Does section 2(1) need to be present in the Mental Capacity Act – a personal analysis by Mike Stone

Preamble

The origin of this piece is a little 'convoluted': it arose because I read some written evidence to the MPs who were considering the Leadbeater Bill (so in the context of assisted dying or as I prefer assisted suicide), and it was mentioned that according to the Mental Capacity Act it is not possible for mental incapacity to be caused by something such as a belief in conspiracy theories. In plain English, the assertion amounted to 'because of section 2(1) of the MCA, there has to be a 'psychiatric diagnosis' before someone can be found mentally incapable of making a decision'. That isn't what I myself saw, when I read the MCA.

Before I continue, I will show the sections of the MCA which are relevant to my analysis of the situation:

1(2) A person must be assumed to have capacity unless it is established that he lacks capacity

2(1) For the purposes of this Act, 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.

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

Most people who work with or write about the MCA, describe 2(1) as 'the diagnostic test' [or 'the diagnostic threshold'] and section 3(1) is described as 'the functional test'.

I've always thought of 3(1) as a description of how a capacitous person makes a decision, not as a description of how we can 'test capacity' (I'll return to this latter – an analysis of what we can actually know is fundamental to my approach in this analysis). And when I first read the MCA, I looked at 2(1) and immediately thought 'well – true, but totally unhelpful'. I considered it to be 'totally unhelpful' because it seemed to me that 'because of an impairment of, or a disturbance in the functioning of, the mind or brain' **covers all possible reasons for** an absence of the mental capacity to make a decision. Put another way, would anyone find it sensible to suggest that 'thinking occurs outside of the human mind'? Or [would it be considered reasonable] to dispute that whatever thinking involves, and whatever the mind is, the mind depends on the brain?

I've found it quite challenging – not to mention slow – writing this piece. Depressingly so, because I was already at page 25 and had been thinking for about two weeks, before I realised something very obvious. I would like 'normal people' to be able to understand the MCA, because I want 'family-carers', relatives and clinicians to be working together during end-of-life situations when best-interests determinations are necessary. I did my best with MCA Best Interests some years ago, with my analysis at

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/MCA-Best-Interests-compressed-to-a-single-sentence-an-ansatz/972/

where I suggested that when making a best-interests determination:

'The objective is to make the best-interests decision which would result in the most satisfactory future when considered from the perspective of the incapacitous person as an individual.'

I had always disliked the idea, present in much of the guidance which I used to read, that **first** a psychiatric diagnosis should be looked for. The guidance is now going to change, to become that first you look at section 3(1), and then only if the person seems to lack mental capacity after 3(1) has been considered, does section 2(1) become relevant. In fact, if you do consider that section 2(1) is stating that a psychiatric diagnosis is necessary, then it is

perfectly logical to start by looking to see if there is a psychiatric diagnosis – because, if there isn't a psychiatric diagnosis, then the person **must be** mentally capable.

The original version of the MCA's Code of Practice tells readers:

'… it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to an accident or being under anaesthetic or their ability to make a decision may be affected by the influence of alcohol or drugs.'.

Well, if Jeremy hardly ever drinks, and during his mate's stag night Jeremy drinks far too much and ends up 'legless and totally blotto', nobody is going to invoke 'a psychiatric diagnosis', are they?

However, while I will need to do some 'digging into' section 2(1), this piece is an analysis of the question of whether it is necessary and helpful to include section 2(1) in the MCA, or should we only use a test such as 3(1) to establish the presence or absence of mental capacity. I also try to analyse, whether removing section 2(1) would make much, or indeed any, difference in terms of how the MCA works in practice.

I will now explain what it took me a couple of weeks to 'spot' – which either shows that my brain is getting old and slow, or perhaps that for once it helped that I read a section of the MCA's Code of Practice yesterday.

If you consider and assert that a person lacks the mental capacity to make a decision, then you need to justify why you believe that. It is possible that you might involve a psychiatrist. **But, you don't – or at least should not – ask the psychiatrist 'do you consider the person has got a psychiatric diagnosis?'. You ask the psychiatrist 'do you consider the person lacks the mental capacity to make the decision?'.**

That question, points the psychiatrist back into considering section 3(1) of the MCA. And, it is not the psychiatrist who needs to believe and justify a conclusion that the person lacks the mental capacity to make the decision: it is you, because the reason why you are considering the person's mental capacity, is that you are involved in the situation in such a way that you might need to call on the defences provided by the MCA if you intervene [or decide to not intervene] without the person's consent. So, you are investigating mental

capacity, in the context of 'next steps' – one next step potentially being the application of the MCA's best-interests framework:

https://www.dignityincare.org.uk/Discuss-and-debate/Dignity-Champions-forum/I-think-we-need-a-different-way-of-explaining-and-teaching-the-Mental-Capacity-Act-MCA/1114/

A brief Digression into Language

I did a web-search for 'diagnosis' and found:

DIAGNOSIS:

the identification of the nature of an illness or other problem by examination of the symptoms. "early diagnosis and treatment are essential"

the distinctive characterization in precise terms of a genus, species, or phenomenon.

