

# When past and present wishes collide: the theory, the practice and the future

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*The Mental Capacity Act 2005 ('MCA 2005') requires those acting or deciding in a person's best interests to consider, amongst other matters 'the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity': s 4(6) MCA). Encapsulated within this injunction is the potential for a clash between past and present wishes. In this article, we outline the background to this position, how the judges of the Court of Protection have grappled with situations where past and present wishes clash, and where we may be going in future, in particular in light of the demands of the Convention on the Rights of Persons with Disabilities ('CRPD')..*

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## The background – the law

The Law Commission, in its consultation papers and reports in the 1990s, strove to identify the correct approach to the making of decisions on behalf of those lacking the capacity to do so. In so doing (and as explored in an earlier article in the *Elder Law Journal*: Ruck Keene and Auckland [2015] Eld LJ 293), they proposed an objective best interests test, albeit modified by a strong element of substituted judgment – ie analysis of what the person in question would have done. In so doing, over the course of their consultation papers (CPs 119 and 128–30) and their final report (*Mental Incapacity*: Law Com No 231), they reached the conclusion that best interests decision-making should take into account 'the ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider if able to do so.' The Commission identified (at para 3.29 of Law Com No 231) that '[r]ealistically, the former views of a person who is without capacity cannot in every case be determinative of the decision which is now to be made. Past wishes and feelings may in any event conflict with feelings the person is still able to express in spite of incapacity. People who cannot make

decisions can still experience pleasure and distress. **Present** wishes and feelings must therefore be taken into account, where necessary balanced with past wishes and feelings' (emphasis in original). They did, not, however discuss what should happen where a conflict arose. Nor did resolution of such a conflict feature in the Joint Committee's pre-legislative scrutiny report on the draft Mental Incapacity Bill (HL Paper 189–1; HC 1083–1).

It is also worth noting that the addition of the specific reference in s 25(2) of the MCA 2005 to relevant written statements came late in the legislative life of what became the Act. It was included as a government amendment in the House of Lords in response to lobbying by the Making Decisions Alliance and other stakeholder organisations to ensure statutory recognition for advance statements, and was intended to 'clarify that if someone with capacity has written down their wishes and feelings in respect of a matter, including positive preferences, those must be explicitly taken into account in a best interests determination. . . . The more specific and well thought out the statement, the more likely it will be persuasive in determining best interests' (Minister for Constitutional

Affairs, Baroness Ashton, *Hansard*, HL Deb, vol 670, ser 5, cols 1441–1442 (17 March 2005)). However, neither in introducing the amendment nor in the Code of Practice as subsequently published to accompany the Act (see paras 5.40–5.45) did the government identify how clashes between past and present wishes and feelings might be resolved.

Separately, lurking deep within the MCA 2005 was another place where there was the potential for a clash, in the context of advance decisions to refuse treatment ('ADRTs'). The Law Commission had proposed such measures, but had limited the ability of a person to 'undo' them to the circumstances where they had (when they had capacity to do so) withdrawn or altered them. Section 25(2)(c) MCA 2005, as enacted, included not only such a provision but also the somewhat cryptic provision that an ADRT ceases to be valid where a person 'has done anything else clearly inconsistent with the advance decision remaining his fixed decision.' On its face, the word 'do' in s 25(2)(c) is pregnant with questions: does it mean that the person can undo the validity of their advance decision only by 'doing' something at a point when they have the capacity to realise that they are undoing their decision in the process, or does it mean that P can undo an ADRT by seeking – or even accepting – medical treatment even after the point when they have lost capacity to decide whether to accept or refuse it? In other words, could P's present, incapacitous, wishes and feelings as regards medical treatment trump their prior capacitous refusal enshrined in an ADRT?

### The background – the philosophical perspective

As matters stood in October 2007, therefore, there was ripe ground for debate as to how to proceed in the – not unusual – situation of a clash. Some of these issues had been considered from an academic perspective (see, for instance, Maclean 2006), but in the absence of case-law. Before we turn to look at how the courts have grappled with these situations in practice, it is important to recognise that this debate was one that had been played out in

philosophical circles, and (coincidentally) had been crystallised as the same time as the Law Commission was working on its original mental capacity project.

