interests' framework under section 4 does not indicate how the different factors should be weighed or applied. There is also no specified 'hierarchy between the various factors that have to be considered.'[441] This leaves a lot of discretion to the person making the determination as to the importance they attach to varying factors. Taylor points out that although the MCA requires 'decision makers to consider a range of issues wider than a patient's clinical interests, [it] provides insufficient guidance on how the statutory principles should be applied in practice.'[442] Therefore, it has been left to the common law to determine how best the section 4 factors should be interpreted and how much weight should be placed on a patient's wishes in the assessment. This was deliberately left to allow the decision to be fact and decision specific.

3.1.2 Lady Hale's judgment in *Aintree v James* [2013]

The Supreme Court considered the relevance of patients views in *Aintree University Hospitals NHS Foundation v James* [2013].[443] Lady Hale 'made a small but significant change of emphasis'[444] when describing the relevance of the patient's wishes. She stated that 'the purpose of the best interests test is

[437] The Law Commission, 'Mental Incapacity' (1995) <https://www.lawcom.gov.uk/app/uploads/2015/04/lc231.pdf> accessed 6 March 2022.
[438] Ibid, 42.
[439] Ibid, 68.
[440] n86, 266.
[441] *Re X, Y and Z* [2014] EWHC 87 (COP) [28].
[442] Helen Taylor, 'What are "best interests"? A critical evaluation of "best interests" decision-making in clinical practice' (2016) 24 *Medical Law Review* 176, 204.
[443] n421.
[444] n432, 254.

to consider matters from the patient's point of view...'[445] thus placing more emphasis on the importance of the individual and their wishes, notwithstanding their lack of capacity. Lady Hale purported that 'so far as it is possible to ascertain the patient's wishes and feelings, his beliefs and values… should be taken into account because they are a component in making the choice which is right for him as an individual human being.'[446] This explanation is significant because it demonstrates an appreciation that best interests differ from person to person, thereby validating the importance of undertaking unique assessments of every patient. In order to understand what is right for each patient, their wishes need to be heard, even when they lack capacity to make a decision themselves. This is a notable development from the court's previous stance that they would only consider 'the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests.'[447] Meaning that now, rather than the patient's wishes being a coincidental approval of proposed treatment, they have force in their own right. In practice, this means that life-saving medical treatment might not be in a patient's best interests when other considerations are deemed more important. Despite the emphasis Lady Hale paced on considering patient's wishes, she made sure to stress that they are not conclusive of best interests. She noted that considering a patient's wishes 'is not to say that his wishes must prevail…'[448] thus, drawing the distinction between patients with capacity and those lacking it.

In *M v N* [2015],[449] Hayden J states that 'respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not.'[450] However, out of ten medical case judgments that Hayden J gave between January 2015 and September 2020,[451] there were only two cases in which he 'expressly declined to follow what he knew considered would have been P's wishes and feelings.'[452] This is striking because it suggests that although not always, in the majority of cases the patient's wills and preferences are followed. Furthermore, Ruck-Keene argues that 'even where they override those wishes and feelings, the judges recognise that they have to give a proper justification for doing so…'[453] Therefore, regardless of the cases in which the patient's wishes and feelings are not followed, *Aintree v James* [2013] has had an evolutionary impact on the weight placed on patients wishes in the best interests assessment. As Halliday clarifies, the 'Courts are now less inclined to start from the position that the preservation of life will trump all other

[445] n421, [45].
[446] Ibid.
[447] *Re M (Statutory Will)* [2009] EWHC 2525 (Fam) [35].
[448] n421, [45].
[449] *M v Mrs N & ORS* [2015] EWCOP 76 [28].
[450] Ibid.
[451] n61, 31.
[452] Ibid, 35.
[453] Ibid, 46.

considerations in the assessment of best interests…'[454] Following *Aintree*, there has been a shift away from the dependency on medical evidence and preserving life, towards a deeper appreciation of a patient-focused approach.

However, Lady Hale did not quantify or describe to what extent a patient's wishes should be considered in the best interests assessment. There has been extensive academic debate following *Aintree* as to how Lady Hale's judgment should be translated into other scenarios. The following section will seek to establish an accurate interpretation of section 4(6). This will be used as the standard against which its application in obstetric cases will be compared. Ultimately showing that pregnant women's wishes are rarely given any weight when determining their best interests.

I suggest that Lady Hale's judgment has been adopted in other cases post-*Aintree*, as judges seek 'to take seriously the wishes and feelings of the subject of the proceedings where those wishes and feelings are identifiable.'[455] As Jackson argues where there is 'persuasive evidence of a patient's preference for no treatment'[456] this tends to be decisive. For instance, in *Wye Valley NHS Trust v B* [2015],[457] Jackson J declared that it would not be in the best interests of a man who lacked capacity to amputate his foot against his wishes. This declaration was made, notwithstanding the medical advice that without an amputation he would likely die within a few days. The Judge, Justice Peter Jackson spoke to B in hospital where he adamantly expressed 'I don't want it. I'm not afraid of death. I don't want interference. Even if I'm going to die, I don't want the operation.'[458] Following this discussion, Jackson J placed significant weight on B's desire to refuse the surgery when making the best interests determination for B. He followed in Lady Hale's footsteps as he commented that 'where a patient lacks capacity it is accordingly of great importance to give proper weight to his wishes and feelings and to his beliefs and values.'[459] After speaking with B, Jackson J appreciated that intervention against his wishes would be felt as an attack against 'his core quality… "fierce independence" …'[460] Thus, regardless of the medical fact that B was likely to die without the amputation, Jackson J found that an amputation would not be in his best interests. B had a strong, unwavering desire to not undergo an amputation and was willing to accept the consequences of death. Any intervention would have been unwarranted and damaging to B's sense of self and identity.

[454] n7, 188.
[455] n61, 46.
[456] n86, 272.
[457] *Wye Valley NHS Trust v B* [2015] EWCOP 60.
[458] Ibid, [37].
[459] Ibid, [10].
[460] Ibid, [43].

Jackson J also stated in his judgment that 'a person [lacking] decision-making capacity is not an "off-switch" for his rights and freedoms.'[461] Through this, he is arguably stating that the wishes of a patient who lacks capacity still matter. The test for capacity might be binary: either you have capacity or you do not. However, this should not mean that your views either count for all or nothing. The views of a patient who lacks capacity are still 'as important to them as they are to anyone else…'[462] and they should remain central in any decision made about their medical treatment on their behalf. Lacking capacity does not mean that your wishes have no relevance to your best interests. A patient may lack capacity and still wish to consent to or refuse treatment to which it is agreed is in your best interests. Unfortunately, in obstetric cases this stance is not readily accepted. There is the continual finding that the woman's best interests 'require the safe delivery of the baby and therefore obstetric intervention.'[463]

3.1.3 UNCRPD Article 12(4)

The introduction of the UNCRPD influenced this interpretation of the best interests assessment. The UNCRPD is not incorporated into law and not legally binding as such, but it creates general obligations which state signatories should endeavour to adopt. Article 12(4) states that 'measures relating to the exercise of legal capacity *respect* the rights, will and preferences of the person…'[464] Martin interprets this use of language, finding that 'respect must be something stronger than consider, even though it is less than absolutely bound by.'[465] I agree, respect is indicative of feelings of sincerity and due regard. As a word, it has more depth than other plausible verbs such as 'acknowledge' or 'consider'. The use of the word 'respect' suggests a level of endorsement and acceptance for the views of patients who lack mental capacity, that goes beyond their wishes being just another factor in the best interests assessment. Martin's interpretation of Article 12(4) compliments the approach taken by Lady Hale in *Aintree v James* [2013], that patients views require some priority, even if they are not ultimately determinative. Jackson supports Martin's analysis, stating that respect 'implies more than simply taking P's views into account.'[466] Thus, this supports the notion that patients wishes should be prioritised in the best interests assessment.

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[461] Ibid, [11].
[462] Ibid, [11].
[463] n7, 64.
[464] United Nations, 'Convention on the Rights of Persons with Disabilities' (2006) <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-12-equal-recognition-before-the-law.html> accessed 28 November 2021.
[465] W Martin, 'Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales compatible with the UN Convention on the Rights of Persons with Disability? If not, what next?' (Essex Autonomy Project, 2014).
[466] n432, 266.

However, the UN Committee takes this position further when interpreting Article 12(4). They submit that it 'requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives.'[467] This is a controversial interpretation because it essentially suggests that any best interests determinations are incompatible with the convention, thus, a court would no longer have the remit to declare a treatment lawful if it contradicted a patient's express wishes. This would effectively erase the distinction between patients with capacity and those who lack capacity.

Donnelly rejects 'the contention that all substitute decision-making... should be abolished'.[468] However, she does believe that the UNCRPD is evidence of the need for statutory reform, suggesting that 'the MCA should be strengthened by the inclusion of a stronger statement of the primacy importance of the individual's wishes and feelings….'[469] In chapter IV I will explore the suggestion to reform the best interests test in the MCA. Donnelly's viewpoint is also highlighted for the purpose of providing further support for Lady Hale's interpretation of the best interests test in *Aintree*. Following the UNCRPD, a patient's wills and preferences require *respect*, therefore they deserve central consideration in every best interests assessment that goes beyond merely ascertaining their views.

3.1.4 The relevance of a patient's wishes

Following the development of the law in *Aintree* and the UNCRPD, Herring states that 'the wishes of the incompetent person should be followed unless there is a good reason for not doing so…'[470] Cave and Tan make a similar conclusion about the present interpretation of section 4(6), sustaining that 'decision-makers should not merely "consider" wishes and feelings but should "ascertain" them as far as is practicable and give weight, departing from them only where it is necessary and proportionate to do so.'[471] Herring, Cave and Tan's deductions appropriately surmise the most current and fitting interpretation of section 4(6) MCA. Indeed, the evidence presented thus far demonstrates that patient's wishes and feelings should be of central importance in the best interests assessment.

Aintree and subsequent judgments demonstrate that simply ascertaining views is insufficient under the MCA. As Donnelly argues 'it cannot be enough for a decision-maker simply to acknowledge the views

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[467] Rosalind Croucher, 'Seismic shifts – reconfiguring 'capacity' in law and the challenges of article 12 of the United Nations Convention on the Rights of Persons with Disabilities.' [2016] *International Journal of Mental Health and Capacity Law* 7, 13.
[468] Mary Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005' (2009) 17 *Medical Law Review* 318, 318.
[469] Ibid, 319.
[470] Jonathan Herring, 'Entering the Fog: On the Borderline of Mental Capacity' (2008) 83 *Ind LJ* 1619, 1636.
[471] n329, 5.

of the person lacking capacity before reaching a decision which takes no account of these views.'[472] The courts need to take it further and recognise patient's wishes as the primary source of evidence for determining best interests. This is to ensure that any decision made embodies who that patient is as an individual. This is important to ensure their autonomy and humanity is respected, otherwise it runs the risk of treating a patient 'as a means; that is, in accordance with other's goals without regard to that person's own goals.'[473] This was discussed in further depth in Chapter I under section 1.1.4.

Overall, this section has sought to establish that section 4(6) should be interpreted so that the patient's wishes and feelings are of central importance in the best interests assessment. Only when proven otherwise should their treatment wishes be overruled. This patient-focused approach aligns with the intention that individuals should be placed at 'the very heart of the decision-making process'[474] under the MCA. Recent case law has indicated that courts 'look to prioritise the decision that P would have made themselves'[475] rather than deferring to medical expertise. Patient's wishes should be allocated primary weight, rather than being a convenient factor when it supports the clinicians wishes. This development is significant. It places an onus on the courts to view the patients as individual people, with unique desires and wishes, rather than patients to be managed. Translated into the realm of obstetrics, it should mean that the women concerned are viewed as individuals, rather than being defined by their pregnancy and motherhood. It should instil an obligation to investigate their wishes and to ask the right questions, so they are given the opportunity to relay their opinions. Any ascertained wishes should be at the forefront of the discussion about their best interests' assessment, only to be departed from where it is shown that intervention is required. This requires a unique and individualistic approach to be taken with each patient's best interests determination.

