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1 2 3 4 5 6 7 8 9 Lost Voices in Research: Exposing the Gaps in the Mental Capacity Act 2005

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 Despite laudable intentions, since its inception, the Mental Capacity Act 2005 of England and Wales (MCA) has proved to be a controversial piece of legislation.¹ Some commentators have criticised the technical legal provisions of the Act, exposing the problems with the legal test for capacity and the interpretational ambiguities associated with best interests.² Others have focused on the more philosophical questions underpinning the legislation, exploring the frictions that exist between the concepts of paternalism versus autonomy, and protection versus empowerment³. The majority of legal scholarship has concentrated on how these various tensions arise, and are dealt with, in relation to the treatment of incapacitated patients.⁴ However, there is an additional and somewhat unexplored dimension to the MCA, that of research.⁵ Sections 30 to 33 of the MCA allow intrusive research to be lawfully carried out on, or in relation to, a person who lacks capacity.⁶ The legislation does not, therefore, completely prohibit research. Rather, it purports to adopt a permissive approach, seeking to recognise the potential value that incapacitated participants can bring to answering particular research

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 See Mary Donnelly, ‘Changing Values and Growing Expectations: The Evolution of Capacity Law (2017) 70 *Current Legal Problems* 305; Amel Alghrani *et al.*, ‘The Mental Capacity Act 2005—Ten Years On’ (2016) 3 *Medical Law Review* 311.

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2 Mary Donnelly, ‘Best Interests in the Mental Capacity Act: Time to say Goodbye?’ (2016) 24 *Medical Law Review* 318; Mary Donnelly, ‘Determining Best Interests Under the Mental Capacity Act 2005’ (2011) 19 *Medical Law Review* 304.

3 Paul Skowron, ‘The Relationship between Autonomy and Adult Mental Capacity in the Law of England and Wales’ (2018) *Medical Law Review*: doi: <https://doi.org/10.1093/medlaw/fwy016>; Beverley A Clough, ‘New Legal Landscapes: (Re) Constructing the Boundaries of Mental Capacity Law’ (2018) 26 *Medical Law Review* 246; Camilla Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue and Autonomy* (CUP 2017); B. Clough, “‘People Like That’: Realising the Social Model in Mental Capacity Jurisprudence” (2015) 23 *Medical Law Review* 53.

4 Helen J Taylor, ‘“What Are “Best Interests”? A Critical Evaluation of “Best Interests” Decision-Making in Clinical Practice’ (2016) 24 *Medical Law Review* 176.

5 Gillian Loomes, ‘Researching About Us Without Us: Exploring Research Participation and the Politics of Disability Rights in the Context of the Mental Capacity Act 2005’ (2018) 44 *Journal of Medical Ethics* 424; JV McHale, ‘Research, Ethics Review and Mental Capacity: Where Now After the Mental Capacity Act 2005?’ (2009) 5 *Research Ethics Review* 65.

6 Mental Capacity Act 2005, s 30 – 33.

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questions. Nonetheless, given that often research may be conducted not for the benefit of an individual, but only for the benefit of others, the MCA remains sensitive to the enhanced vulnerability of incapacitated participants and inserts additional measures of protection. First, a project will only be deemed lawful under the MCA once an appropriate independent body, which is now defined as an approved MCA Research Ethics Committee (MCA REC), has authorised it.⁷ Secondly, before researchers can proceed with MCA REC sanctioned research, a personal or nominated consultee needs to be appointed who must offer an opinion about the willingness and likely wishes of any potential incapacitated participant.⁸

The MCA operates from the basis that research involving incapacitated participants can ordinarily proceed, unless the activities in question fall with the Act's definition of intrusive research.⁹ Where research falls within the definition, it will be *prima facie* unlawful unless it adheres to additional requirements stipulated by the legislation. These additional requirements state that any research must be connected with an impairing condition affecting P, or its treatment.¹⁰ An MCA REC must also consider from the outset whether or not there are reasonable grounds for believing that research of comparable effectiveness could be carried out on persons who have capacity to consent to taking part in it.¹¹ Finally, the best interests test, which is used to render lawful an array of other decisions under the broader terms of MCA, does not apply to research.¹² This is replaced by a set of conditions that demand an assessment of the potential benefit to risk ratio that an incapacitated research participant may be exposed to and, in cases where there may be no value whatsoever to that individual, of the potential benefits that may be conferred on persons affected by the same or similar condition.¹³ Due to incapacitated participants being unable to consent for themselves, and that findings may often only benefit others, research is set apart from other aspects of the legislation. The intention behind this was to provide a suitable balance between appropriate protection on the one hand,

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48 ⁷ Mental Capacity Act 2005, s 31 (1); Mental Capacity Act 2005 (Appropriate Body) (England) Regulations 2006.
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50 ⁸ Mental Capacity Act 2005, s 32 (1) – (5).
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52 ⁹ Mental Capacity Act 2005, s 30 (2) (a) – (b). We explore this definition in more detail below.
53 ¹⁰ Mental Capacity Act 2005, s 31 (2) (a) – (b).
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55 ¹¹ Mental Capacity Act 2005, s 31 (4).
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57 ¹² Peter Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005* (2nd edn, OUP 2008) at 89.
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59 ¹³ Mental Capacity Act 2005, s 31 (5) (a) and (b).
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and the need to maintain sufficient scope for participant inclusion and empowerment on the other.¹⁴