It should actually say 'signs and symptoms' but the point is that diagnosis is the identification of the nature of the illness: it is not simply the listing of the patient's signs and symptoms. If a patient is unable to walk, then there are many possible reasons why the patient can't walk: **diagnosis involves identifying the precise reasons**. It isn't a diagnosis to say 'The patient cannot walk, and possible reasons could be [followed by a list of all possible reasons why the patient is unable to walk]'. **Section 2(1) is not a diagnosis – so it doesn't describe 'a diagnostic test'**.

I will point out, that different people use the same words to express different meanings, and different people also use different words to express different meanings, which often complicates discussion [sometimes enormously!]. As Lady Hale said in 'Montgomery' (my added italics and bolds):

https://www.supremecourt.uk/cases/uksc-2013-0136

117. These additional observations, dealing with the specific example of pregnancy and childbirth, are merely a footnote to the comprehensive judgment of Lord Kerr and Lord Reed, with which I entirely agree. *Were anyone*

*to be able to detect a difference between us, I would instantly defer to **their way of putting it***. I would allow this appeal.

A brief Digression into how law and science work

I don't really 'think verbally', to express it imperfectly I think more by using concepts and patterns, and my degrees were in a science. Science is fundamentally empirical: theories are developed from observation, theories are used to make predictions about 'what if' scenarios, and if observations clash with the current theory, then the theory is changed [if we can work out a new theory which fits the observations better!]. Whereas the law, so far as I can see, has a slightly tricky approach to 'proof and refutation'. Lawyers argue from 'precedent' [as well as from Statute] and precedent is only refuted when a judge in a subsequent court ruling 'overturns a previous precedent': that doesn't have the same empirical nature as 'observation'. Put simply, observation does rely on a competent observer, but if that part is okay then there is not 'opinion in observation' – whereas the opinion of a judge is present in precedent.

Judges in court cases also only consider the case in front of them – whereas scientists can devise and perform whatever experiment they consider will best-test the validity of a theory. I think this can have the consequence, of 'legal precedents' not necessarily being mutually-compatible, and the law taking much longer than might be expected to resolve such a problem.

Some Discussion of section 3(1)

Section 3(1) is not a perfect description of how humans make decisions, even setting aside the issue of whether our consciousness is where decisions are made or if 'consciousness is 'a presentation' of something which has already happened in our subconscious'. It is true that section 3(1) describes how we believe we arrive at many decisions. And 3(1) is a correct description of how a laptop computer works.

I am going to point out something here: **we can replace 'information' in section 3(1) with 'outcomes of the options' because decisions are choices between available options, and we select our chosen option because we prefer 'the future which that option leads to'.**

If we consider human ‘thinking’ and ‘decision making’ then there are complicating factors:

* As soon as you rewrite 3(1) with ‘information’ replaced by ‘outcomes of the options’, it becomes apparent that the sequence of section 3(1) is an approximation – because while considering the outcomes (at stage (c)) you might understand those options more fully, and you might even identify one or more further options: there can be ‘a feedback loop’ between 3(1)(a) and 3(1(c).

* Humans do not only use ‘verbal reasoning’. We also sometimes use ‘hunches’ - ‘this looks wrong – somehow’ or something similar. We conclude that, but we cannot explain exactly why ‘something ‘seems off’’. I suspect that we are in fact comparing ‘the pattern of’ what is in front of us, with what we’ve seen during our life and what the outcomes of those previous events were. For much of our evolutionary history, it seems likely that we were not verbal – but we must have been faced with decisions to make. Crows are I assume not verbal, but if you are walking past a nearby crow and you keep walking, the crow will often ignore you – as soon as you stop and especially if you stop and look at the crow, the bird will move away from you. This presumably can’t be ‘verbal’ inside the crow’s mind, but there is something in its mind which amounts to ‘human walking past and ignoring me – not dangerous’ and ‘human has stopped walking and is looking at me – dangerous’. Even if you want to, you cannot ‘explain your hunch’ - which is why we describe it as a hunch.

Section 3(1)(c) uses ‘use or weigh’ and not, for example, ‘weight then use’. I am going to simply assume – and not prove – that the wording of section 3(1) leaves sufficient ‘wriggle room’ for us to be able to ‘shoehorn into it’ the issues such as ‘hunches and feedback loops’ which I have mentioned.

However: despite 3(1) perhaps being imperfect, I do consider that it is an attempt to describe how humans make decisions in the general case – that if perfect it would need to be correct for all decision-making.

Some Discussion of the Mind and Brain

It is very difficult to separate the mind and the brain, when writing about thinking.

Modern beliefs about the brain's neuroplasticity, in so far as I understand them, assert that the physical structure of the brain can be altered by repeated thoughts – from 'Dr Internet':

"Neuroplasticity" is the fancy medical term used to describe your brain's ability to learn and adapt. Think of it as an internal rewiring process that allows your mind to grow and meet new and increased demands.

and

Neuroplasticity is the brain's ability to change and adapt due to experience. It is an umbrella term referring to the brain's ability to change, reorganize, or grow neural networks. This can involve functional changes due to brain damage or structural changes due to learning. *Plasticity* refers to the brain's malleability or ability to change; it does not imply that the brain is plastic. *Neuro* refers to neurons, the nerve cells that are the building blocks of the brain and nervous system. Thus, neuroplasticity allows nerve cells to change or adjust.