The question is a deceptively simple one, arising out of the weight put upon personal autonomy as a fundamental good – a central principle of the MCA 2005, as well as a long-standing ideal in Western philosophy. However, if a person suffers a crisis of some kind such that they no longer have capacity to make decisions for themselves, and their current wishes and feelings conflict with their pre-incapacitous wishes, which should prevail? Put another way, which version of their autonomy should we seek to honour?

The most famous discussion of this dilemma was advanced by Ronald Dworkin in 1993 in his work *Life's Dominion* ('Dworkin'). Although he covered all types of patients we focus here on his account of those with progressive and incurable dementia. Dworkin begins by retelling an encounter between a medical student, Firlik, and a 54-year-old Alzheimer's victim named Margo. He details the relationship between the two, 'Margo said she knew who Firlik was each time he arrived, but she never used his name' (Dworkin 220). She was always reading mystery novels but Firlik 'noticed that her place in the book jumps randomly from day to day' (ibid). She also attended an art class for Alzheimer's patients, but he realised that they all seemed to continuously paint the same picture (Dworkin 221). Firlik himself was confused by the encounters as 'despite her illness or maybe somehow because of it, Margo is undeniably one of the happiest people I have ever known', but he still asks 'When a person can no longer accumulate new memories . . . what remain? Who is Margo?' (ibid).

The key question for Dworkin is this: when we are considering the rights of a person who has not always been 'demented' (to use his term) but who once had capacity should we view them as a demented person, 'emphasising [their] present situation and capacities, or as someone who has become demented, having 'an eye to the to the course of his whole life?' (ibid).

Subsequently Dworkin asks us to imagine that Margo had, when fully competent, executed a formal document, much like an advance directive, specifying that if she developed Alzheimer's disease, she should not be given any treatment for any life-threatening disease she may contract, or even, in that event, 'she should be killed as soon and as painlessly as possible?' (Dworkin 226). What would be the right thing to do in this situation? Would it be to exercise her precedent autonomy, or her current wishes and feelings?

Dworkin sets this example against two ways of viewing autonomy, the first 'the evidentiary view' which holds we should respect the decisions people choose to make for themselves even if we regard them as unwise. This view holds that generally the individual knows what is in their best interests. The second type of view of autonomy put forward by Dworkin, which he believes to be the more important, is the 'integrity view.' On this view the value of autonomy 'derives from the capacity it protects: the capacity to protect one's own character' (Dworkin 224) Dworkin writes 'if we accept this integrity-based view of the importance of autonomy, our judgement about whether incapacitated patients have a right to autonomy will turn on the degree of their general capacity to lead a life in that sense' (Dworkin 224–225).

As well as separating the two forms of autonomy, Dworkin makes a point of drawing a comparison between two types of interests, experiential interests and critical interests which both operate as part of the integrity view to 'express one's character. For Dworkin, our lives are governed by these two special types of interest. Experiential interests are those interests we do because we enjoy the experience of doing them: for instance, why Margo enjoys her 'peanut-butter-and-jelly' sandwiches, or why someone would wish to see Casablanca for the twelfth time. These interests seem an important part of our life.

However, Dworkin deems these interests to be inferior to our critical interests. These are our hopes and aspirations which lend

coherence to our lives. Examples of these kinds of interests would be establishing relationships, raising children, achieving success in our chosen career field. These interests also explain why the way in which we die matters. For, Dworkin death has a 'special symbolic importance: they want their deaths, if possible, to express, and in that way vividly confirm, the values they believe most important to their lives' (Dworkin 211).

Building on the hierarchy of human interests, Dworkin applies these conclusions to Margo and concludes that Margo's critical interests are such that we should honour her prior choice because when she issued the directive she was exercising her 'precedent autonomy' (Dworkin 228) and was using her critical interests as part of her expression of her autonomy. Although Dworkin understands how this can be upsetting in the scenario of Margo, he says any decision to treat her in this event 'violates rather than respects her autonomy' (Dworkin 229).