However, as Fovargue identifies, 'it is disappointing that an holistic approach to these assessments, as mandated by the Supreme Court in Aintree, is not identifiable in the majority of the post-MCA MHA child birth cases.'[476] In obstetric cases women's views are often not even ascertained, let alone given weight to in determinations. When a woman refuses obstetric intervention, her wishes are simply given lip service and always overridden by the requirement that her foetus be delivered for the benefit of her mental health best interests. Consequently, the reality in obstetric cases is that women's wishes are of little to no relevance in the best interests assessment. I therefore argue that as a 'patient category' they are falling behind the progression of best interests that has occurred in cases such as *Aintree* and *Wye Valley*.

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[472] n468, 20.
[473] n4.
[474] n262.
[475] n7, 188.
[476] n55, 627.

3.1.5 The application of section 4(6) in obstetric cases

A pattern has emerged whereby pregnant women's wishes are not being respected to the same extent as other patients who lack capacity. Courts place significant weight on non-obstetric patients' preferences when they are expressed decisively and represent their core wishes, such as in *Wye Valley NHS Trust v B* [2015].[477] Whereas pregnant women's wishes are rarely cited in Court, let alone decisive in their best interests' assessment. Halliday argues that 'the contrast between the way pregnant women and others are treated is extremely clear...'[478] This is especially evident when comparing the neglect of R's strongly expressed wishes in *Guys & St Thomas's NHS Foundation Trust* [2020][479] against the almost deferential treatment that B's wishes received in *Wye Valley NHS Trust v B* [2015].[480]

In *Guys & St Thomas's NHS Foundation Trust* [2020],[481] R told her medical staff that a caesarean section was 'the last thing she would want.'[482] Her views regarding the Hospitals proposed treatment were clear and resolute. Yet the Court dismissed her views, arguing that 'people use this phrase loosely'[483] and instead permitted intervention should she loose capacity and it be deemed in her best interests. It is notable that in *Wye Valley*, Jackson J permitted B to refuse treatment even though there was a risk of death. Whereas Justice Hayden grants the caesarean section declaration where there is minimal physical risk to R. This indicates that women's wishes are being neglected in obstetric cases where there is less physical risk to them than other comparable non-obstetric adult cases. This demonstrates that the law still adopts an 'overly-paternalistic approach'[484] in obstetric cases. Even Hayden J admitted that the declaration may appear 'draconian'[485] in nature to some, but maintained that it was essential nonetheless.

Another concerning aspect of this judgment is that R had capacity during the court case, therefore the wishes cited in court were given at a time when she was able to make the decision for herself. Yet Justice Hayden made no attempt to highlight these and encourage that they form an essential part of her

[477] n457, 60.
[478] n7, 194.
[479] *Guys and St Thomas's NHS Foundation Trust & South London and Maudsley NHS Foundation Trust v R* [2020] EWCOP 4.
[480] n457.
[481] n479.
[482] Ibid, [56].
[483] Ibid.
[484] M Bach and L Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Law Commission of Ontario, October 2010) 130.
[485] n453, [5].

best interests' assessment in the future, should she loose capacity, therefore essentially suggesting that R's competent wishes were worth less than B's incompetent wishes. This demonstrates the depth of the inequality between pregnant women and other patients. Instead of listening to and acknowledging R's wishes, Hayden J instead found that it was 'reasonable to conclude that R would wish for a safe birth and a healthy baby.'[486] It is concerning that Hayden J thought this assumption would provide a keener insight into R's desires than the opinion she expresses herself. As Ruck-Keene purports 'Hayden J clearly took the view that cases relating to caesarean sections… were in a different class to other types of medical treatment decisions.'[487] It is disturbing that women's wishes and preferences appear to be 'afforded a lesser degree of respect than decisions made'[488] by other types of patients.

Furthermore, the British Medical Association (BMA) guidance makes it clear that any action taken that diverges from the decision the patient would have taken had they had capacity 'would need to be reasonable, justifiable and clearly recorded.'[489] The BMA is a recognised trade union for UK doctors who produce guidance to ensure practice is compliant and delivering the best patient care.[490] R did express a clear course of action whilst she had capacity, yet the Court decided to diverge from this preference. It is maintained that requiring a caesarean section for the safe delivery of her baby is not a reasonable or justifiable explanation for doing so, as foetal interests should not displace a woman's autonomy. The interaction of the rights of the woman and the interests of the foetus are described in more depth in the introduction to this thesis.

The case of *Re AA* [2012][491] was conducted without any reference to the woman's, AA's, wishes and preferences. Her wishes were not cited in court and therefore potentially not even ascertained. The section 4(6) element of the best interests assessment was therefore essentially ignored, as her wishes were not acknowledged in the judgment. This sits in stark contrast to the position in *Aintree* where Hale purported that 'the purpose of the best interests test is to consider matters from the patient's point of view.'[492] Not only were matters not considered from AA's point of view, but there is no evidence of what AA's point of view even was. This implies that consideration of best interests in obstetric cases are a long way off the progressive stance that the patient's wishes and feelings should be of central importance in their best interests determination.

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[486] Ibid, [63].
[487] n418, 37.
[488] Ibid, 47.
[489] British Medical Association, 'Best Interests Decision-making for adults who lack capacity' (2019) <https://www.bma.org.uk/media/1850/bma-best-interests-toolkit-2019.pdf> accessed 10 March 2021.
[490] British Medical Association, 'GP Practices' <https://www.bma.org.uk/advice-and-support/gp-practices> accessed 8 September 2022.
[491] n6.
[492] n421, [45].

The recent case of *East Lancashire Hospital NHS Trust v GH* [2021][493] demonstrates this continuing trend. The pregnant woman in this case, GH, suffered from agoraphobia. As a result, she expressed the wish not to go to hospital but to give birth at home. Nonetheless, Mr Justice MacDonald held that it 'was in her best interests to be conveyed from her home to hospital by ambulance'[494] and receive whatever treatment was necessary for the management of her delivery and pregnancy. In coming to this decision, Mr Justice MacDonald said that he had heard evidence from 'Dr Sarah Davies, Consultant Obstetrician, regarding the risks and benefits to GH of remaining at home… and the risks and benefits of her being admitted to hospital…'[495] This does seem to indicate some effort to consider several holistic factors in coming to a decision. However, it still seems largely medically orientated and driven, as he only references evidence from 'Dr Sarah Davies' the consultant obstetrician. There is no explicit reference to the mental and emotional risks to GH should she be transferred outside of her home against her wishes. He emphasised that although 'GH remined stable at the current time… the facilities of the hospital would be required as a matter of urgency'[496] should 'GH's condition or the condition of the baby deteriorate…'[497] Mr Justice MacDonald appears to justify his decision on the basis that GH had indicated, whilst she had capacity, 'that whilst she wished for a home birth, she agreed to be admitted to hospital should that be required.'[498] However, since GH was stable at the time of the case, it is concerning that Mr Justice MacDonald did not first consider her wishes to stay at home. Instead, it appears that Mr Justice MacDonald jumped straight to pre-emptive action in line with Dr Davies medical advice. It is conceded that maybe it would still have been in GH's best interests to be forcefully taken to Hospital, but her wishes should have received more attention for the best interests assessment to be considered holistic. Alas, it appears to be pre-determined on the basis of medical evidence and advice about what is best for the delivery of the baby.

Beauchamp and Childress assert that 'best interests judgments are meant to focus attention entirely on the value of the life for the person who must live it, not on the value the person's life has for others.'[499] However, in some cases, the best interests standard has 'been interpreted in highly malleable ways, thereby permitting consideration of values irrelevant to the individual's benefits or burdens.'[500] In obstetric cases, there is evidence of this 'malleability' in the way judges emphasise the importance of the medical evidence presented, whilst minimising the expressed wishes of the patient. In *East*

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[493] n422.
[494] Ibid, [2].
[495] Ibid, [14].
[496] Ibid, [10].
[497] Ibid, [10].
[498] Ibid, [5].
[499] n4, 140.
[500] Ibid.

Lancashire Hospital NHS Trust v GH [2021],[501] GH had agreed to being admitted to hospital should it be 'required'. However, there is considerable room for interpretation around the word 'required'. As GH was medically stable at the time of this case, she might not have considered it a requirement to go to hospital yet. Nonetheless, Mr Justice MacDonald took advantage of this previously competent statement to justify his best interests determination.

From *St George's Healthcare NHS Trust v S* [1998][502] until the date of publication of this thesis, there has not been a single reported case where the pregnant woman's decision to refuse medical intervention has been deemed to be in her best interests'. This is problematic, as this trend is incongruent with other non-obstetric cases where there is more evidence of approving the patient's wishes. That is not to say that the judges were wrong in every single one of these obstetric cases, but their findings are to be questioned in some. Overall, this evidence presents a bleak picture of women in obstetric cases. Where non-obstetric patients wishes are receiving respect, pregnant women's views tend to be ignored. Until the courts accept that the woman's views are important in determining their best interests, they will continue to receive second-class treatment as a patient. Discussion has shown that rather than being listened to and empowered, women are more typically silenced and managed.

3.2 The management of pregnant women

As outlined in the introduction, the recent tranche of case law shows that there is a focus on women with a serious mental illness (SMI). As Halliday contends, these women are not at the 'centre of the decision…'[503] instead they are 'treated as an object, a recipient of care, a risk to be managed.'[504] Baron contends that pregnant women are 'seen as, at best, an inconvenience for the doctor "managing" their labour, and at worst, an obstacle to the safe delivery of the infant.'[505] Indeed, the focus of the best interests determination has shifted from protecting the woman to ensuring protection *from* the woman.

In *A University Hospital NHS Trust v CA* [2016][506] the risks considered were not just those relevant to the patient, but included the physical risks posed to the foetus and medical staff. The judgment outlines plans to use physical restraint if necessary 'to prevent causing immediate harm to herself *or others*…'[507] This consideration is valid to a certain extent as the physical safety of the clinicians is important,

[501] n422.
[502] n24.
[503] n7, 189.
[504] Ibid.
[505] n55, 629.
[506] n265.
[507] Ibid.

however it is concerning that it formed such an informative element of C's best interests assessment. In addition, they state that a caesarean section is being considered because 'C is presenting as too acutely mentally unwell to… bring about the safe deliver of her baby…'[508] and that without this medical intervention 'the risk to mother and baby during a natural vaginal delivery are high…'[509] This included the potential risk of hypoxia to the foetus. In C's best interests' assessment, the interests of the foetus and the physical risks towards it should not have been the determining factors. In *Re MB* [1997], Lady Justice Butler-Sloss held that a foetus has no legal interests until birth that were 'capable of being taken into account when a court has to consider an application…'[510] In principle, this position has been continually reinforced. Mostyn J in *Re AA* [2012] stated that 'the interests of this unborn child are not the concern of this court as the child has no legal existence until he or she is born…'[511] Therefore, the interests of the foetus should only play a part in the best interests determination in-so-far as they are relevant to the woman's own interests and wellbeing. For example, where the woman's mental health genuinely requires the safe delivery of the foetus and therefore the wellbeing of the foetus should be a feature in the determination. Yet in numerous obstetric cases, such as *A University Hospital NHS Trust v CA* [2016],[512] the risks to the foetus are continually found to be the driving force in the best interests determination even where they are not the most important factor for the woman. The best interests determination is intended to focus 'on the value of the life for the person who must live it, not on the value the person's life has for others.'[513] Yet the language used in judgments appears to demonstrate a focus on *managing* the woman, rather than *helping* her. This evidence suggests that pregnant women are often viewed as the problem, rather than being recognised as a patient in need of care.