At nhs.net you can find 'Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave'.

So, 'expert opinion' is currently that we can affect how we think, by [listening and then] thinking – there are feedback loops within the mind/brain which mean our mental processes are altered by our earlier thoughts [as well as by physically-caused damage to our brains].

The Now

Functionality is a property of the Now.

Decisions are made in the Now, by choosing between available options, and we select the option which we hope will lead to the version of the future which we prefer.

It seems very ‘perverse’ to consider that our mental capacity to make a decision, depends on what has caused an impairment or disturbance in our mind or brain. The section of that written evidence, which I mentioned on page 1, is in italics here (this is something I had written in a draft version of this piece):

It is perverse to have arrived at ‘*it might be thought problematic that a conclusion has to be reached that the person **has** capacity to seek assistance because their difficulty processing the relevant information results from strong interpersonal or social pressure, rather than (say) the effect of dementia’* on the basis of ‘because their inability (for instance) to use or weigh the relevant information cannot be linked to a specific impairment or disturbance in the functioning of their mind or brain’ for a couple of reasons. The first reason, is that as I’ve pointed out above, it is now considered that ‘social pressure’ can impair the mind, by causing physical changes to the brain in the way that dementia does. The second reason is that section 3 does NOT state that the reason for mental incapacity is an inability to use or weigh the relevant information: section 3 is more than section 3(1)(c).

I have explained on page 6 how section 3 is more than section 3(1)(c) and how section 3(1) is an imperfect description of human thinking. I’m also not entirely sure what the authors of the written evidence mean by ‘social pressure’, and I will be looking at ‘social environment’ and similar further into this analysis.

How the GMC ‘translate’ section 3(1)

In the GMC’s **Treatment and care towards the end of life: good practice in decision making** which was published in 2010, the GMC described the process of a consultation with a patient who is considered capacitous in terms which mirror MCA section 3(1), and the equivalent of 3(1)(c) in the GMC guidance (section 14) is:

(c) The patient weighs up the potential benefits, burdens and risks of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which. They

also have the right to accept or refuse an option for a reason that may seem irrational to the doctor or for no reason at all.

Section (b) includes ‘The doctor explains the options to the patient, setting out the potential benefits, burdens and risks of each option.’.

If we believe the GMC, then a patient can consent or refuse for **a reason which seems irrational to the doctor or even for no reason at all**, and if we ponder sections 24-26 of the MCA which describe Advance Decisions to Refuse a Treatment then it is clear that an ADRT does **not** need to explain ‘**why** I’m refusing’.

It seems to me, that capacitous patients are not required to explain why they have decided as they have – doctors can ask, and some patients will give an explanation, but patients are not obliged to explain ‘their reasons’.

When you put all of this together, it becomes something of a challenge to explain how you turn section 3(1)’s description of capacitous decision-making into a test for mental incapacity in the context of the decision-making. Which I will return to later.

Filters: how and where?

It seems to me, that when we are ‘investigating’ either mental capacity or a psychiatric condition, our ‘tools’ are observation, listening, asking questions and [if the questions are answered] listening to answers. It also seems to me, that a ‘functional test’ of mental capacity to make a decision is: about the decision, the mind’s functioning, and ‘the moment’. Whereas a psychiatric disorder is more: about the mind’s functioning somewhat apart from any particular decision, and about a longer period of time than ‘the moment’.

If ‘a diagnostic test’ is to be applied after the functional test appears to have been failed, then **there is still a requirement to filter out the aspects of mental functionality which are not relevant to the decision.** Doctors, psychiatrists and judges often seem to find that particular requirement very ‘challenging’. There is, wrapped-up within a ‘psychiatric diagnosis’, a lot of understanding which is

extraneous in the context of an assessment of the person's mental capacity to make a particular decision.

So, if you go 'functional test failed – psychiatric diagnosis present – does the psychiatric condition cause the failure of the functional test?' then we 'have two filters': we need to 'filter' what we know while we consider the functional test, then we also need to filter for relevance our understanding of the psychiatric condition. And as I have pointed out, all of this understanding comes from observation, listening, and asking questions and [if the questions are answered] listening to answers.

It seems plausible, that if we get the 'observation, listening, asking questions and [if the questions are answered] listening to answers' right when applying a functional test, then there perhaps isn't any need for a diagnostic test.

Also, to my own 'pattern-based' way of thinking, it seems strange that when a functional capacity assessment is a 'borderline pass' then it is not necessary for the presence or absence of a psychiatric diagnosis to be known, whereas for a 'borderline fail' a psychiatric diagnosis is somehow fundamental.