Dworkin's arguments have subsequently been criticised by others, a useful summary of the debates being found in ch 5 of Donnelly 2010. For present purposes, we can highlight two main challenges framed by an early critic, Rebecca Dresser (Dresser 1995). The first is that there is no psychological continuity between the two Margos – they are different people – such that the previous version of Margo has no dominion over the current Margo because they are not the same person, and so her present wishes and feelings should be valued above the previous request to die. A second challenge is that the assumption that the need for narrative coherence is simply false: most people, in reality, do not think like this but rather take their life one day at a time, and fail to distinguish between experiential interests and critical interests in the way Dworkin wishes us to do. As Rebecca Dresser pointed out, following her speculative critical interests could result in a seemingly contented peanut-butter-and-jelly sandwich eating Margo being killed against her current presently expressed will. Many might balk at such a conclusion.

## The principles in practice in the Court of Protection

The broader question of the way in which the Court of Protection has approached the weight to be placed upon P's wishes, feelings, beliefs and values has been explored elsewhere (see Ruck Keene and Auckland 2015). As set out in the concluding section of this article, it is clear that the trend is towards placing a greater weight upon the wishes and feelings, beliefs and values of the individual, and that this trend is only likely to be reinforced by statutory change in the future.

It is easy for the courts to place weight upon the pre-incapacity wishes of the individual where there is no inconsistency between their current wishes and feelings, either because the two march together or because the individual is currently unable to express any wishes and feelings. The case of *Westminster City Council v Sykes* [2014] EWHC B9 (COP) is an example of the former; *PS v LP* [2013] EWHC 1106 (COP) an example of the latter.

However, to date, there has been strikingly little case-law as to what should be done where the identifiable past and present wishes of the individual clash, and what little case-law there has been points in different directions. In this section of the article, therefore, we provide an essentially neutral review of the cases, reserving editorial comment thereupon to the concluding section.

One notable trend in the case-law is to seek to contrast clear and consistent pre-incapacity wishes and feelings with 'fluctuating' or 'inconsistent' post-incapacity wishes and feelings. This can be seen in the medical context in, for instance *Cambridge University Hospitals NHS Foundation Trust v BF (By Her Litigation Friend the Official Solicitor)* [2016] EWCOP 26, [2016] COPLR 411, in which MacDonald J placed particular weight upon the fact that a woman with a fluctuating mental health condition had previously consented to a potentially life-saving operation to which, in the midst of a crisis, she was now unable to consent. MacDonald J held that it was 'it is

important to note that during the periods since 31 March 2016 when BF has expressed fluctuating wishes regarding the surgery, mostly against having the same, the evidence shows clearly that her expressed wishes have been closely connected to her florid psychosis and the repeated urgings of the "bad voice".' Another example is *An NHS Trust v CS (By Her Litigation Friend the Official Solicitor)* [2016] EWCOP 10, [2016] COPLR 187, where Baker J prioritised the clear views expressed by a woman prior to an assault by her partner that she wished to have the pregnancy resulting from the relationship with him terminated, notwithstanding the fact that after the assault in which she had suffered serious brain injury and loss of capacity to make a decision, she appeared on occasion to be saying she wished to keep her child.

A final example of a judge attempting to 'smooth' or rationalise apparent inconsistencies in present wishes and feelings so as to maintain consistency with pre-incapacity views can be seen in the statutory will context in the case of *Re J* [2016] EWCOP 52, in which the judge placed weight on the fact that of the six occasions on which the woman in question had expressed a wish after the loss of her capacity, she had expressed a wish on five of those occasions to leave the entirety of her estate to the same individual she had sought to leave it to prior to the loss of capacity.