The action taken by respective hospital trust's in both *United Lincolnshire Hospitals v CD* [2019][514] and *Guys & St Thomas's v R* [2020][515] is indicative of this 'management' attitude towards pregnant women. In both cases, the hospital trusts sought anticipatory declarations to ensure that they could lawfully treat the women should they lose capacity in an emergency situation and wish to refuse the recommended treatment. By seeking these declarations before the women involved even lacked capacity, they are demonstrating a desire to 'sort the situation' or rather, sort the pregnant woman before she becomes a problem. Fovargue suggests that the courts use of anticipatory declarations in these cases could have been motivated by the 'fact that in both judgments there is a sense that in order to ensure that a healthy baby was delivered, there must be something that can be done to deal with women who

[508] Ibid.
[509] Ibid.
[510] n1, [60].
[511] n6, [1].
[512] n265.
[513] n4, 140.
[514] *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24.
[515] n479.

currently have capacity, but might not once labour has started.'[516] I agree with this assertion as there is discussion in both judgments regarding the safety of the foetus and in CD's case, Francis J states that he would 'have no hesitation in making the order… if faced with a situation where the choice is to make such an order or to risk life itself.'[517] This statement demonstrates the courts willingness to find any solution to ensure that the life of the foetus is protected.

I do not criticise taking preventative action. In fact, any potential problems should be identified as early as possible so that doctors have adequate time to address them. I do, however, criticise the manner in which they approached this case early. As Fovargue claims, 'how such declarations can be interpreted as autonomy protecting is a mystery.'[518] Instead of recognising the time as an opportunity to empower the women to make their own decisions, they used it to gain permission to take control of her. It is accepted that such a case is preferable to 'leaving [the issue] to be dealt with in an emergency.'[519] However, this misses the point that instead, this time could have been used to empower these women to make their own decisions. For example, through the creation of an advanced decision or in R's case, simply discussing her wishes in more depth so as to ascertain a more representative care plan should she loose capacity.

In *Wye Valley NHS Trust v B* [2015],[520] Jackson J makes the informative point that 'there is a difference between fighting on someone's behalf and just fighting them.'[521] Where a patient communicates strong wishes, I argue that the courts are no longer acting on the patient's behalf where they enforce treatment against their will. When R stated, 'a caesarean section is the last thing [she] would want',[522] it was unjustified to maintain that obstetric intervention would be in her best interests. Unless the courts let go of these paternalistic tendencies women in obstetric cases will continue to be 'managed' rather than 'empowered'.

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[516] Sara Fovargue, 'Anticipating Issues with Capacitous Pregnant Women: *United Lincolnshire NHS Hospitals Trust v CD* [2019] EWCOP 24 and *Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R* [2020] EWCOP 4' (2020) 28(4) *Medical Law Review* 781, 790.
[517] n514.
[518] n516, 793.
[519] Chris Stark, 'Capacity at birth – care planning, contingent and anticipatory declarations' (2019) < https://www.brownejacobson.com/health/training-and-resources/legal-updates/2019/07/capacity-at-birth-care-planning-contingent-and-anticipatory-declarations> accessed 3 March 2021.
[520] n457.
[521] Ibid, [45].
[522] n479, 16.

3.3 Expectations of 'motherhood'

Another factor to be considered in the best interests assessment is section 4(1), that determinations must not be made 'merely on the basis of- (a) the person's age or appearance, or (b) a condition of his, or an aspect of his behaviour…'[523] The underlying force of section 4(1) is to ensure that 'unjustified assumptions'[524] aren't made about what is in a particular person's best interests. Otherwise, treatment decisions might not reflect what is actually in the best interests of an individual patient. As Michalowski contends, 'the Court should consider the patient's preferences and refrain from imposing its own value judgments on the patient.'[525] Unfortunately, as we shall see, the courts do make assumptions about women's best interests in obstetric cases. They make presumptions based on their expectations of 'motherhood' and how a pregnant woman should act. Judgments are riddled with expectations that 'women will act altruistically, setting aside their own wishes and values for the sake of the foetus.'[526] This even persists in obstetric cases where evidence suggests the woman does not want to prioritise the wellbeing of the foetus over her own wishes. This approach sits in direct opposition to the meaning of section 4(1), because they are basing their best interests judgments on the 'unjustified assumption' that a pregnant woman would want the wellbeing of the foetus to be prioritised. These assumptions should be abandoned and authentic assessments that consider the woman as an individual need to be adopted instead.

The attitude towards women who wish to refuse treatment that is required for the benefit of their foetus, has persisted from early 1990s case law through to the present day. In *St George's Healthcare NHS Trust v S* [1998],[527] Judge LJ stated that S's wish to refuse a caesarean section was 'bizarre'[528] and to have prioritised herself over the foetus was 'morally repugnant'.[529] He went further, stating that 'no normal mother-to-be could possibly think like that…'[530] This implies that generally a pregnant person should always wish to act in the best interests of her foetus. This has resulted in best interests' determination becoming pre-determined, whereby the woman's best interests are phrased as requiring the safe delivery of the foetus. Twenty-five years later and this assumption is still deep-rooted in the best interests' assessments. As Fovargue comments 'the key driver in the decision-making process is, as it appears to be, to approve the best way to secure the safe birth of a child…'[531] Justice Hayden

[523] n20, section 4(1).
[524] Ibid.
[525] n11, 121.
[526] n7, 89.
[527] n22.
[528] Ibid, 957.
[529] Ibid, 937.
[530] Ibid, 957.
[531] Fovargue LQR, (page 14).

articulated this presumption explicitly in *Guys & St Thomas's* [2020][532] when he said, 'it will rarely be the case… that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus.'[533] Thus indicating that where a caesarean section is required for the safety of the foetus, it will generally be permitted. It is accepted that for some women the safety of their foetus is their top priority and therefore important in their best interests' assessment. However, there is a danger in making this assumption in other obstetric cases where there is no evidence to support it. The purpose of section 4(1) is to avoid this eventuality where unjustified assumptions are being made about what is in a patient's best interests. This needs to be recognised properly in obstetric cases, as it states that when determining 'a person's best interests, the person making the determination must not make it merely on the basis of'[534] certain characteristics of the individual.

3.4 Regaining capacity

Another factor to consider under the best interests assessment is 'whether it is likely that the person will at some time have capacity in relation to the matter in question… [and] when that is likely to be.'[535] The importance of allowing an individual time to regain capacity is that it would allow them to then exercise their autonomy and remove the need for someone else to make the decision for them. This is explained in the Code of Practice stating that 'there are some situations where decisions may be deferred, if someone who currently lacks capacity may regain the capacity to make the decision for themselves.'[536] This supports the underlying purpose of the MCA, for it is meant to 'empower people to make decisions for themselves wherever possible…'[537] This is achieved through section 4(3) because it demands that clinicians wait, if possible, to allow for a patient to regain capacity so that they might determine their own treatment. Best interests' assessment is meant to be a last resort. The MCA does not wish to take away a patient's autonomy unnecessarily.

In most of the recent case law, the women concerned have had SMI's. CD[538] suffered from schizophrenia and C[539] had bipolar effective disorder. It is a feature of both of these SMI's that you do not always lack capacity. It often fluctuates, meaning that there are often times of lucidity where their wishes can be sought and this is mandated by the MCA which states the decision maker should consider

[532] n453.
[533] n453, [3].
[534] Mental Capacity Act 2005, section 4(1).
[535] n24, section 4(3).
[536] n244.
[537] Ibid.
[538] n514.
[539] n57.

'whether it is likely that the person will at some time have capacity…'[540] Clinicians should therefore have been working with this knowledge to find a way to communicate with the pregnant women about their treatment options. However, there were never attempts to truly capitalise on these moments. For instance, in *The NHS Acute Trust & The NHS Mental Health Trust v C* [2016][541] as C was not due to give birth immediately, Halliday argues that 'the remaining weeks of pregnancy could… have made a key difference in stabilising her mental health and enabling her to participate in the decision about how to give birth.'[542] They had the option to empower C to make her own decision through methods such as cognitive behavioural therapy and mood stabilising drugs. Instead, they undertook a more controlling and managing approach. She continually maintained a preference for a vaginal delivery. Had they simply ensured her preference was expressed in a moment where her capacity was intact, they could have used this as evidence in the future, should she loose capacity. Thus, ensuring any decision they made on her behalf would be in line with what she would have decided had she had capacity at the time. Instead, it seems clinicians prefer to ignore this possibility. They appear anxious to proceed straight to court in order to receive a declaration that they may initiate the treatment plan they consider best for her and the foetus.

In both *United Lincolnshire Hospitals v CD* [2019][543] and *Guys & St Thomas's v R* [2020],[544] the women concerned had capacity at the time of the hearings. At the point in time when the cases were heard, both women were deemed to have capacity, therefore their cases did not technically fall under the juridication of the Court of Protection. They used section 15 of the MCA to justify their involvement and intervention, this states that 'the court may make declarations to the lawfulness or otherwise of any act done, *or yet to be done,* in relation to that person.'[545] Fovargue acknowledges that whilst their 'reading of section 15 appears to be correct, my struggle is with how this interpretation sits alongside other key provisions and principles in the MCA…'[546] The judgment of capacity under the MCA is meant to be both issue and time specific. Section 2(1) of the MCA requires the decision-maker to consider the patient's capacity 'at the material time', however the judges here were making decisions about hypothetical future scenarios when the pregnant women *might* lack capacity. This was a concerning approach to take as it insinuates that in coming to these declarations, they are stating 'we are deciding now what will be in your best interests when you no longer have capacity…'[547] This attitude does not

[540] n20, section 4(3)(a).
[541] n57.
[542] n7, 192.
[543] n514.
[544] n479.
[545] n20, section 15(1)(c).
[546] n516.
[547] Ibid.

fit neatly into the empowering ethos of the MCA, nor does it demonstrate a willingness to support the pregnant woman's autonomy, instead they appear to be prematurely limiting their autonomy.

In both cases the women's wishes were known and conveyed to the Court. CD wanted a natural delivery but was willing to have a caesarean section should it be necessary. Thus, she approved of the plan that should she lack capacity during labour and change her mind the clinicians could proceed with a caesarean section should it become necessary. On the other hand, R stated that a 'caesarean section is the last thing [she] would want.'[548] Had she been in labour at the point of this case, the clinicians would have been forced to respect her wishes. Whereas the court made no attempt to empower this decision or highlight its importance to clinicians should they complete a best interests assessment in the future. They also failed to enquire further into her wishes and ask exactly what she meant by 'a caesarean section is the last thing'[549] she wants. Had they consulted with R further whilst she had capacity, they could have formed a better understanding of R's desired treatment plan. Instead, R was largely ignored and managed like an obstacle to tame. Overall, these cases show a general lack in willingness to consult women and empower them. Clinicians should be trying to find moments of capacity in their patients to provide opportunities for them to express their wishes. Instead, I propose that there is an almost deliberate naivety amongst clinicians as to moments of capacity and ways in which they could help patients regain capacity, thus allowing them to take charge of the situation and the woman instead.