Ireland does not have the 'diagnostic test'

In any event, while the lawyers I've been discussing this with seem to consider the presence of 2(1) to be 'fundamental', one of them has pointed out that Ireland has constructed a law similar to our MCA which does not have a 'diagnostic test'. I'm told the Irish law effectively includes our section 3(1) but does not have an equivalent to our 2(1) – extracts from e-mails:

Except (and I'll leave this for now) section 2 is where we get the definition of capacity from. Section 3 – importantly – amplifies what it means to be able to make a decision, but you don't lack capacity for purpose of the MCA unless the reason you can't make it is down to the impairment / disturbance – which you get from s.3. If you go to Ireland, all you have is the equivalent of s.3, and I'll leave you with the question of whether it means all those who consider that Bill Gates is behind the C-19 vaccine because he's microchipping it all lack capacity to make decisions about vaccination in Ireland…

And from another lawyer:

On whether the diagnostic threshold is a good thing... I have mixed views on this, and I'm intrigued to see where this goes in Ireland. On the one hand, there is a disability equality argument here - why do we treat some kinds of 'incapacity', caused by disability, differently to other situations where a person has problems making a decision to the standard of the functional test? Examples of other possible reasons for people making 'incapacitous' decisions include: 'undue influence' or coercive control type situations, unusual/odd beliefs (e.g. religious, conspiracy theories), addiction (alcohol, gambling - though I don't think this has been litigated? Could potentially meet the s2(1) criteria I think), manipulation by advertisers, there's even a case about a 'difficult personality' being the issue rather than a problem with the mind/brain. There have been cases about young people being 'brainwashed' by terrorists, and whether that impairs capacity.

Basically, if you remove the diagnostic threshold, you *massively* expand the scope of the MCA, to include huge chunks of the population, without any kind of recognised mental disability at all, in ways that the public would probably have strong views about. This would be such a huge change to the law that you'd need a public consultation on it, and to be frank, I think it would absolutely kick off in the media and in Parliament…

From a human rights perspective, it's part of a much bigger set of arguments about why we detain people with mental health problems who are believed to pose a risk to themselves or others, when we don't do this for other 'risky' populations (e.g. people with drug/alcohol addiction, offenders that we know have a high chance of recidivism, people who engage in incredibly reckless and risky activities and behaviours). I don't really know what the answer to this is - what do you think?

There is quite a lot in those which I agree with, but as we do have a situation when a law has been constructed without a 'diagnostic test', it is time for me to move on and to ponder the logical consequences of such a law.

The logical consequences of only applying a Functional Test

One of the things which has annoyed me in recent years, was the media reports about a young woman called Sudiksha Thirumalesh. I was loosely-following the situation of the young woman as it was being reported in the media, a couple of years ago, and as I wrote in an e-mail to some of the people I discuss the Mental Capacity Act with:

I think that the young woman was 'stitched up'. She should have said - and the case should have then analysed - 'I accept that I will probably die, and I accept that I want to try a treatment which could be described as unproven or experimental, but my understanding is that if I'm capacitous I decide which risks I'm willing to accept'.

There was an argument being presented that Sudiksha 'must be mentally incapable of making decisions about her treatment because she doesn't believe the prognoses being given to her by the doctors'.

There are several things worth thinking about, in the context of the above. One of them, is that as a family-carer for my mother who was dying at home, it was clear to me that there are subtle differences in the interactions with GPs, district nurses, 999 paramedics and if they become involved police officers (and in the case of police officers, the difference is marked as opposed to subtle). It is rather as if you are involved in a game, and without anyone making things clear to you, the game changes from football to rugby, and then to hockey. You don't even know which 'game' everyone is 'playing', and you are definitely not sure of the rules.

One of the 'rules', in the context of mental capacity, seems to be that the person whose capacity is being assessed needs to say 'I understand the risks, and I'm willing to accept them'. Which is what Sudiksha had been saying. So why was the court considering different questions: it is worth pondering why the court looked at 'Did Sudiksha not believe the prognoses the doctors were giving her?' instead of 'Sudiksha accepted that the chance of the treatment she wanted to try working was tiny, but she was mentally capable and she wanted to accept the risks of trying untested or experimental treatment'.

I can't help feeling, that there is something fundamental here: that judges rely on the notes made by doctors of their conversations with patients. And

patients can be feeling too ill for detailed conversation, or might dislike a particular doctor, or can even think the conversation is not about the topic the doctor is actually looking at. The more court judgements I read, the more I consider this issue – can you rely on the notes made by clinicians as 'accurately 'telling the whole story'? – to be problematic.

I'm tempted to suggest, that 'a cynical patient' might want to insist that all conversations with doctors and nurses should be recorded on the patient's mobile phone, just in case the conversation is to be subsequently presented to a judge. However, that would totally screw-up the functioning of the NHS.

So, all I can do, is to point out that even with the best of intentions, there is something unsatisfactory if judges mainly rely on the records made by clinicians of interactions.

'Who decides about the risks' bothers me, because I used to come across the following type of situations. A person is determined to die at home, and places that above receiving 'optimum care'. The person's family are supporting him. Because of 'a medical crisis' the person would be 'scooped up and deposited in hospital', followed by the doctors replying to 'I want to go home – I want to die at home' with 'you can't go home, you are too ill – you would probably die on the way home'. I'm not saying that all doctors adopted that attitude, but some seem to have done so. And, the Neuberger Review of the Liverpool Care Pathway found examples of dying patients who were being denied the opportunity to drink water, on the grounds that drinking [because the fluid might end up in the patient's lungs] was 'too risky'.

I will now begin to analyse the e-mails from the lawyers (pages 10 and 11).

First, I will point out that the issue of the mental capacity to make a decision does not include things such as blame, liability, culpability, remedy, mitigation etc. I'll start with Covid, which was mentioned in those e-mails.