The two most recent cases grapple more directly with an apparent clash between past and present wishes and feelings, and point in entirely opposite directions. Chronologically, the first in time (although published on Bailii later) is *SAD and ACD v SED* [2017] EWCOP 3. This case concerned a 53-year-old woman, SED, who had bipolar disorder. SED had granted a property and affairs LPA appointing family members including her daughters as her attorneys. She later sought to revoke the LPA but her daughters challenged the revocation suggesting that SED lacked capacity to do so at the relevant time. District Judge Glentworth found that SED did in fact lack capacity because she was in a hypomanic state at the time (and that state

continued at the time of the hearing before her): the question was whether she should then go on to revoke it under s 22(3) of the MCA 2005 as SED strongly urged her to do, by written evidence, by oral evidence and by submissions made on her behalf at the final hearing. SED – recognising that she required assistance – instead sought that a professional deputy be appointed to manage her property and affairs. Her daughters resisted the application on the basis that, when she did not lack capacity to do so, she had made arrangements which were designed to cater for those periods when she no longer had the capacity to manage her property and affairs. They further contended that she would suffer significant distress when she recovered and found that preparations had come unstuck in such a way that, rather than her finances being managed by those close to her, a professional had been appointed bringing implications both in relation to costs and greater formalities. As District Judge Glentworth noted, therefore, both SED and her daughters placed reliance on her wishes and feelings, but relied upon them to point to diametrically opposed outcomes:

‘[28] . . . The Respondent’s wishes and feelings have been a focal point, both her past wishes and feelings relied on by the Applicants and demonstrated by her making the LPA and her present wishes and feelings which have formed the basis for her objection to this application and the submissions made on her behalf. For the Applicants it was submitted that significant weight should be placed on the fact that the LPA is clear evidence from a time when the Respondent did not lack capacity of what she intended should happen when, as she was aware was likely, she again lost capacity to manage her property and affairs. On her behalf, I was referred to the decision of Peter Jackson, J in *Wye Valley NHS Trust v. Mr B* [2015] EWCOP 60. It was submitted that the Respondent’s is a fluctuating condition. It is part of who she is. She has a cyclical illness and it cannot be said that her wishes and feelings can be delineated in a way which gives more weight to those expressed in a phase

when the hypomania is absent than when, as now, it is something which she is living with and which affects her behaviour. The general policy behind the MCA is to empower people to make their own decisions and to promote individual autonomy. Any argument advanced on the basis that it is necessary to save the Respondent from herself must be strong and cogent.

[29] In my judgment, this case is one where the Respondent’s wishes and feelings are central to my decision. This is the first occasion when the Respondent has experienced a period of hypomania since the LPA was made and had direct experience of the arrangements she set up as a result. She has raised very real concerns about the difficulties she has experienced. I am satisfied that although it was her intention that her close family members should be responsible for managing her personal finances now that she has experienced that in practical terms she finds the reversal of roles, where her daughters are exerting financial control, uncomfortable. It is for this reason that she sought to revoke the LPA and that she has contested this application. For the reasons I have given, I am satisfied that it is in her best interests for the LPA not to be reinstated and for a deputy to be appointed. . . .’

Very shortly after District Judge Glentworth determined this application, Charles J had to decide whether it was in the best interests of Paul Briggs for him continue receiving life-sustaining treatment via clinically assisted nutrition and hydration (‘CANH’) having suffered a catastrophic brain injury in a road traffic accident. His decision – *Briggs v Briggs* [2016] EWCOP 53, [2017] COPLR 42 – centred on the tension between the sanctity of life, often quoted as the starting point for such decisions, and the right of self-determination. Although Mr Briggs had not made a formal ADRT, on hearing his family’s evidence, Charles J was convinced that ‘if Mr Briggs could make the decision himself . . . he would conclude that he would not give consent to his treatment by CANH’. The evidence was particularly

forceful because Mr Briggs had lost colleagues whilst in the army and had witnessed many accidents in his job as a traffic policeman, and he had therefore had many informed discussions where he had made clear that he would not want to continue to receive CANH in the situation in which he was now in.

In assessing how much weight to then give to these wishes, Charles J gave a detailed account of what he called the ‘enabling provisions’ of the MCA, namely provisions relating to ADRTs (ss 24–26) and those allowing for the appointment of LPAs (ss 9–14). He concluded that these provisions signalled a clear legislative intention to allow people to bind their future selves when lacking capacity, even if, ‘because of brain or other injuries, they may be very different and have very different perspectives on a whole range of issues including the quality of their life’.