3.5 Encourage participation

The MCA also dictates that the person making the determination must 'so far as reasonably practicable permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him'[550] This section reflects that the MCA is intended to be 'a flexible framework that places individuals at the very heart of the decision-making process.'[551] Thus, where patients lack capacity they should still be involved, 'so far as reasonably practicable'[552] in the decisions made about their treatment. The importance of encouraging the participation of the patient is highlighted by Winnick who states that 'inclusion in the decision-making process enhances individual well-being and self-esteem.'[553] The attention paid to this participation

[548] n479, 16.
[549] Ibid.
[550] n20, section 4(4).
[551] n262.
[552] n20, section 4(4).
[553] B Winnick, 'The right to refuse mental health treatment: a therapeutic jurisprudence analysis' (1994) 17 *International Journal of Law and Psychiatry* 99, 100.

requirement is well demonstrated in non-obstetric cases. In *Wye Valley NHS Trust v B*,[554] Jackson J went so far as to visit the patient in hospital to determine his wishes to satisfy the participation requirement under section 4(4) MCA. As discussed earlier, this case concerned a patient with paranoid schizophrenia, suffering from a gangrenous leg and refusing to consent to an amputation that was believed necessary to save his life. This demonstrates the importance that has been attached to encouraging the patient's participation in in non-obstetric decisions. Jackson J ensured participation by facilitating a conversation with B to ascertain his wishes and feelings.

In comparison, 'there is little sense in the post-MCA MHA childbirth cases that the patient's views were deemed to be of great value or that the patient should meet the judge in order for her views to be ascertained.'[555] The extent to which this section is disregarded is shown starkly in *Re AA* [2012].[556] In this case, the woman was not even informed of the application made to Court. She was completely unaware that she was the subject of the case. Consequently, there was 'no possibility for her to participate and her wishes were not referred to…'[557] Not only was she not involved in the decision, but she was disregarded entirely. This indicates something more sinister than non-participation; it suggests deliberate exclusion.

The National Maternity Review in 2015 assessed 'current maternity care provision and consider how services should be developed'.[558] This report emphasised the importance of the woman in decisions that concern her. It states that 'once a woman has made her decisions, she should be respected, and the services should wrap around her.'[559] This approach is supported by the Code of Practice, which sets out a positive obligation on decision-makers to use 'all practical means'[560] to enable and encourage participation. It sets out suggestions for how to facilitate this participation, including 'using simple language, speaking at appropriate volume and speed, using appropriate words and sentence structure…'[561] However, as Fovargue and Miola argue, 'despite the requirements of the MCA… their voices are absent in the decision-making process.'[562] It is concerning that greater attempts are not made to ensure the participation of the pregnant woman to whatever extent possible in her best interests

[554] n457.
[555] n55.
[556] n6.
[557] n7, 68.
[558] NHS, 'National Maternity Review Report' (2016) <https://www.england.nhs.uk/mat-transformation/implementing-better-births/mat-review/> accessed 9 March 2021.
[559] Ibid.
[560] n262, 76.
[561] Ibid, 31.
[562] n51, 254.

determination. As mentioned earlier, AA's wishes were not mentioned at all in *Re AA* [2012][563] and therefore it appears that her views were given no consideration in the judgment. There is no indication whether any attempts were made to encourage her participation in the proceedings. Furthermore, if her mental health precluded her from communicating easily, there is also no evidence provided that demonstrates efforts to communicate via other methods as the Code of Practice suggests, for example by 'breaking down information into smaller points and using illustrations and/or photographs to help the person understand the decision to be made.'[564] Altogether, this evidence presents another worrying instance whereby clinicians and courts are falling short of the standard set in the MCA and accompanying Code of Practice. There needs to be greater attempts to engage with these pregnant women to encourage their participation and better ascertain their wishes and feelings in decisions that affect them.

3.6 Least restrictive method

When deciding how people who lack capacity should be treated, it is important that 'when deciding between possible actions, [there is a] presumption in favour of the least intrusive one.'[565] This means that where there are multiple treatment options, you should start by considering the least intrusive; meaning least physically invasive. This is one of the key principles of the MCA and is expressed in section 1(6): 'Before the act is done… regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'[566]

For instance, in *A Local Authority v K* [2013][567] the court considered the least restrictive method for achieving non-therapeutic sterilisation for the patient K, a 21-year-old woman with Down's syndrome. K's parents wanted her to undergo sterilisation, however the court found that 'there are less restrictive methods of achieving the purpose of contraception that sterilisation, and… these ought to be attempted.'[568] As a result, the parents application for sterilisation was refused.

Similarly, in obstetric cases, there are less restrictive methods than caesarean sections to consider and therefore, they should be utilised as a last resort, rather than being automatically assumed. Hall and

[563] n6.
[564] n262, 31.
[565] n86, 260.
[566] n20, section 1(6).
[567] *A Local Authority v K* [2013] EWHC 242 (COP).
[568] Ibid, [33].

Bewley state that 'fatality rate for all caesarean sections is six times that for vaginal delivery…'[569] Due to the increased physical risks that are inherent in caesarean sections, it is important that other, less risky methods are considered first. However, this does not appear to be the norm in obstetric case judgments. For instance, in *Re AA* [2012][570] the declaration for a caesarean section was given without real consideration of alternative options. Mostyn J justified the intervention based on the 'significant risk' of uterine rupture, even though this risk sat at 1%. NICE guidelines suggest otherwise though, as they state women who have had four caesareans (two more than AA) should be informed that 'the risk of uterine rupture, although higher for planned vaginal birth, is rare.'[571] Thus, a caesarean section in AA's case was arguably not necessary to ensure her physical wellbeing. Instead, the courts should have 'permitted AA to go into labour naturally and to intervene if it became necessary.'[572] Instead, Mostyn J jumped straight to permitting a caesarean section. Interestingly, Mostyn J did acknowledge that in deciding best interests he 'must have regard to the principle of least restriction.'[573] However, he then seemingly dismisses its validity, stating that it 'by no means seeks to define the expression "best interests".'[574] Mostyn J essentially acknowledges that there was a potentially less restrictive method, but rejects it in favour of managing the pregnant woman. This was to ensure her foetus could be delivered in a controlled environment before being taken into care. This example shows the extent to which women are not prioritised in their own best interests' assessment. Consequently, the least restrictive method of ensuring a woman's best interests is often dismissed to ensure that the clinicians requested treatment can be endorsed.

The most recent case law shows an improvement from the *Re AA* judgment. In both *United Lincolnshire Hospitals v CD* [2019][575] and *Guys & St Thomas's* [2020],[576] the Court held that a caesarean section should be a last resort, only to be employed if necessary. Thus, encouraging a natural delivery to be attempted first: in line with both women's wishes. This appears a positive development because it prevents clinicians from jumping straight to a caesarean section without considering other methods first. However, I suggest that this progress is not sufficient. This is because ensuring the safety of the foetus fell under the circumstances in which a caesarean section might become 'necessary'. Therefore, satisfying the least restrictive method essentially equates to ensuring the least restrictive method to ensure not only the safety of the woman, but also the foetus. This includes further circumstances in which a caesarean section can be categorised as the 'least restrictive' method.

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[569] Marion Hall and Susan Bewley, 'Maternal mortality and mode of delivery' (1999) 354 *The Lancet* 776, 776.
[570] n6.
[571] NICE, 'Caesarean Section' (2021) < https://www.nice.org.uk/guidance/ng192> accessed 2 August 2022.
[572] n7, 69.
[573] n6, [3].
[574] Ibid.
[575] n514.
[576] n479.

3.7 Falling short of the standard

In this chapter, I have sought to demonstrate how issues manifest through the best interests test in obstetric cases. Analysis of obstetric judgments, including *Re AA*, *Guys & St Thomas's v R* and *United Lincolnshire Hospitals v CD* has demonstrated that the standard set by the MCA is not currently being met. In particular, Lady Hale's interpretation of section 4(6) is not readily adopted and pregnant women's wishes and feelings are not receiving adequate consideration in their best interests determinations. As Fovargue summarises, 'it is disappointing that an holistic approach to these assessments, as mandated by the Supreme Court in *Aintree*, is not identifiable in the majority of the post-MCA MHA childbirth cases.'[577] Instead, the safe delivery of the foetus appears to be 'the key driver in the decision-making process…'[578] and as a result, judgments appear to be pre-determined.

In addition to issues related to section 4(6), I highlighted other standards set by the MCA that the courts are seen to fall short of in the case evidence. This included evidence of allowing unjustified assumptions (section 4(1)) to infiltrate the decision made about the pregnant person's best interests. There was little evidence of encouraging participation from the pregnant person (section 4(4)) or providing adequate support or time for them to regain their capacity and make the decision for themselves (section 4(3)). One of the introductory principles under the MCA is to employ the least restrictive method required to serve the individual's best interests. However, we continually see caesarean sections endorsed even where there are less physically invasive methods available that would safeguard the physical and emotional best interests of the pregnant woman. There needs to be greater adherence to the content and message of the MCA and stronger application of its principles to allow the intention of the statute to dictate the pregnant woman's determination. This discussion adds to the overall argument of the thesis, that there is still a significant issue to address in obstetric case law. Until these problems are resolved, I suggest that the level of autonomy that pregnant women possess is insufficient and below the standard observed in cases regarding non-obstetric patients.

In chapter's II and III, I set out the ways in which the problem has been manifesting in the post-*Re MB* case law through the capacity test and best interests' determinations. The next chapter will endeavour to address these issues and propose potential solutions. These solutions should not be read as an exhaustive list, but as recommended examples that could instigate change if attempted. They should be taken as food for thought with further investigation required to flesh these ideas out fully.

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[577] n55, 616.
[578] Ibid.

Chapter IV: Addressing the problems in obstetric cases

4.0 Introduction

The case law analysis conducted in the previous three chapters affirms Halliday's suggestion that 'nothing has changed since the end of the twentieth century … the golden principle of medical law (patient autonomy) is just as compromised as it ever has been.'[579] Indeed, evidence has confirmed that this problem persists.

In this chapter I will attempt to address the problems considered in the previous two chapters by suggesting particular solutions. I will do this through reference to specific sections in this thesis. I do not suggest that there is a 'magic bullet', but rather that a number of changes could work together to have an impact. I recommend that systematic and cultural change at various levels is required. My overarching argument is that no legal or social solution will work by itself to address the inter-dependence in the various issues related to an overarching paternalism and lack of trust of women. Multi-layered change would be optimal and achievable.

The main aim of the thesis is to advance thinking on the problems in obstetric cases; the aim is predominantly explanatory. This chapter has an additional normative aim as I start to suggest areas where further research is needed. However, this is the start rather than the end of that journey and I make suggestions rather than concrete proposals. It will not be possible to suggest every possible solution. Instead, the aim of this chapter is to consider certain examples to demonstrate that there are a multitude of ways of dealing with the issues. These will include a mixture of hard law reform, soft law reform and practicable medical solutions, which I will work through in this order by highlighting the different problems they might address.

Firstly, I will propose a hard law reform – amending the best interests test under section 4 of the Mental Capacity Act 2005. The intention of this reform is to ensure the patient's wishes and feelings play a larger part in their own best interests' determination. This is the only hard law change proposed. I considered reform of the capacity test contained in section 2 and 3 MCA, however, I do not believe this will have a lasting impact. Evidence from chapter II demonstrated that capacity is a malleable concept and therefore it is believed that improved guidance that clarifies its definition would have a more meaningful impact.

[579] n55, 198.

Secondly, I will consider soft law solutions. This will include updating the Code of Practice to include more detailed guidance for the judiciary to follow when conducting the capacity test. I will also propose increasing judge accountability in an attempt to strengthen the explanations that are provided by judges when explaining their determinations of incapacity and best interests determinations. It is worth noting that this chapter will not address the imminent implementation of reforms of the deprivation of liberty safeguards[580] as this is a topic worthy of a thesis in itself.

Finally, I will highlight multiple practicable solutions that could be adopted by medical practitioners and judges to help the pregnant person. These practical solutions are concepts that are already practiced within the mental capacity law sphere but require greater emphasis and attention in obstetric cases. This includes greater efforts from medical staff to enable pregnant women to make their own decisions and better partnership and communication between the medical staff and pregnant woman generally. I will also consider Halliday's recommendation that hospitals should more readily utilise advance decision-making earlier on in a woman's pregnancy.