There is an 'Empirical Reality' to our world. Most people are willing to accept that a virus did cause the illness we call Covid, but some people believed that there wasn't a Covid virus, the vaccination was to microchip everyone, etc. So – if you don't believe there is a Covid virus, can you be mentally capacitous in the context of consenting to a Covid vaccination? It is difficult to see how you

could be: put bluntly, why would you accept the risks associated with being vaccinated, if you considered that the vaccination wasn't protecting you from a pathogen?

But in reality, the issue is somewhat moot: individuals who did not believe that Covid was a real virus, etc, would not be trying to get vaccinated. The Government could have tried to pass a law which would have made vaccination compulsory. Which would have **changed the options** for those people: the options would then have become 'Do I get vaccinated against a non-existent virus, or do I refuse to accept a vaccination which the law is imposing on me?'. If the Government had tried to change the law, then it seems certain there would have been something between heated debate and furore.

What the Government chose to do, was to avoid any discussion of capacity and conspiracy theories, and instead to run a 'campaign about Covid misinformation' to try and persuade people to accept the vaccination.

A better example involves surgery. Suppose the surgeon says 'This operation has very-successful outcomes for the patients who do not die on the operating table – but about 2 patients in every 10 die on the operating table'. It isn't problematic if a patient says 'Well – if I die, I'll be in heaven'. That might mean the patient is more-accepting of the risk of dying than a secular patient would be, and that isn't problematic. But what if the patient says 'I will not die on the operating table – God will make sure that I survive the operation, and that it will be very successful'? The surgeon might point out, **that in her empirical experience** it has never made any difference whether her patients are religious or secular – the risk of dying during the operation is about 2-in-10 for everyone. If the patient still says 'God will make sure that I survive the operation' then can the surgeon consider that consent has been given? The GMC (pages 8 and 9) seems to consider that during such a discussion, the doctor describes risks – and the patient decides whether or not to accept the risks. If the patient can BOTH decide on the outcomes of the surgery, and also can decide how to 'weigh' those outcomes, then the whole situation 'looks rather weird'.

The patient can definitely adopt a 'positive mindset' and 'firmly hope for the best' when considering having the operation, but that isn't the same thing as 'I will not die on the operating table – God will make sure that I survive the operation, and that it will be very successful'.

Suppose a person says 'I'm going to jump off the top of that tall building – God will ensure that I bounce, and walk away unharmed'. I think most of us, would think 'No – you'll splat, and either be dead or very injured'.

I'm not quite certain, if that person has got a legal right to put to the test his belief that 'God will ensure that I bounce'. I'm not sure what the legal situation is with 'I'm going to kill myself, because God has told me to do that'. But in our society, I am sure that we do not accept 'I'm going to kill him, because God has told me to kill him'.

I used to use a different example of leaping off the top of a tall building. If a person says 'I'm going to jump off and fly away' then the person is probably not capacitous, and not suicidal. Whereas if a person says 'I'm going to jump off and fall to my death' then the person could be capacitous and suicidal.

In one of his court cases Mr Justice Jackson said:

https://www.bailii.org/ew/cases/EWCOP/2015/60.html

I am quite sure that it would not be in Mr B's best interests to take away his little remaining independence and dignity in order to replace it with a future for which he understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter.

In the 'I'm going to jump, and God will ensure that I walk away unharmed' situation, wouldn't the ideal outcome be to leave the person's faith unshaken and to ALSO prevent the person from jumping and then living on with life-changing injuries. And if the person did jump, surely we would expect those injuries to occur: so, as well as living with the clinical damage, the person would probably live with the equivalent of 'why has God abandoned me?'.

So ideally, shouldn't our approach be to see if we can persuade the person that 'God would perhaps protect you – but, does God really want you to put it to the test?'.

Almost everyone, whether they use 'computer-style' thinking as described by 3(1), or 'hunch-based intuitive' thinking, will be choosing an option because they are trying to achieve an objective. It does seem to indicate some sort of

flaw, if we are certain that the outcome of the option which the person has chosen DOES NOT FIT WITH the person's stated objective.

That reasoning, fits with the situations involving the jumping from a tall building and either 'flying away' or 'bouncing unharmed' as involving a person who lacks the mental capacity to make the decision.

Suppose that a man is having a cast removed by a nurse. Once the cast is off, the man says 'Good. I realised a couple of weeks ago, that my wife has been replaced by an alien. Now the cast is off, I'll be able to kill the alien'. I'm not persuaded that we need 'a psychiatric diagnosis' to see that the nurse should be trying to do something in this situation - which would probably be to detain the man under the Mental Health Act. However, returning to the MCA, and the argument I've just presented, the man's objective is to kill an alien – whereas in reality he would be killing his wife, not killing an alien who had replaced his wife.

If we use a computer-style model for mental functioning, then we can see that the computer-world's Garbage In, Garbage Out also applies to human decision-making. Even if the 'using and weighing' functionality of our mind is impeccable, if the 'input' which we are considering departs from reality, then we get 'a garbage decision'. For example, when a person is experiencing a world which is largely hallucinatory.