It was agreed that Mr Briggs, in a best case-scenario, would experience contentment and happiness but have no insight into his condition. We note, based upon reports of what happened during his hearing (which, unusually took place entirely in public with no reporting restrictions) that we have our doubts as to precisely what either ‘contentment’ or ‘happiness’ could meaningfully be said to involve in his case. However, taken at face value, such ‘contentment’ and ‘happiness’ would mean that his past and present wishes would then be in direct conflict in a situation where it was argued that, ‘as a result of his brain damage Mr Briggs [was] now a different person.’ Notwithstanding these submissions, however, Charles J concluded that ‘a fundamental principle is that a person with capacity can make decisions that determine what is to happen to them in the future and so ‘an earlier self can bind a future and different self’. In a decision that arguably points in an entirely different direction to that of *SAD v SED*, Charles J therefore gave primacy to the past wishes of Mr Briggs and decided that continuing CANH was not in his best interests.

Finally, and to complete the picture, we should note the obiter comments of

Keehan J in *Re QQ* [2016] EWCOP 22, considering s 25(2)(c) of the MCA 2005. In circumstances where he had already found that, in fact, the woman in question had not had capacity to make an ADRT, Keehan J left open the possibility that the concept of ‘doing’ something which rendered an ADRT invalid might include acts done even after P has lost capacity. Unfortunately, the comments are so shortly expressed that they do not definitely answer the question that we posed at the outset of this article in respect of this section.

### The future

The Law Commission has recently recommended (Law Com No 272, *Mental Capacity and Deprivation of Liberty*) that s 4 of the MCA 2005 be amended so as to place decision-makers under both a duty to ascertain a person’s wishes and feelings in relation to a matter, and to place particular weight upon those ascertainable wishes and feelings deciding what course of action is in the person’s best interests. The Law Commission has not, however, sought to impose any statutory solution to the resolution of conflicts of the nature identified above. Before we turn to look out what our answer to the dilemma might be, it behoves us first to see whether there is any assistance to be found in the CRPD.

This is not a place for a full exegesis of the demands of this Convention (for more details, see Series 2014 and the reports of the Essex Autonomy Project available at <https://autonomy.essex.ac.uk/crpd/>). For present purposes of most importance is that the CRPD demands – by Art 12 – that persons with disabilities are supported to exercise their legal capacity on an equal basis with others, and that such support respects their rights, will and preferences. General Comment 1 issued by the UN Committee on the Rights of Persons with Disabilities, amplifying the requirements of Art 12, addresses the problem where a person is unable to express their will and preferences, and requires in such case that a decision be made on the basis of the ‘best interpretation’ of that will and preferences (United Nations Committee on the Rights of Persons with Disabilities, 2014). The

Committee stresses the importance of mechanisms for advance planning to assist a person where they are currently unable to communicate their will and preferences. However, there is no assistance from the CRPD itself or the Committee as to what should happen where a person appears to have a clash between their past and present selves on either side of some identifiable turning-point. This is perhaps a reflection of the fact that the Committee itself does not accept the validity of the concept of mental capacity (see further in this regard Alex Ruck Keene's forthcoming article entitled 'Is Capacity in the Eye of the Beholder?' in the *Journal of Advances in Mental Health and Intellectual Disabilities*), which makes it logically difficult to talk of a pre-and post-incapacity state.

However, the Convention talks of both 'will' and 'preferences'. Although the Committee does not differentiate between the two, it is undoubtedly arguable the two terms must have different meanings, on the basis that legal instruments do not trade in tautologies. Does this open the way to a conclusion that one trumps another (and, if so which one?). The classic case here is a person with severe anorexia, who does not want to eat, but who does wish to live (see, for instance, Richardson 2013). In such a case, the person's will to live could be seen in stark contrast to her preference not to eat, possibly opening the way to allow the former to be followed in contrast to the latter. The psychiatrist George Szukler has taken this further and argued that it is appropriate to characterise the will and preferences of a person with bipolar disorder as set down in writing when well as representing a more authentic version of herself which can and should be prioritised over a current refusal of treatment during a manic episode (see George Szukler, 'Mental health disabilities and "will and preferences"' (Disability Rights UK blog, 7 September 2016).