I will draw the discussion to a close in this chapter by re-emphasising the rights that pregnant women are owed and stressing that the underlying paternalism that feeds the problems in obstetric cases needs to be addressed for women's autonomy to be properly empowered. It is believed that the legal and practicable solutions suggested above will work to trigger and slowly push this social change onwards.

4.1 Hard law reform; Best interests test

As discussed under **section 3.1** of chapter III the courts rarely, if ever, take the woman's 'wishes and feelings'[581] into consideration when determining her best interests. This is particularly problematic considering Lady Hale's judgment in *Aintree v James* [2013],[582] where she emphasised the importance of considering 'matters from the patient's point of view'[583] during the best interests determination. This position has been adopted in cases concerning other patients, such as in *Wye Valley NHS Trust v B* [2015].[584] However, it has still not been normalised or established in obstetric cases. I argue that this issue needs to be addressed if pregnant women are to be treated with the same consideration that other patients are accorded.

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[580] Department of Health & Social Care, 'Liberty Protection Safeguards: what they are' (2021) <https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are.> accessed 22 December 2021.
[581] n24, section 4(6)(a).
[582] n394.
[583] Ibid, 608.
[584] n431.

One way in which this might be achieved is through reforming the best interests test under the MCA. Currently, the section 4 checklist contains no indication as to how the factors should be weighed or what importance the patient's wishes should have in the determination. I suggest that a duty to prioritise the patient's wishes should be included in the MCA to address the assertion that the courts have not sufficiently adopted the approach advocated by Lady Hale in obstetric cases. This is with the aim of compelling judges to pay due attention to pregnant women's wishes and feelings. This style of reform was suggested in the Law Commission Reforms paper on 'Mental Capacity and Deprivation of Liberty'.[585] In this Report, the Law Commission identified that the 'law fails to give sufficient certainty for best interests decision-makers on how much emphasis should be given to the person's wishes and feelings…'[586] They suggest that Parliament reforms the wording of the section to emphasise the primacy of patient's wishes. Their recommendations will be evaluated to discern the likely impact on best interests' assessments in obstetric cases.

The Law Commission Report concluded from the evidence they acquired that 'best interests decisions regularly fail to give essentially any weight to – let alone prioritise – the person's wishes and feelings.'[587] This is an issue because it is not in keeping with national and international developments that require a more patient centred focus to the best interests test. As the Report stated, 'the trend in national and international developments… is firmly towards requiring greater account to be taken of the wishes and feelings of the individual concerned.'[588] Since the introduction of the MCA (based on the Law Commission's 1995 report on mental incapacity), 'circumstances have changed greatly…'[589] through the introduction of the HRA and UNCRPD. These developments need to be reflected at the core of the MCA. Currently it does not go far enough to assert the importance of the patient's wishes and feelings in the best interests determination. This reform is needed to ensure that judges understand the necessity of this consideration. Although the construction of the MCA is already clear that wishes and feelings should be included in the determination, additional significance placed on this concept would help to encourage further engagement and implementation of it in judgments. Until this occurs, the dignity and autonomy of patients generally and obstetric cases in particular are at risk of not being properly safeguarded.

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[585] Law Commission, 'Mental Capacity and Deprivation of Liberty' (2017) <https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/lc372_mental_capacity.pdf.> accessed 19 October 2022.

[586] Ibid.

[587] Ibid, 11.

[588] Ibid, 159.

[589] Ibid, 33.

The Law Commission Report suggested that Parliament should make clearer that 'steps need to be taken to identify a person's wishes and feelings and to bolster the weight to be given to ascertainable wishes and feelings in the best interests determination.'[590] They recommended a change in the wording of section 4. First, they advised that courts should 'ascertain' rather than simply 'consider' the person's wishes and feelings. They argue that the term 'consider' is a passive formulation that is too weak. Thus, by changing the tone of the verb they hope to emphasise the importance of patient's wishes. They also suggested that in making the determination the decision-maker 'must give particular weight to any wishes or feelings ascertained...'[591] therefore elevating it in status above the other factors to consider. I believe that these proposed reforms could have had a meaningful impact in tackling the problems in pregnant women's best interests' determinations.

4.1.1 Ascertain wishes

Currently, judges need only 'consider' a patient's wishes and feelings. Section 4(6) of the MCA refers to these wishes and feelings as both the patient's '*past and present* wishes and feelings' (emphasis added), therefore this refers to both the individual's previous wishes and their current ones. The Cambridge dictionary definition of 'consider' merely requires a Judge to 'think about'[592] the patient's wishes. I agree with the suggestion that this is too weak a formulation. It allows judges the freedom to quickly brush over a patient's wishes and justify intervention on other section 4 factors.

To achieve a more patient-centred focus, the language requires modification. The Law Commission's suggestion that courts 'ascertain' rather than simply 'consider' wishes and feelings is praised. 'Ascertain' under the Cambridge dictionary means 'to discover something' or 'to make certain of something'.[593] This would obligate judges to explore the patient's wishes and be sure they are representative and true. Under section 4.4, I propose the obligation that judges speak to the patients to aid in their determination of their current wishes. I believe that the obligation to ascertain and discover a patient's wishes, rather than to just 'consider' them will make them harder to dismiss or override. They will have to be stated more clearly in court, resulting in a more prominent statement which should result in their playing a greater role in the determination.

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[590] Ibid, 159.

[591] Ibid, 45.

[592] Cambridge Dictionary, 'Consider' <https://dictionary.cambridge.org/dictionary/english/consider.> accessed 3 January 2022.

[593] Cambridge Dictionary, 'Ascertain' <https://dictionary.cambridge.org/dictionary/english/ascertain.> accessed 3 January 2022.

It is admitted, however, that this is not an infallible solution. A stronger acknowledgment of a patient's wishes does not necessarily equate with their definite application in the best interests assessment. Judges will still be permitted to point to other section 4 factors that support a determination that is at odds with the patient's wishes. Furthermore, this might be the most appropriate conclusion if the patient's wishes are evidently at odds with their best interests. However, in obstetric cases, I have argued that the woman's wishes to refuse obstetric intervention are never found to be in her best interests and therefore legal reform does indeed appear necessary to prompt change in the court's handling of obstetric cases.

4.1.2 Give particular weight to wishes

There are multiple factors that the person making the determination must consider under the section 4 MCA test. It does not elaborate any further on how this procedure should be approached by judges. Therefore, as the Law Commission argued 'it is difficult to see how almost any best interests decision could be unlawful provided that the decision-maker has consulted the right people and turned their minds to the relevant considerations.'[594] This is a critical point. The current best interests formulation means that judges can 'cherry-pick' or emphasise certain factors to legitimise a particular determination. Any one case could have numerous different substantiated outcomes depending on who has decided the case and what factors they believe to be most significant. It is acknowledged that decisions are always fact and context specific and therefore there is always room for differentiating interpretation and application of a statute in any context. However, I am arguing that there is too much room for interpretation currently, as judges are able to easily bypass the consideration a patient's wishes and feelings. As a result, in obstetric cases this has led to unfair dismissals of pregnant women's wishes. Therefore, I agree with the Law Commission's assertion that it is not 'simply a matter of properly applying the Mental Capacity Act.'[595] Section 4's current formulation requires reform to become unambiguous and assertive in its focus on patient's wishes.

The Law Commission proposed that section 4 should be revised to read that in making the determination the decision-maker 'must give particular weight to any wishes or feelings ascertained.'[596] The difference here being that a patient's wishes must receive 'particular weight', rather than remaining as just another relevant consideration. A status that none of the other section 4 checklist factors would have. This requirement would elevate the section 4(6) factor, giving it a level of primacy that is not attached to the other considerations. As the Law Commission explained, it would give 'ascertained wishes and feelings

[594] n585, 158.
[595] Ibid.
[596] Ibid, 158.

a higher status than all the other factors which a decision-maker is required to consider…'[597] The result of which, should hopefully be a more focussed approach on the patient's wishes and feelings. By elevating its status, Parliament would be clearly signalling that this is the most important factor to consider, which should force, or at least encourage, greater engagement with the patient's wishes. It is accepted that giving 'particular weight' is a relatively ambiguous concept that leaves room for interpretation. However, even with the possibility that some judges still might not place enough weight on the patient's wishes, I submit that this change in language will have some impact, even if limited. Statutory reform is a serious legal action that will not be ignored by the judiciary.

Overall, it is proposed that reforming the best interests test will help to tackle the issues discussed in **section 3.1** of this thesis. By compelling judges to ascertain wishes and then give subsequent weight to those wishes, the patient's views will not be easily brushed aside in court. I suggest that this will result in a best interests determination that is more substantiated by the pregnant woman's subjective interests and feelings.

4.2 Soft law reform; Update Code of Practice guidance

In chapter II, I argued that the courts fail to complete proper and impartial assessments of capacity. The threshold against which pregnant women are assessed is more demanding than that of other patients. This indicates that contrary to the stated legal position, the de facto position is that a separate concept of capacity exists in obstetric cases, coined 'obstetric incapacity'. One way in which this 'obstetric incapacity' manifests is through a judge's reasoning under the functional limb (section 3(1)) of the capacity test, as discussed in **section 2.6** of chapter II. There is a problem here because judges appear to make their capacity determinations against inherent normative judgments as to how a woman with capacity *should* be acting.

Section 1(4) requires judges to not treat a person 'as unable to make a decision merely because he makes an unwise decision.'[598] In some cases, judges make a point of highlighting this principle and their adherence to it. However, in practice I argued under **section 2.3** that this principle is not being properly observed. When deciding whether a pregnant woman is able to make the medical decision herself, I have argued that expectations of motherhood are influencing their judgments. As Bryan contends, there is this expectation that 'competent or "sane" women accept medical advice and act altruistically to

[597] Ibid.
[598] n20, section 1(4).

protect their offspring.'[599] Consequently, pregnant women are found unable to 'use or weigh' information because of the decision they wish to make, rather than the way in which they make it.

The most common justification specified by judges for finding a pregnant woman unable to make a particular childbirth decision is that she is unable to 'use or weigh information'. In a study conducted by Ruck-Keene, examining 23 cases where the patient lacked capacity, the 'inability to use or weigh was cited in 21 out of 23 cases.'[600] This study was not specifically about obstetric cases. However, it is still indicative of the fact that the 'use or weigh' factor is the most listed reason out of the four detailed under section 3(1). Banner argues that 'underpinning the assessment of the descriptive criteria for capacity is an intrinsically normative judgment.'[601] When completing the functional limb of the capacity test under section 3(1), it is agreed that judges make capacity judgments against normative standards. This means that when assessing the patient's ability to use or weigh information, the judgment 'hinges upon whether the patient is appropriating and using the information given in the way that he… ought to.'[602] This is a considerable problem because it allows for individual subjectivity and interpretation when assessing capacity. Whereas the concept of capacity is meant to be a relatively objective standard against which a patient can be reliably assessed. As identified under **section 2.6**, the problem with the assessments of capacity under the functional limb is that its meaning is not clear or unambiguous. This problem of ambiguity and the malleability of the capacity definition was discussed in detail under **section 2.8**. As Banner explains, 'it is unclear how the criteria ought to be interpreted and applied…'[603] Due to a lack of guidance to explain the meaning of understanding, retaining, using and weighing information, judges are forced to base their judgments on their own interpretations of the words. Their 'judgment about whether a person is using or weighing information hinges on whether that information is perceived by an observer as being used in the right kind of way.'[604] This means in obstetric cases, where there are strong paternalistic motives involved, pregnant women are being assessed against expectations that she is 'compliant, nurturing and self-sacrificial.'[605] To combat the inherent normativity in capacity assessments there needs to be more specific guidance to inform judges as to what it means to 'use or weigh' information. As Banner identifies, '"use or weigh" is a newer legal construct and

[599] n50, 121.
[600] Keene, Kane, Kim and Own, 'Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection' (2019) 62 *International Journal of Law and Psychiatry* 56, 66.
[601] Natalie Banner, 'Unreasonable reasons: normative judgements in the assessment of mental capacity' (2012) 18(5) *Journal of Evaluation in Clinical Practice* 1038, 1040.
[602] Ibid.
[603] Ibid, 1038.
[604] Ibid, 1040.
[605] n43, 51.

needs more attention in legal and clinical research.'[606] Until the Code of Practice is made more robust, judges will continue to interpret the phrase in the manner they deem most appropriate.