The third thing which seems fundamentally different in the context of arriving at a decision, is whether or not 'unshakeable beliefs' are present. The significance of 'unshakeable belief' in the context of mental capacity is quite intricate, but **the introduction of an unshakeable belief into the process of mental functioning, is of itself the significant point: it surely doesn't matter, logically, in the context of how that unshakeable belief influences decision-making, what caused the unshakeable belief to be present.**

So, I am suggesting two things which [individually] can point towards an assessment that the person is not mentally capable to make the decision:

The option which the person has chosen, does not fit with the person's known objective;

The person does not accept the 'empirically proven' outcomes of one or more of the options.

I am not going to become entangled in any nuanced differences between criminality and civil liability, so I'm going to say how I suspect things would look to the-average-layperson.

Suppose we consider two different individuals, each being under the influence of a large dose of LSD and therefore experiencing hallucinations which are severely-impairing their ability to make decisions – each does things which would ordinarily result in criminal or civil liability. One person deliberately took the LSD, whereas the second person's food or drink was 'spiked' with LSD. I think most people would consider that the first person should be regarded as culpable. Whereas the person whose food or drink was 'spiked' doesn't seem to be culpable – the culpability should rest on the shoulders of the person who spiked the food or drink. It also seems obvious, that if there is a psychiatric diagnosis covering hallucinations caused by LSD, that the diagnosis must apply to each of these people: how the LSD got into their systems, surely cannot be relevant to their hallucinations [and, therefore, it cannot be relevant to the diagnosis].

I'll consider some of the things raised by the e-mails on pages 10 and 11, using the reasoning which I have developed previously.

'Unshakeable belief' groups together brainwashing, religious upbringing, indoctrination and 'Covid Conspiracy Theorists'.

Bullying and Coercion are not situations of mental incapacity: those situations change the options which the person being bullied or coerced is considering.

For example, the choices of ‘Do I pick up and eat the last cake on the table, or do I leave it’ become, if a bully says ‘If you eat that cake I’ll whack you on the head’, ‘Do I pick up and eat the last cake on the table and risk being whacked on the head, or do I leave it’.

Addiction and Phobias group together. I recently watched a TV programme with a man who had a phobia of moths. If he could see a moth next to a door then he couldn’t bring himself to walk through the door: he knew that the moth couldn’t hurt him, but he had mental-pictures of moths attacking him and he was terrified of moths. So, he knew it made no sense that he couldn’t go near to moths, but even so he couldn’t go near to moths. Similarly an addicted person might know he or she is addicted to something such as gambling, might want to stop gambling, but might find it impossible to stop gambling. In these situations, the person is compelled to select an option which doesn’t lead to the outcome they would prefer.

Advertising is interesting. There are some rules imposed on advertisers, which are along the lines of ‘advertising must be truthful and not misleading’. The assumption seems to be that companies must be allowed to try and attract customers, and that most people know that ‘advertising is advertising’. I’ve recently glanced at a piece about a case which involved someone who was claiming what it seemed to me amounted to ‘I was personally very-susceptible to advertising, and the advertising of a Gambling Company compelled me to gamble’: arguments about privacy and consent were being presented in the case. But if our society considered that most people were susceptible to advertising to the extent that advertising amounted to ‘coercion to buy/use’ then surely we would ban advertising by law?

It seems to be logically correct, that while a person is in excruciating pain to a degree such that the person is simply unable to focus on almost anything except for the pain, it isn’t possible for the person to ‘make capacitous decisions’ about much at all – because ‘the pain is ‘pushing out’ everything else from the person’s consciousness’. I doubt that this situation is covered by ‘a psychiatric diagnosis’ but it surely DOES create ‘an impairment of the functioning of the mind’.

I will mention something about ‘environments’. Because of the ‘neuroplasticity’ mentioned on page 7, if a person lives in a social environment

where ‘fixed beliefs’ are prominent – for example a religious environment, or a family where everyone asserts ‘Covid conspiracies’ - then the same ‘fixed belief/s’ can become a part of the person’s mental functioning. I’m not certain, if this is what was meant by *strong interpersonal or social pressure* in that written evidence to the Leadbeater MPs (page 8). And I am not equating the ‘environments’ above to bullying or coercion – as I wrote on page 17 I do not consider that bullying and coercion affect mental capacity. **At least not in the short term**. Because of the ‘neuroplasticity issue’ long-term exposure to an ‘environment’ might create a ‘fixed belief’, and I do consider that ‘fixed beliefs’ might be judged as causing mental incapacity (I’m finding it too clunky to keep writing ‘mental incapacity to make the decision’!).

I will also point out, that I do not consider MCA mental capacity to make a decision as being the same thing as ‘autonomy’ during decision making. And I don’t think – having just done a word-search in Acrobat Reader – that autonomy or autonomous appear in the Act.

It is clear, that the logic of the line-of-argument I have developed in this piece, means that a decision that mental capacity is inadequate for capacitous decision-making could be arrived at ‘because of a bit of this, some of that, and a little of whatever’. ‘this’ might be a failure to accept the ‘empirical reality’ of an outcome: ‘that’ might be ‘a fixed belief’; and ‘whatever’ might be the presence of hallucinations which might be affecting decision making. When I read Court of Protection rulings – which I don’t do for fun, so I only read them if I need to – I think I usually come across lawyers who present their arguments as ‘It is because of this: if that argument isn’t accepted, then I suggest it could be because of that; and if that also fails to convince you, then I suggest it could be because of whatever’. Which, of course, **isn’t** ‘it is because of the combination of this, that and whatever’.