In truth, however, the logic of the Committee's approach, though, would appear to drive inexorably towards the prioritisation at all points of a person's immediately identifiable wishes and feelings

(to use the language of the MCA 2005). This would present substantial challenges for instruments such as ADRTs. It would also have implications for LPAs, on the basis that an attorney could only ever seek to take into account the presently identifiable wishes and feelings of the donor. Indeed, more radically, the logic of the Committee's approach suggests that whether the power should continue should depend primarily upon the present views of the donor.

If this is correct, and this is an area that calls for further exploration, this does seem strangely counterintuitive, and radically to minimise the ability to exercise legal capacity of many people with disabilities, not least those who are aware – and wish to minimise the effects – of periods when they are 'not themselves' (according to their own understanding and depiction of their life story).

Conversely, and as made very clear in *Briggs*, Charles J (at least) takes the view that built into the MCA is a strong bias towards 'precedent autonomy'. We would respectfully agree that that is correct, but would be very concerned if this led to the equally dogmatic approach of always following the identifiable pre-incapacity wishes and feelings of the individual in a conflict situation, because, as the Law Commission recognised in 1995, these can result in situations that instinctively feel wrong in the same way that may be the case in relation to some iterations of the Margo scenario outlined above. We consider – and hope – it improbable that Charles J would have reached the same conclusion in *Briggs* had there been concrete evidence before him that Mr Briggs was in any way able (or would ever be able) to manifest wishes and feelings that conflicted with his prior self at anywhere close to the level of intensity as was the case in *SED*.

Moreover, we consider that even ADRTs, which undoubtedly seek to 'bind in' a strong version of precedent autonomy, may not always lead to a situation where conflict is resolved in favour of the prior person. It is difficult to imagine any situation in which a doctor would refuse to treat a patient who

has made an ADRT, now on the face of it lacks capacity to consent to refuse to medical treatment (such that the ADRT is 'live'), but who is in some way positively indicating that they wish treatment covered by the refusal. It is also difficult to imagine a court concluding that that doctor was acting improperly, assuming, of course, that the doctor had not been seeking to circumvent the ARDT by administering treatment and taking mere acceptance as an express wish to receive treatment.

How then to square the circle? Academic lawyers have continued to grapple with these issues (see, for instance, Heywood 2015 and Coggan 2016), and more consideration will undoubtedly be needed as we move forward in the light of the CRPD. An opportunity for such exploration in the domestic context presents itself in the context of the work that is being done as part of the Wellcome Trust Global Mental Health and Justice project to examine how self-binding directives can be used to support the legal capacity of those with bipolar disorder when in states that they themselves characterise as crisis (see further [www.mentalhealthandjustice.org.uk](http://www.mentalhealthandjustice.org.uk)).

More immediately, we offer our concluding observations in the spirit of advancing the debate amongst practising lawyers and before the courts.

One answer is that we may want to approach matters differently if we know (insofar as it is ever possible to know such things) that the person will not regain capacity, and thus will never know that their pre-incapacity wishes and feelings were not honoured, as opposed to the position where there is a realistic prospect that the person will regain capacity and be very aware of that fact.

Another answer is that we may want to place different weight upon person's prior wishes and feelings if they relate to a situation that they have not had direct experience of, but rather represents their best projection of what they might wish in that situation.

A final answer is that we might want to take a more radical step, and to say that where there is a true clash between the person's past wishes and feelings and their present expression, then it is, in fact, wrong as a matter of principle to seek to balance one against the other and to say that one should trump the other. Rather, we might want to say that the one cancels the other out, and that the decision-maker should therefore proceed as if this were a person in respect of whom there were no ascertainable wishes and feelings. In such a case (of which *Abertawe Bro Morgannwg University Local Health Board v RY and Another (Rev 1)* [2017] EWCOP 2 is a recent example from the medical treatment context), then we must fall back on the other factors set out in s 4 of the MCA 2005 and, above all the principle set down in s 1(5), so as more broadly to construct the decision which seeks to achieve the purpose sought by the decision-maker in a way which is properly able to be said to be least restrictive of the person's rights and freedoms in a broader sense.

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