Commentary

Michael Gunn

Murray & Jacoby (2002, this issue) emphasise the functional nature of capacity and draw attention to the dangers of adopting any other approach. The status approach (where determining whether someone is capable is dependent on diagnosis) makes assumptions about individual capacities and abilities that may be, and often will be, untrue. The outcome approach fails to realise that no one is expected always to make decisions with which others would agree. It is the process of decision-making that matters, and this must be determined in the case of an individual and in relation to a particular decision at a particular time.

In considering apparently variable definitions of capacity, Murray & Jacoby state that a careful examination of these definitions 'will reveal more similarities than at first sight'. Research colleagues in the Department of Psychiatry at the University of Cambridge and I have reached a similar conclusion.

We also looked at the definition of capacity in the context of wills and compared it with the definition of capacity in the context of medical treatment (Gunn *et al*, 2001). We noted that it is difficult to imagine a test that did not expect the testator to be able to identify his or her property, to identify those people who might expect to be the beneficiaries, and to understand the nature and effects of the decision (as established in *Banks v Goodfellow,* 1870: p. 565). We take the view that a person is not capable of making a decision unless at least the more obvious effects of that decision are understood, as well as its nature. It is not possible to understand what is a will unless it is understood that it is a decision that is intended to take effect upon death so as to determine to whom property shall go, and that some people who might expect to receive property may be disappointed. So, simply to understand that it is about the distribution of property would not be sufficient without also understanding when it takes effect (and a limited meaning of the nature of the decision might not achieve this result). We argue that, since the definition of capacity in the context of medical treatment also includes understanding the more obvious effects and consequences of the treatment, the approach in the two areas is the same. Incidentally, the 1870 decision is particularly illuminating on the effect on capacity of delusions and other consequences of mental illness.

Having placed considerable emphasis on the importance of identifying whether someone is capable of making a decision and the requirement to accept that decision, Murray & Jacoby also draw attention to the reality that there are some powers that may apply, regardless of the capacity of the individual. Compulsory admission to hospital under the Mental Health Act (MHA) 1983 can occur where someone is capable. Indeed, a comparison of the criteria for compulsory admission in Part II with the circumstances in which treatment may be carried out in Part IV of the MHA make this very clear indeed. It is possible for a person to be compulsorily admitted to hospital by relying on the need to protect others, or for the patient's own health or safety. There is a serious philosophical problem here. In brief, it is that while it may be acceptable to interfere with another's liberties on the basis of the harm he or she presents to others (and the protection of others element in the MHA may satisfy this requirement), the paternalistic alternative (i.e. the patient's own health or safety) is much more difficult to accept, unless he or she is incapable, in which case acting in his or her own best interests is philosophically acceptable and legally permissible, as was made clear by the House of Lords in *Re F (Mental Patient: Sterilisation) (*1990). The same analysis may be made of the power under the National Assistance Act. Quite rightly, Murray & Jacoby indicate that it may be possible to challenge this power under the Human Rights Act as not being fully compliant with the European Convention on Human Rights, Article 5.

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There are some strange areas of English law. Perhaps one of the strangest is that to which Murray and Jacoby draw attention. After the decision of the House of Lords in the Bournewood case (*R v Bournewood Community and Mental Health NHS Trust, ex parte L*, 1998) it is possible for an incapable and non-dissenting adult to be admitted to a psychiatric institution by virtue of the MHA 1983, Section 131. This does not involve any of the formal powers of the MHA in relation to admission and offers none of the safeguards that are integral to the structure of that legislation. I would, therefore, ally myself with those old age psychiatrists who, as reported by Murray & Jacoby, are of the view that this decision 'deprived vulnerable patients of certain rights under the MHA'. Currently, the only alternative to this position is to use the compulsory powers of the MHA. Clearly, these are more than is normally necessary to preserve the position of staff or patients (who are often on psychogeriatric or learning disability wards). Further, the consequences for health authorities would have been dramatic had it been necessary to compulsorily detain such patients. So, bureaucratic concerns and costs are, in one sense, to be viewed as more important than protecting vulnerable adults. The decision must be reviewed and this may well be done by the European Court of Human Rights before English legislation resolves the matter. A better position than that which currently applies would be to limit the MHA to circumstances where the person presents a danger to others or where he or she consents to admission. Cases where the person is not capable of deciding could be handled under a new Mental Incapacity Bill.

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