Some discussion of Prognoses

In a ruling by Mr Justice MacDonald where ‘use or weigh’ appears five times, and ‘weight’ appears ten times, we can also read:

https://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCOP/2015/80.html&query=court+and+of+and+Protection+and+Justice+and+MacDonald+and+sparkle&method=boolean

‘Further, in my judgment it is also important in this case not to confuse a decision by C to give no weight to her prognosis having weighed it with an inability on her part to use and weigh that information.’

In the same judgement, we can read (the italics are present in the judgement and I would point the reader to the italicised ‘**after**’)

‘Whilst it is the case that on occasion C received a very positive assessment of her prognosis *after* incidents of refusing treatment (for example on 29 September 2015, on 21 October 2015, when Professor G explained in the presence of C that “we feel that the patient should get better very soon and that they [her kidneys] could improve any day now” and on 3 November 2015, when Professor G told C that her prognosis was good and that she could “*be out with a drink in your hand by Christmas*) it is not in my judgment accurate to characterise the prognosis C was being given as consistently positive.’

This makes me think of the case involving Sudiksha Thirumalesh which I mentioned on page 12. There were arguments in that case about whether Sudiksha believed the prognoses being given to her by doctors when she was asking to be allowed to travel abroad to accept a ‘last hope’ treatment. And if I remember correctly, one of the things which influenced the young lady is that on some occasions earlier in her life she had, to use my phrase here, ‘done better than the doctors had told her she would’.

It might be worth mentioning something which has been described as ‘the Protection Imperative’ at this point. Ben Troke, in a free chapter of his book

http://www.lawbriefpublishing.com/2024/03/free-chapter-from-a-practical-guide-to-the-law-of-deprivation-of-liberty-by-ben-troke/

discusses the Protection Imperative in a section titled ‘Best interests and the protection imperative’.

It seems to me, that this is essentially the same issue as ‘medical paternalism’ and also the way that doctors often talk about ‘medical best interests’ when involved in a court case which is about **MCA Best Interests**. A doctor who I discuss the MCA and EoL with, has told me that one of the more difficult things for him to teach to his students, is the difference between MCA best interests and ‘medical best interests’. I’m deeply puzzled as to what ‘medical best interests’ means, unless it means ‘the best clinical outcome’. But whatever

that term means, it isn't a useful concept in the context of the MCA: what the doctors need to do is to describe the clinical outcomes of the available options, and then that is fed-into decision-making [whether it is the decision-making of a capacitous patient, or the correct application of the MCA in making a best-interests determination].

The above is probably, I think, what Mr Justice Charles was very-gently pointing at in Briggs when he said (my added italics):

'A court can if necessary make binding findings of fact and it carries out the weighing exercise required by the MCA with the benefit of hearing evidence that is tested and argument. As a consequence, it is likely to be in a better position to determine the existence of, and the weight to be given to, the matters set out in s. 4(6) of the MCA that are based on the past when P had capacity than, for example, treating doctors are. So, if P's family are asserting that they favour a different conclusion to that reached by the medical team, *it is likely that in many cases to be reasonable if not inevitable for doctors to give great and probably determinative weight to medical and ethical issues in their exercise of the MCA best interests test* pending the resolution of the existence of the matters in s. 4(6) and the weight to be given to them by a court.'

There was reporting of the discussions during that case, by Celia Kitzinger, and if memory serves me when he was talking to the doctors, Mr Justice Charles was rather more direct in making it clear that the law requires MCA Best Interests to be considered, not 'medical best interests'.

Returning to the judgement from Mr Justice MacDonald, he told us this:

'Further, and more importantly, with regard to the question of causation, and in particular whether what was being seen might be the operation of a personality disorder or simply the thought processes of a strong willed, stubborn individual with unpalatable and highly egocentric views the evidence was likewise somewhat equivocal.'

I'm not convinced that his wording 'of a strong willed, stubborn individual' is correct. Mr Justice MacDonald was admirably clear when he said:

'The decision C has reached to refuse dialysis can be characterised as an unwise one. That C considers that the prospect of growing old, the fear of living with fewer material possessions and the fear that she has lost, and will not regain, 'her sparkle' outweighs a prognosis that signals continued life will

alarm and possibly horrify many, although I am satisfied that the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and lifelong disability are factors that also weigh heavily in the balance for C. C's decision is certainly one that does not accord with the expectations of many in society. Indeed, others in society may consider C's decision to be unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general. None of this however is evidence of a lack of capacity.'

My concern is that 'strong willed and stubborn individual' suggests 'resistance to some sort of coercion' - so, I must ask, who was doing the coercing? The doctors? The above section of the judgement, makes me think that the other section should probably have said something like:

'Further, and more importantly, with regard to the question of causation, and in particular whether what was being seen might be the operation of a personality disorder or simply the thought processes of an individual whose values and preferences are rather atypical and who has unpalatable and highly egocentric views, the evidence was likewise somewhat equivocal.'

