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Editorial

CLINICAL ETHICS

Falling through the cracks: The plight of vulnerable adults with capacity

Clinical Ethics
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DOI: 10.1177/14777509241276618
journals.sagepub.com/home/cet

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With the establishment of the Mental Capacity Act ('MCA') 2005 in England and Wales, the days of court interventions into the lives of adults with mental capacity – that is, the legally recognised cognitive threshold for decision-making authority – appeared to be numbered. If you were an adult that met the required cognitive threshold for capacity, then you were legally recognised as able to give *genuine* consent for care interventions and medical treatments. If you were lacking in capacity, then the MCA 2005 provided specific procedures that granted a designated third-party the authority to make decisions in your best interests.

But there is a gap in the Act through which a certain group has fallen – adults with capacity who are judged to be 'vulnerable'. *Capacitous vulnerable adults* are not covered by the Act, so, in England and Wales, the High Court continues to exercise its 'inherent jurisdiction' to intervene in the lives of adults with capacity who are deemed to be at risk from giving *genuine* consent.

The High Court has claimed that the primary purpose of exercising its inherent jurisdiction is to allow vulnerable adults with mental capacity to 'regain their autonomy of decision making'.[1] This involves alleviating those risks by which a capacitous vulnerable adult was deemed to be 'vulnerable' in the first place so that they can give *genuine* consent. But, as I've argued in a previous editorial, giving *genuine* consent should not be equated with exercising one's autonomy.[2]

By suggesting that vulnerable patients need to regain their autonomy of decision-making, what healthcare practitioners and the courts have missed is that vulnerability and autonomy are not incompatible concepts.[3] Many capacitous vulnerable adults can reason soundly in accordance with their own values, desires and motives and come to a decision that coheres with those motivating reasons, thereby fulfilling the conditions of rational deliberation that, according to colleagues, many medical ethicists take to be a necessary feature of autonomy.[4] In such cases, there is no autonomy to be 'regained'. The fact that a patient is judged to be vulnerable does not in itself indicate that they are incapable of making autonomous decisions with regards to care and medical treatment.

The problem is that healthcare practitioners and the courts have operated on the assumption that vulnerability and autonomy are incompatible.[3] This has led to competent but vulnerable patients being denied the opportunity to make medical decisions that concern them. More worryingly, it has also led to their explicit wishes being overturned.[5,6] This can *violate* the autonomy of capacitous vulnerable adults in two ways. Firstly, if a competent vulnerable patient expressly refuses a proposed medical intervention, then the denial of their decision-making authority prevents them from exerting the boundaries of their sovereign authority over their body. Secondly, when the vulnerable patient is demonstrably able and willing to make autonomous decisions, acting in their best interests in a way that is not in accord with their expressed wishes is representative of the court's and/or healthcare staff's failure to acknowledge the patient's *status* as an autonomous agent. Acting in this way precludes the patient from making claims to autonomy altogether.[3]

Of course, one might suggest that bodily violations and harms to a capacitous vulnerable adult's autonomy are the ethical prices that must be paid so that healthcare practitioners and the courts can protect these individuals from other harms. However, once we recognise that vulnerability and autonomy are not incompatible, then an argument can be made for treating vulnerable adults with capacity the same as other competent patients *where possible*. In the face of harms to a vulnerable patient's autonomy arising from legal and healthcare approaches to vulnerability in general, it is the duty of both healthcare practitioners and the courts to seek to promote the autonomy of capacitous vulnerable adults *where possible*.[3]

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Funding

The author received no financial support for the research, authorship and/or publication of this article.

References

1. *DL v A Local Authority* [2012] EWCA Civ 253.
2. Lewis J. Respect for autonomy: consent doesn't cut it. *Clin Ethics* 2023; **18**: 139–141.
3. Lewis J. Safeguarding vulnerable autonomy: situational vulnerability, the inherent jurisdiction and insights from feminist philosophy. *Med Law Rev* 2021; **29**: 306–336.
4. Schaefer GO, Kahane G and Savulescu J. Autonomy and enhancement. *Neuroethics* 2014; **7**: 123–136.
5. *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).
6. *Mazhar v Lord Chancellor* [2017] EWHC 2536 (Fam).