New guidance needs to make clear that using or weighing information focusses on the 'process not content of the decision.'[607] This sentiment is technically already addressed in the section 1(4) principle that a person must not be deemed unable to make a decision merely because their decision appears unwise. However, I believe that this principle needs to be re-iterated within the context of using and weighing information. In particular, it would be helpful to list the 'kinds of decision processes that could reasonably follow from the information given…'[608] to prevent judgments being based on 'the correct range of outcomes…'[609] Academics such as Bartlett assert that the test of capacity is flexible, easy to manipulate and results are 'unlikely to be valid and reliable between decision-makers.'[610] This begs the question of whether the capacity test should be reformed due to its inherent flexibility and room for interpretation? However, reforming the definition of capacity would affect all other areas of mental capacity law, so I am hesitant to suggest this as a solution based on the multiple unknown consequences this might have. Instead, I believe that expanding the guidance, specifically in obstetric cases, when assessing capacity would have a more effective and direct impact. I suggest that examples should be provided, specific to obstetric cases, that demonstrates how the capacity test should be applied in practice. Equally, for other vulnerable adult categories- such as those with dementia or anorexia nervosa- specific guidance could be provided as well. However, this would require further research to determine which other groups of patients would benefit from greater guidance about the application of the capacity test in their situations.

In conclusion, I propose that updating the Code of Practice with more detailed guidance about when a patient is 'unable to use or weigh information' will have a significant impact on how the judges approach the functional limb of the capacity test. It will help to outline the distinction between when a pregnant woman is making a subjectively 'unwise decision' and when she is truly unable to make the medical decision for herself; thus, combatting the problems discussed in **section 2.3** and **section 2.6** of this thesis. The guidance should seek to outline example scenarios where a pregnant woman genuinely lacks capacity against situations where the patient actually has mental capacity but simply disagrees with the medically advised caesarean section. This requires the patient's reasoning to be set out in full so that her decision-making process can be properly analysed to distinguish between genuine incapacity

[606] Ibid, 1040.
[607] Ibid, 1041.
[608] Ibid, 1042.
[609] Ibid, 1040.
[610] P Bartlett, 'The Necessity Must be Convincingly Shown to Exist: Standards for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983' (2011) 19(4) *Med Law Rev* 514, 529.

and perceived irrationality. To fully understand how the patient reached her decision there is an obligation on clinicians and judges alike to develop better partnerships with these pregnant women and communicate with them, in the most appropriate manner, to create a holistic picture of her thought processes. This will be discussed further in **section 4.4**. Furthermore, this clarity will help to limit the number of convenient findings of incapacity which was a problem discussed in **section 2.8**. Additional details in the Code of Practice will further consolidate the capacity test, leaving it less susceptible to manipulation.

4.3 Soft law reform; Increase judicial accountability

It was highlighted in both chapter's II and III, under the capacity test and best interests' determinations respectively, that the judges' rationale for their judgments was insufficient. Thus, I recommend that an obligation should be placed on judges to explain their reasoning in more depth (increased judicial accountability). They should be expected to provide more thorough justifications for the outcomes they come to. How this is achieved is something that requires further research and consideration. This might be through the Code of Practice or through Practice Directions. The current Practice Direction [2020][611] does not refer specifically to obstetric cases and ought to do so. For example, it could make clear that when a case comes before a court, judges should explain how wishes and feelings have been taken into account.

In Ruck-Keene's study, he draws attention to 'the importance of asking whether those charged with making determinations of capacity have explained the basis upon which they have reached their conclusion.'[612] Judges articulate that a woman lacks capacity *because* she is unable to make the decision *because* she is unable to use or weigh information. However, they often fail to sufficiently elaborate on *why* she is unable to use or weigh information. As a result, I believe that their judgment ends prematurely. Placing an obligation on judges to explain their decisions fully would force a more in-depth consideration of a capacity assessment and could in-turn lead to greater realisations of capacity instead of the quick acceptances of incapacity as highlighted throughout chapter II.

The current deference to medical opinion to substantiate findings of incapacity (**section 2.7**) would be targeted and addressed, encouraging the courts to justify their findings of incapacity more robustly on legal reasoning. The envisaged change would be judgments that clearly articulate their findings that goes beyond ready agreement with clinical professionals. Ultimately, capacity is a legal term and

[611] n25.
[612] n600, 71.

therefore requires adequate legal analysis. Judges would also be dissuaded from unconvincing conclusions, such as linking lack of insight to a lack of capacity (**section 2.4**). Overall, it is hoped that more stringent guidance would limit the convenient findings of incapacity that currently occur in obstetric cases (**section 2.8**).

Increasing judicial accountability through an obligation to explain their reasoning in more depth would not only have an impact on capacity assessments but would also help to ensure best interests determinations are more thoroughly substantiated. As stated above, the exact method of this requires further research and consideration. It could be that the Code of Practice sets out specific questions that judges must answer to justify their conclusion. Alongside the proposed reform to section 4 MCA, it would encourage courts to explain their rationale for choosing a particular determination. It is hoped that this would minimise the current expectations on motherhood that are inherent in the best interests test (**section 3.3**) causing obstetric intervention to be continually justified on the basis of safeguarding the pregnant woman's mental health by ensuring the wellbeing of the foetus. It would force more extensive evidence to be acquired to substantiate these assumed claims. Furthermore, it could help to encourage less restrictive methods of treatment to be endorsed, as section 1(6) requires but currently not appropriately heeded (**section 3.6**). Overall, imposing stricter rules on justifications will help to lead to best interests determinations that are more tailored to the individual woman, consequently recognising her autonomy and right to bodily integrity.

4.4 Practicable solutions; Placing women at the centre

In the introduction to this thesis, I outlined that the underlying problem in obstetric cases is the paternalistic attitude to care. This section builds on this problem to suggest that one necessity in tackling this paternalistic viewpoint is to re-instate the focus of these claims as being on the woman. As Halliday argues 'the way forward lies in putting the woman back at the centre of the decision-making.'[613] Clinicians and courts need to move away from a culture of management and control. Instead, they need to be working towards a position where pregnant women are treated with the respect and autonomy that they are due.

There are numerous practical solutions which could help to progress towards this aspiration. First, there needs to be better partnership between the pregnant patient and clinicians. Better co-operation would even out the power inequality and help to prevent situations of conflict and lessen the management of patients discussed in **section 3.2**. In addition to improving the working relationship between pregnant

[613] n7, 219.

women and clinicians, there should be greater attempts to enable the woman to have capacity to make the decision herself, as discussed in **section 2.2** or to at least be involved in the best interests decision that concerns her, by encouraging participation as discussed in **section 3.5**. This will help to re-centre the focus on the woman and her unique wishes. Finally, the basic rights that a pregnant woman is owed will be outlined, such as the right to a fair and just trial. I will ask that these are made clearer to the pregnant woman and strictly adhered to.

All of these actions will help to fulfil the core purpose of the MCA; placing 'individuals at the very heart of the decision making process.'[614] The goal of hospital trusts in obstetric case scenarios should not be the attainment of their preferred course of action. It should be about supporting and enabling the pregnant woman to regain or retain capacity to make her own decision or where that is not possible, promoting her wishes to be the central focus in the best interests assessment. The details of how this might be actioned is something that requires further research and consideration.

4.4.1 Practicable solutions; Advance decision-making

It has been noted throughout this thesis, such as in **section 3.2**, that pregnant women are often managed in obstetric cases. Whereas I argue that pregnant women should be regarded as active players or 'senior partners'[615] in decisions made about their bodies. If doctors worked *with*, and not *for* pregnant women, a lot earlier on in the pregnancy then I suggest that a lot of the problems encountered could be avoided.

To achieve a 're-centring [of] the relationship between women and healthcare professionals'[616] Halliday recommends a 'greater use of advance decision-making… through anticipatory decision-making.'[617] Buchanan describes advance decisions as 'a refusal of consent given much earlier than in other circumstances.'[618] These would facilitate the opportunity for a pregnant woman to make a decision about her treatment options, in advance, whilst she has capacity. This mechanism goes further than a simple birth plan which most women are encouraged to create. A birth plan is simply 'a record of what you would like to happen during your labour…'[619] whereas an advanced decision is a 'much more

[614] n244.
[615] n7, 230.
[616] n7, 220.
[617] Ibid.
[618] Monica Navarro-Michel, 'Advance directives in Spain. Perspectives from a medical bioethics approach.' (2005) 13 *Medical Law Review* 137, 169.
[619] NHS, 'How to make a birth plan' < https://www.nhs.uk/pregnancy/labour-and-birth/preparing-for-the-birth/how-to-make-a-birth-plan/> accessed 10 September 2022.

detailed and formal anticipatory decision…'[620] These work to bind the clinician to the woman's wishes and prevent any unwanted obstetric intervention.

Halliday thinks these are advantageous schemes and should be more widely utilised because they 'act as a communication bridge in the event of incapacity…'[621] The pregnant woman can convey her wishes and 'provide a clear statement'[622] of what treatment she does not wish to undergo in advance. Indeed, I agree that allowing pregnant women the opportunity to make decisions for themselves at an earlier stage in the pregnancy would accomplish respect for the woman's autonomy and bodily integrity. It puts the patient at the centre of the decision, even when they lack the capacity, by allowing them to decide what happens to their body in advance. It would work to combat the problems touched upon in **section 2.2**, whereby women are not enabled to make decisions for themselves.

The potential benefits of an advanced decision can be demonstrated clearly in the context of cases such as *The NHS Acute Trust & The NHS Mental Health Trust v C* [2016].[623] The patient C, was detained under section 2 MHA because she suffered a manic episode with psychotic symptoms. She was found to lack capacity to refuse to consent to obstetric intervention. I argue that her doctors could have taken advantage of her capacity earlier on in the pregnancy to attain an advanced decision. Her condition had been generally well controlled by psychotropic medicine; therefore, it was unfortunate that they did not utilise this time to ensure that future decisions made about her body would protect her autonomy and bodily integrity. Such foresight would have been reasonable considering that C did have a long history of bipolar affective disorder. I argue that her doctors should have considered the possibility she could have lost capacity in the future and been unable to make medical decisions for herself.

Guys and St Thomas's v R [2020][624] demonstrated an opportune case to utilise an advanced decision. At the time of the hearing, R was deemed to have the capacity to make treatment decisions about her labour and succinctly expressed that a 'caesarean section is the last thing [she] would want'.[625] However, instead of listening to R and working with her, the Hospital Trust opted for an advanced declaration from the courts that obstetric intervention be permitted should R loose capacity. The best course of action to ensure respect for R's autonomy would have been to listen to her capacitous wishes and work with her to form a binding advance decision. This advance decision would have ensured that any decision made in the future was 'patient-centred' or focussed on R. Instead, they chose to take

[620] n7, 222.
[621] Ibid.
[622] Ibid.
[623] n57.
[624] n479.
[625] Ibid, [56].

action that didn't facilitate her wishes should she loose capacity, but rather ensured they could take control and decide in her place should she loose capacity.