Tim and Tina

Tim has a typical mental life, until at the age of 32 he starts to hear a voice in his head. The voice speaks to him a few times each day, Tim always believes what the voice says. The voice only ever states factual information, and what the voice states is always correct. It isn't easy, to see how this particular 'voice in the head' can do anything other than improve the quality of Tim's decision making.

Tina believes she is always accompanied by a human-sized bright-blue rabbit, which goes everywhere with her, but never speaks or does anything else. Tina isn't disturbed by this rabbit's presence – if anything, she finds it reassuring. Tina is also absolutely convinced that the moon is made of cheese. It isn't easy, to think of any decisions which Tina might make, which would be influenced by these unusual aspects of Tina's life.

A little more about Options and Outcomes

The outcomes of options, can ‘include the person making the decision’.

If we have two individuals whose clinical situation is similar, who are each considering the same medical intervention and who are each considered to be in the final year of life and they are starting to be afflicted by various problems, then the outcomes they are considering can still be different. Suppose George is by nature ‘a happy person’ and James is by nature ‘an unhappy person’. Although being a happy person, or an unhappy person, will be true both before the medical intervention being considered and also within all of the outcomes, for George the outcomes will all include ‘and I’ll be ‘a happy person’’ whereas for James his outcomes will all include ‘and I’ll be ‘an unhappy person’’.

So, when a capacitous-and-depressed person is considering a life-sustaining intervention, then a mentally-capacitous person in that situation would **rationally** consider ‘… and I will still be depressed’ within the outcome of the life-sustaining intervention.

A re-presentation of section 3(1)

At this point, I will return to my point on page 5 that we can replace ‘information’ with ‘outcomes of the options’ for section 3(1). I will now do that, to create:

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the options and outcomes of the decision,

(b) to retain options and outcomes,

(c) to use or weigh options and outcomes as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

This is not so obvious, but in all honestly I can't see that it makes things any more opaque, or less transparent, if we also change 'use or weigh' to 'think about' - so I would re-present section 3(1) as:

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the options and outcomes of the decision,

(b) to retain options and outcomes,

(c) to think about the options and outcomes as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

I will consider indoctrination, and I will use the behaviour of soldiers during WW2. Troops in the armies of all combatants probably, to varying degrees, committed 'atrocities' during WW2. In his book 'D-Day, the battle for Normandy', Anthony Beevor points out that in the conscript armies of the West, a few soldiers were really motivated to fight, a similar percentage tried to avoid combat, and the majority would fight if led or pushed into doing so, but for that majority getting out of the war relatively uninjured was their main objective. He also writes that this was almost certainly not true in the highly indoctrinated Waffen-SS units. They were convinced of Germany's rightful dominance and in 'final victory'.

Certainly by the Allies, the SS were regarded as being more prone than most troops to committing atrocities. Once it was in power in Germany, the Nazi Party set out to 'indoctrinate' the youth of the country (Hitler Youth, German League of Girls (Bund Deutscher Mädel), etc), and the individuals in the SS were probably deeply indoctrinated. But I don't think that 'we'- think of post-war war crimes trials – have ever decided that those indoctrinated individuals 'lacked mental capacity'.

It could be argued, that they were capacitous, because they understood the consequences of their decisions – see my two 'guides' on page 17. When SS

soldiers were executing prisoners, or committing other atrocities, they knew what the outcome of their action would be, and they didn't dispute 'empiricism' (they didn't assert that people they had killed were not dead, etc). But it can definitely be argued that the SS had got 'unshakeable beliefs' which had been caused by indoctrination.

Whereas, for 'Covid Conspiracy Believers' the belief which has been created does conflict with empirical evidence.

I've done a quick bit of web-searching for 'psychosis' and some of the returns were:

nhs.uk

Psychosis is when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations).

Someone who develops psychosis will have their own unique set of symptoms and experiences, according to their particular circumstances.

And from what I suspect is a US website:

Psychosis refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not.

This definition of psychosis, as requiring '**some loss of contact with reality**', fits easily with my 'The person does not accept 'empirically proven' outcomes of options.'

My 'Conclusions' so far

It makes it clearer, if we re-present section 3(1) as:

3(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the options and outcomes of the decision,

(b) to retain the options and outcomes,

(c) to think about the options and outcomes as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

Two things which [individually] can point towards an assessment that the person is not mentally capable to make the decision:

The option which the person has chosen, does not fit with the person's known objective;

The person does not accept 'empirically proven' outcomes of options.

And, this is also something which can be relevant:

An unshakeable belief which is inconsistent with empirical experience of the world.

And, developing something I wrote on pages 9 and 10, I am asserting that:

If we can apply the 'functional test' of 3(1) correctly, then that will **automatically connect** our conclusions about capacity and incapacity **to the actual decision being considered** in a way which is NOT true for a 'psychiatric diagnosis'. And, as we investigate both 3(1) and also psychiatric conditions by means of the same tools - observation, listening, asking questions and [if the questions are answered] listening to answers – then it is a plausible 'Ansätz' to suggest that if we can refine how we apply a functional test, then we do not need to subsequently also apply a 'diagnostic test' when we use the same tools, and gather the same 'evidence', for both of those tests.