The benefits of advance decisions are notable; however, they are not useful in every scenario. For example, in an emergency situation where no advance decision has been made and the opportunity has been lost to do so. Furthermore, there is the potential that as this is also a legal mechanism there is the possibility that this could be manipulated in certain circumstances (like capacity) since an advance decision can be set apart if it is not specific enough or the circumstances in reality are materially different to those envisaged in the advance decision. Michalowski argues that the English courts have approached advance treatment refusals 'with a bias against their validity and applicability, unless they are clear and unambiguous, which by their nature in most cases they cannot be.'[626] Nonetheless, advance decisions are still a mechanism that should be considered in obstetric cases and used to enable women to make their own decisions where possible.

4.4.2 Practicable solutions; Partnership and communication

Advance decisions would be a useful and appropriate tool in some scenarios. They would help to move away from management and towards a partnership whereby clinicians consult with patients to create a legally enforceable plan that accomplishes their wishes. However, I advocate that more informal, less legal conversations and processes are equally as important in achieving this partnership. This means including the pregnant woman in important conversations and facilitating ways in which she might work with her attending clinician.

The current lack of this partnership dimension is amply evidenced in obstetric cases. For instance, in *Re AA* [2012],[627] the Hospital Trust did not even inform AA of their application to court. By keeping AA in the dark, it seems as though AA was viewed as an issue to be managed, rather than a human with rights to be upheld. It was stated in the judgment that the hospital trust wished for an elective caesarean so that they could deliver the baby in a controlled environment before removing the baby in to care. This attitude suggests that the Hospital made a judgment about AA's character and decision-making ability and decided to exclude her from the proceedings. By failing to include AA, they are taking control in such a way that fails to put AA at the centre of their considerations, thereby suggesting she is not the main player in this decision, merely a factor in their calculations. AA and her wishes should have been the prime focus and yet she was essentially side-lined and used to achieve the Hospital Trust's

[626] Sabine Michalowski, 'Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of the Absolute Right' (2005) 68 MLR 958, 981.
[627] n6.

desired outcome; safe delivery of the foetus. Instead, I believe that the clinicians should have been working with AA and discovering and discussing her wishes. Clinicians should work to build collaborative partnerships with pregnant women to help them to feel valued and respected as a human and individual. This is currently not happening and vulnerable pregnant women are being too quickly dismissed. It is worth acknowledging though that there might be some practical difficulties with this approach if the pregnant person has mental health issues. However, this should not preclude clinicians from trying.

The partnership needs to be developed from the very start of the pregnancy when there is time to support and plan. This is a preferable situation to leaving it last minute to an emergency hearing when the chance for collaboration has run out. As Walstead points out, 'last minute urgent applications make it difficult for a court to take into account all the relevant factors in resolving such a difficult and important issue.'[628] It takes all the power away from the woman when it is left last minute and puts the court in the undesirable position of handling an emotive and serious situation. It is concerning that the hospital trust were content to delay these proceedings and not take advantage of the time before AA's labour to collaborate with her. The time and monetary pressures of the healthcare system should of course be noted. However, planning with a pregnant woman from the start of her pregnancy should not be seen as a privilege, but a necessity.

In the recent case of *East Lancashire Hospitals NHS Trust v GH* [2021],[629] the court held that it would be lawful to compel the patient, GH, who suffered from acute agoraphobia to be taken into hospital. GH had not left her home since 2017, regarding it as her 'safe space' and therefore wished to have a home birth. However, she went into labour that became obstructed and therefore the medical staff wanted to move her to a hospital for urgent in-patient treatment. GH had previously agreed that she would go to hospital if necessary. However, there was no consideration for the fact that she might change her mind about going to the hospital if necessary and still wish to deliver at home regardless. There is no evidence that any preparations were made with GH to discuss this possibility and how she would want to proceed. In the end, GH safely delivered her son at home without any need to go to the Hospital. It is still unfortunate that the hospital trust allowed the situation to progress to the point where the court were granting a declaration to treat GH against her wishes, including by 'means of the use of sedation and reasonable force if further gentle persuasion fails.'[630] Had they made adequate preparation plans this might have been avoided. This includes the possibility of providing support and treatment to

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[628] Mary Welstead, 'Was from His Mother's Womb Ultimately Ripp'd (Macbeth Act 5, Scene 8): Court-Ordered Caesarean Births' (2015) *The International Survey of Family Law* 33, 36.
[629] n422.
[630] Ibid, [40].

overcome or at least reasonably manage her agoraphobia. Preventative measures that focus on the woman are preferable to emergency management cases.

There are multiple other cases where the women concerned have suffered from phobias or otherwise treatable mental health conditions. Therefore, a large part of ensuring partnership between women and clinicians should be facilitating treatment for their mental health so that they are able to partake. Halliday contends that the 'number of cases brought before the courts is indicative… of a failure in communication between the doctor and her patient.'[631] I believe this has been demonstrated in the previous cases, where little communication was attempted with the patient and in response, to solve the conflict, or any potential conflict, they turn to the courts to make the decision. However, I argue that the best way to ensure the patient is the focus of any decision they make or that is made on their behalf, is for clinicians to consult and plan with them. The fact this is not achieved is suggestive that they would rather work with the courts to gain control, rather than work with the pregnant woman to create a plan that takes into account her wishes.

Partnership and collaboration will help to address the current power inequality that pregnant women face. If they are included in decisions about them, then it will help them to be in control of their own body. Another benefit of collaboration and partnership is the trust it creates. As Halliday states, 'the basis for such a cooperation lies in trust, not compulsion.'[632] Where trust is not present, fear and uncertainty can grow instead. This has led to certain women feeling unsafe and running away from hospital environments, which in turn presents more dangers. The Royal College of Obstetricians and Gynaecologists (RCOG) acknowledged this fact, stating that 'to seek a court order to try to override the competent woman's refusal would be detrimental to the doctor-patient relationship.'[633] Therefore it is not only important to create cooperation to enable the woman's autonomy, but also to ensure her safety. For example, in the US case of *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson* (1964)[634] the plaintiff hospital reported that the patient Mrs Anderson had left the Hospital after stating that she 'did not wish blood transfusions for the reason that they would be contrary to her religious conviction as a Jehovah's Witness.'[635] Therefore, fearing that she might be compelled into treatment against her will, she removed herself. By doing so, Mrs Anderson was at risk of a severe haemorrhage which would likely cause the death of herself and her foetus. This demonstrates how important it is not to manage a patient or neglect their wishes. The relationship between doctor and patient is so important to ensuring that the patient feels safe and involved in decisions about her body.

[631] n7, 221.
[632] n7, 166.
[633] Ibid, 54.
[634] *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson* (1964) 201 A.2d 537.
[635] Ibid.

It is worth caveating this approach with the acknowledgement that clinicians' actions will be influenced by the possibility of negligence claims and the millions of pounds that this can cost the NHS. Also, it is accepted that there is a lot at stake at the point of the delivery, including the life of the pregnant person, the foetus and also potential lifelong implications if there are disabilities that follow from births that do not go to plan. I still argue that clinicians should continually strive for partnership and communication with the pregnant patient, but within the practical realities of the situation they face.

Overall, by encouraging a culture where partnership and communication are the norm, incremental progress will be made for pregnant women's autonomy. I believe that the principles outlined under the MCA would be more strongly upheld if clinicians worked to understand the pregnant woman through a more tailored and personal approach. Partnering with the pregnant woman would help clinicians to identify how to uniquely help to enable that patient to make their own decision as section 1(3) requires (problem identified in **section 2.2**). Where she genuinely lacks capacity, continued partnership would help to ascertain potential ways of helping the pregnant woman to regain her capacity and encourage participation, both factors that should be embodied through the best interests determination and discussed in **sections 3.4 and 3.5** of this thesis.

4.4.3 Practicable solutions; Enabling women

The previous section discussed the importance of partnership. However, for partnership to be plausible in certain scenarios, the pregnant woman might need support to become capable of partaking. Thus, it is essential that women are provided with reasonable special measures they require, such as health support to manage mental illness. In addition, it is important to enable women in this way so that they may make decisions for themselves. This sentiment already underpins the MCA in the section 1(3) principle which states that 'a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'[636] and is further supported by section 4(4) which requires the decision-maker to 'permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.'[637] However, I purport that not all practicable steps are currently taken to help pregnant women to make their own decision (discussed under **section 2.2),** nor are they encouraged to participate in the decision when they lack capacity (discussed under **section 3.5**).

[636] n20, section 1(3).
[637] Ibid, section 4(4).

Underpinning the MCA is the encouragement that individuals should ‘play as big a role as possible in decision-making…’[638] This value is reflected in section 1(3) which holds that ‘all practicable steps’ should be taken to help an individual make their own decision. This process can be described as ‘supported decision-making’ which the Law Commission describes as ‘the process of providing support to a person whose decision-making ability is impaired, to enable them to make their own decisions wherever possible.’[639] As Bartlett identifies the ‘MCA is meant to empower people with disabilities.’[640] The requirement to support patients to make their own decisions is widely recognised and campaigned for on an international human rights level. Article 12 of the UN Convention on the Rights of Persons with Disabilities ‘has been interpreted by the UN Committee… as indicating that national laws should provide support to people with disabilities to ensure that their will and preferences are respected, rather than overruled…’[641] Thus the basis of supported decision-making sits strongly in the human rights arena and deserves more attention than it currently receives.

A House of Lords report found that ‘the “empowering ethos” of the Act had not been delivered.’[642] A consultation paper also noted that ‘supported decision-making under the Act was “rare in practice” and ‘compliance with the principle is patchy and inconsistent…’[643] This provides evidence that supported decision-making is rarely engaged with. If supported decision-making was utilised then ‘most of the Mental Capacity Act would not apply because, through the provision of support, the person would have decision-making capacity.’[644] Therefore, the prevalence of obstetric cases in courts is evidence of non-engagement with the section 1(3) principle.

In a number of the obstetric cases discussed throughout this thesis, I have argued that a significant proportion of the women concerned could have been capable of making their own decisions. However, they were not sufficiently supported or facilitated to make or communicate their wishes. Providing women with health and social support could make the difference between them taking control of their own bodies and being compelled into treatment. For instance, in the most recent case of *East Lancashire Hospitals NHS Trust v GH* [2021],[645] I suggest that early intervention could have helped GH to manage

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[638] n262, 22.
[639] Ibid.
[640] Peter Bartlett, ‘At the Interface Between Paradigms: English Mental Capacity Law and the CRPD’ (2020) 11 *Front Psychiatry* 1, 4.
[641] Shibley Rahman and Rob Howard, *Essentials of Dementia: Everything You Really Need to Know for Working in Dementia Care* (Jessica Kingsley Publishers 2018) 190.
[642] Select Committee, ‘Mental Capacity Act 2005: post-legislative scrutiny’ (2014) <https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13904.htm.> accessed 21 September 2022.
[643] Ibid.
[644] Ibid.
[645] n422.

her agoraphobia in such a way that she could have retained capacity. Similarly, in cases such as *Re MB* [1997][646] and *Bolton Hospital NHS Trust v O* [2003],[647] where the women suffered from needle phobia and post-traumatic stress disorder, 'cognitive behavioural therapy might have assisted the women to develop coping strategies'[648] so they could make the decisions themselves. Rather than concluding that these women are unable to make their own decision, clinicians should be doing more to facilitate them. Their current approach to women's capacity is reactive, rather than proactive. Women should be given every practicable opportunity to demonstrate their capacity and make their own decisions.

So how do we facilitate this change in attitude and practice? As the Law Commission identifies the 'Mental Capacity Act does not create a formal process for supported decision-making…'[649] This is a problem, because even though section 1(3) might clearly state that all 'practicable steps' should be taken to enable a person to make their own decision, this is unhelpful when doctors and judges are not told what this entails. Therefore, more specific guidance and details should be provided in the Code of Practice. This should provide details of the types of health and social support that a pregnant woman is entitled to before any conclusions of incapacity are drawn. This would provide greater certainty for professionals and patients alike. The Mental Capacity Act 2005 is the primary source of capacity law and direction, but there needs to be more robust guidance in the Code of Practice, alongside the MCA, before it appropriately and effectively achieves the aims it sets out.

The Code of Practice does this to a certain extent already when it sets out guidance and suggestions to facilitate the participation of the patient. These were outlined in **section 3.5** of the thesis, including 'breaking down information into smaller points and using illustrations and/or photographs to help the person understand the decision to be made.'[650] However, these are rarely engaged with in obstetric cases and until these methods are properly employed in obstetric cases, the autonomy and empowerment of pregnant women will continue to be curbed. Donnelly argues that the MCA 'should be seen to require decision-makers to strive, imaginatively if necessary to recognise the preferences of a patient lacking capacity and to ensure that the patient's views are not lost in the midst of the professional evidence adduced.'[651] To effectively realise this vision in practice, it is important that clinicians and doctors engage with the suggestions outlined in the Code of Practice regarding the facilitation of participation. With regards to proposed methods of enabling pregnant women to retain

[646] n1.
[647] *Bolton Hospital NHS Trust v O* [2003] 1 F.L.R. 824.
[648] n7, 221.
[649] n585, 38.
[650] n262.
[651] n468.

or regain capacity, the Code of Practice requires further guidance to be added to aide clinicians with this endeavour.

4.4.4 Upholding women's rights

To facilitate the focus of obstetric cases to re-centre on the woman, she needs to know what rights and duties she is owed. The current guidance is outdated and does not provide sufficient information to pregnant women. It is worth re-emphasising the basic rights that a pregnant woman is owed. As Halliday has eloquently argued, it is important that the judiciary work to 'protect and promote the woman's rights to autonomy and bodily integrity…'[652] Where obstetric intervention is sought by clinicians for the benefit of the foetus, it is especially important that they do not lose sight of the legal rights and wishes of the woman. She deserves to be treated in a manner that is equal to all other patients. Her state of pregnancy does not diminish her rights, nor does it place additional legal duties on her to act in the best interests of the foetus.

Firstly, pregnant women should be made aware and have better accessibility to health and social care provisions. Many of these recommendations were highlighted in the previous section. For example, there needs to be early action to provide therapeutic care for the pregnant woman's mental health or the opportunity create a detailed advanced decision. It is inexcusable not to provide this basic level of care and preparation, especially when the costs and demands of an emergency case are arguably higher than putting foundations in place early in the pregnancy. Furthermore, this would arguably ensure better protection for the woman, where organising and early preparation allows for less error and conflict.

In certain cases, it could be argued that proceedings did not adhere to a fair and just process. Many cases are heard *ex parte*, without an Official Solicitor. Or, where she is represented, her wishes and interests are not adequately advocated. Very rarely is she involved in the proceedings and the focus appears to be on the result of decisions, rather than the fulfilment of the woman's integrity. Cases should not be permitted to proceed where these basic (legal duties) are not in place. Even in emergency scenarios, if the hospital is able to procure a capable solicitor, then the same should be expected on behalf of the woman. Furthermore, these scenarios should and often could be avoided if hospital trusts acted earlier.

There should also be the opportunity in every case that is put before the court for the woman to speak directly with the judge. It is important to break down the 'blind barrier' between the court room and

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[652] n7, 222.

patient. In *A Hospital NHS Trust v CD* [2015],[653] Mostyn J spoke directly with the patient concerned. He described the experience as enlightening and said it helped him in coming to a decision. This was because 'the person [he] met was different in many respects to the person described in the papers.'[654] Speaking directly with the patient should help to breakdown any pre-conceptions of the pregnant woman's capacity or best interests. In turn this will help to make sure that the focus of the case remains specifically on the woman and her individual circumstances and wishes. If it is not possible to meet in-person, then a video call could be easily arranged. The COVID-19 pandemic has highlighted the ease of remote conversation, and this should be utilised in obstetric cases. It is acknowledged that there could be practical challenges when attempting to communicate with pregnant women in labour who have a mental illness. Therefore, it is important that where practically feasible, judges are made aware of moments of lucidity and are flexible to speak with pregnant women in these moments to ascertain their wishes. However, this might not be possible in every scenario, and this is accepted as one of the limitations of this practical suggestion to increase the focus on pregnant women in their delivery decisions. Overall though, I suggest that this approach is still important to attempt and in some cases it will be possible for the pregnant woman to speak with the judge to express her wishes.

4.5 Underlying paternalism

Thus far, this chapter has discussed potential changes that would help to address the problems in obstetric cases. However, I believe the main issue is the underlying paternalism and therefore it is these attitudes towards pregnant women, especially those with SMI that needs to change. As shown throughout chapters II and III, there are indicative issues in the body of case law that point towards paternalism. Michalowski states 'legal principles alone cannot provide adequate respect of patient autonomy…'[655] I agree that until the core problem of paternalism is addressed, problems will continue to manifest in obstetric cases. Legal reforms and guidance, such as that discussed above, might address the current manifestation of the issue. However, it is feared that the issue will simply present in a new way. This worry is supported by evidence over the last 20 years. Before *Re MB* [1997],[656] the question was whether a woman with capacity could validly refuse treatment. However, since this right was established in *Re MB*, the issue now presents itself in questionable findings of incapacity and convenient conclusions of obstetric intervention under the best interests assessment. Due to the inherent flexibility of the law, there will always be a way to continue ensuring the safe delivery of the foetus. It is apt to state that 'the legal landscape of court-authorised obstetric intervention has changed little; rather, the

[653] *A Hospital NHS Trust v CD* [2015] EWCOP 74.
[654] Ibid, [31].
[655] n11, 127.
[656] n1.

battle lines have been redrawn…'[657] The reforms and updated guidance so far discussed will help to address the current issues. However, it is important to acknowledge that this won't solve the issues in its entirety. They will probably not be sufficient without social pressure for change. But since this is a legal thesis, the focus of discussion has been changes that can be made through legal reforms and guidance, rather than that of a social nature.

I have argued throughout this thesis that the underlying an sustained reason for the issues that manifest in obstetric cases is the presence of protection towards the foetus. This can be clearly inferred from case law. The very reason that these cases are brought to court is to attain legal endorsement to obstetric intervention to ensure the safe delivery of the foetus and pregnant person. Thus, even the formulation of these case demonstrates their inherent paternalism. The main impetus for hospital trusts making these applications is not to assess a patient's capacity, but rather to protect and preserve life without ensuing liability.

This treatment of pregnant women is consistent in other medical decisions that concern the foetus. For instance, Romanis discusses similar issues of paternalism and 'prejudice against autonomy in childbirth'[658] but in a slightly different context. She points out that pregnant women are routinely denied choice in childbirth. She focusses on women who wish to have 'maternal request caesarean sections'[659] but have their wishes ignored. This demonstrates a universal issue of management and protection when it comes to pregnant women and denying them 'choice in childbirth'. However this must change, because as Romanis highlights 'there is nothing unique about pregnancy that displaces the ethical norm of respecting patient's sufficiently autonomous choices.'[660] Therefore they are entitled to the same respect and autonomy as other patients. Until this is addressed women are effectively reduced to the reality of being '"foetal incubators" and denied individual agency.'[661]

[657] n7, 87.
[658] n121, 256.
[659] Ibid, 250.
[660] Ibid.
[661] n3, 154.

Conclusion

I introduced this thesis with Lady Justice Butler-Sloss's judgment in *Re MB* [1997][662] alongside Pattinson's assertion that there 'is room for cynicism about whether the courts are truly acting according to their declared principles…'[663] Analysis of the case law post-*Re MB* has demonstrated that Pattinson's scepticism about the impact of the judgment and Halliday's contention that it is a 'hollow victory'[664] (as referred to in chapter II) are both well-founded arguments. I have advanced these arguments by working through and identifying specific issues that have arisen in the obstetric cases since *Re MB,* under the categories of capacity assessments and best interests' determinations. Although these individual issues may appear insignificant in isolation, I have argued that when joined together, they build a compelling and worrying picture of unacceptable obstetric treatment. As a result, the term 'obstetric incapacity' has been introduced in this thesis to describe the lower threshold of incapacity that pregnant women appear to be de facto assessed against by courts to deem them as unable to make the decision to refuse an obstetrician's recommended caesarean section.

Until a case occurs where the courts acknowledge the capacity of a pregnant woman and thus are required to accept her decision to refuse obstetric intervention that could potentially harm the foetus, it is reasonable to continue questioning the level of autonomy and right to self-determination that is afforded in obstetric cases. There has been over 20 years during which this outcome could have been reached and yet this this is still to occur.

With a noticeable lack of evolvement in the outcomes of obstetric cases, it was appropriate to question the judgments and analyse the court's application of capacity law and MCA provisions. The result of which, clearly provided in chapter's II and III, are numerous shortfalls and insufficiencies, which cumulatively suggest that there is a larger problem. As Bryan contends, even though obstetric judgments may appear to be upholding the autonomy of pregnant women, in reality '[they] operate, through their subtexts to expose the pregnant woman to covert non-legal mechanisms of disciplinary control…'[665] Altogether, the evidence throughout this thesis paints a picture of continual curbing of the pregnant woman's right to self-determination and autonomy.

This thesis approached this issue by separating out the different ways in which the test for capacity and the best interests test are manipulated to limit the autonomy of pregnant women. In Chapter II, the

[662] n1.
[663] n3, 154.
[664] n62, 181.
[665] n50, 116.

concept of 'obstetric incapacity' was introduced to explain that the problem is so great that this de facto category exists. I demonstrated the areas of exceptionalism in its various forms, which combined, suggest a much lower threshold against which pregnant women's capacity is set compared to other patients.

Discussion in Chapter III focussed on the best interests test and considered the standard set by Lady Hale in *Aintree v James* [2013] to 'consider matters from the patient's point of view.'[666] However, as Fovargue argues this position 'is not identifiable in the majority of the post-MCA MHA child birth cases.'[667] Indeed, the obstetric case law evidence explored in this thesis presents a cumulative picture that falls below the patient-focused approach that *Aintree* and the UNCRPD promote. As Halliday states 'the contrast between the way pregnant women and others are treated is extremely clear...'[668] The best interests of the pregnant women continue to be dominated by references 'to the impact that harm suffered by the foetus would have upon her mental health.'[669]

The shortfalls highlighted in both chapter's II and III demonstrate that the courts are insufficiently observing the underlying ethos of the MCA in obstetric cases. As a result, the autonomy of pregnant women is not being adequately respected or upheld by the courts. I have described the 'keen judicial desire to find an unwanted caesarean section to be lawful'[670] and suggested that this stems from a 'hidden agenda'[671] to ensure the wellbeing of the foetus and the pregnant person. Thus, in chapter IV I proposed multi-layered change to address the multi-layered problems that stem from the motivations of paternalism and disproportionate protection towards the foetus and pregnant woman. Until such change occurs, pregnant women will continue to fall off the 'cliff-edge' of incapacity 'into the clinging embrace of paternalism.'[672]

In conclusion, pregnant women, should be treated with the same respect and consideration that other patients are afforded, as expected by the ethos of the Mental Capacity Act 2005. Hospitals and courts should be the allies and advocates of pregnant women's autonomy, rather than their adversaries in circumstances where the life of the foetus is at risk.

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[666] n421.
[667] n55, 616.
[668] n7, 194.
[669] Ibid, 87.
[670] n3, 128.
[671] n55, 618.
[672] n61.

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