We argue here, however, that the research provisions of the MCA are obscure and that their misinterpretation could lead to an overly restrictive attitude, which is damaging to notions of inclusivity and empowerment. First, it is not entirely clear what type of research should fall within the purview of the Act, and an apparent focus on medically-intrusive research causes some key areas to be overlooked. Quite apart from that, in initially calling for some consideration as to whether or not more effective research could be carried out on a capacitous individual, the MCA begins by making a dangerous comparison that could undermine the value and status of an incapacitated participant's involvement in research. Thus, some of the Act's research-targeted provisions do not sit comfortably with the growing emphasis on supported decision-making promulgated by Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and so the true extent to which the legislation empowers participants remains a subject of contention.¹⁵ The tailor-made standards for approving research are also poorly worded, and their inclusion perhaps unnecessary. Finally, difficulties are also encountered because the aspects of the MCA that attempt to guarantee that an incapacitated participant's voice is heard in the approval process, operate under some basic misapprehensions.

This paper begins by exploring the exact parameters of the MCA in relation to research.¹⁶ It seeks to address the critical question of precisely what is meant by 'intrusive' research and considers what may fall within this definition. We then argue that in demanding an assessment of the comparative effectiveness of incapacitated compared to capacitous participants, the MCA actually sets off on the wrong foot and needs to fundamentally rethink its starting premise. It also needs to reconsider what research needs to be connected with in order to be countenanced. Thereafter, the rationale for abandoning the best interests principle is analysed and we examine whether the new substantive thresholds serve any meaningful purpose. The discussion finally proceeds to investigate the other safeguards introduced by the

¹⁴ HL Deb 01 February 2005, vol 669, cols 133 – 139. https://api.parliament.uk/historic-hansard/lords/2005/feb/01/mental-capacity-bill-37-pm#S5LV0669P0_20050201_HOL_123 <Accessed 26th February 2019>.

¹⁵ Article 12(2) stresses that States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

¹⁶ For the purposes of clarity, it should be noted that the regulations in the MCA are not concerned with research involving investigational medical products. In addition, special regulations apply to clinical trials and we do not address those here. See Brazier and Cave (n 77).

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12 Act, focusing on the obligations placed on the researcher, the consultee and MCA RECs. We
13 assert that contrasting obligations and expectations are placed on different parties in the
14 approval process, which creates a blurred sense of responsibility and a potential chilling effect.
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17 **B. Setting Off on the Wrong Foot**

18 *i) Imprecise Parameters*

19 The provisions of the MCA apply only to ‘intrusive’ research, which is defined as research of
20 a kind that would be unlawful if it was carried out on, or in relation to, a person who had
21 capacity to consent to it, but without his consent.¹⁷ It is only if research falls within this
22 category that the further provisions of the MCA will be engaged. The principal focus of this
23 definition initially appeared to be on invasive medical research, typically involving some
24 physical interference with a participant’s body.¹⁸ Thus, if a researcher embarked upon a project
25 which involved some physical manipulation of an incapacitated patient’s knee, that would
26 amount to ‘intrusive research’. The reason for this is that if identical research were to be
27 performed on a capacitous participant, her consent would be needed for it to be lawful and not
28 characterised as tortious battery.¹⁹ Nevertheless, there is a grey area in the legislation that calls
29 into question certain types of non-invasive research.

30 Observational research, for example, raises a number of issues and arguably recasts the
31 original scope of the MCA’s research provisions. In order for this type of activity to fall within
32 the definition of intrusive research, a rule of law must be identified that would cause the
33 research to be unlawful if it were to be carried out on a non-consenting capacitous patient.²⁰
34 Battery would not apply unless there was any unauthorised touching, and this would seldom
35 occur in most types of observational research.²¹ Bartlett, however, argues that Article 8 of the
36 European Convention on Human Rights (ECHR) could be engaged to render some
37 observational research unlawful, where a capacitous participant did not consent to it.²² Article
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49 ¹⁷ Mental Capacity Act 2005, s 30 (2) (a) and (b).
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51 ¹⁸ See Law Comm 231, draft bill, cl 11 (4) (d). See also Bartlett (n 12) at 88; McHale (n 5) at 66.
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53 ¹⁹ See *Wilson v Pringle* [1987] QB 237; *Collins v Wilcock* [1984] 1 WLR 1172.
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55 ²⁰ Above (n 17).
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57 ²¹ Some methods of observational research may involve a level of hands-on touching. For example, observing
58 blood pressure levels will demand some physical contact with a participant.
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60 ²² Bartlett (n 12) at 88.

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8 (1) of the ECHR provides that everyone has the right to respect for his private and family life, his home and his correspondence, and section 6 (1) of the Human Rights Act 1998 states that it is unlawful for a public authority, such as an NHS body or a university, to act in a way which is incompatible with a Convention right.²³ Article 8 (1) is qualified and can be legitimately interfered with in certain circumstances under Article 8 (2).²⁴

The difficulty is that not all observational research is the same and could, potentially, interfere with a participant's privacy to varying degrees. In recognition of this, Bartlett draws a distinction between observational research that may involve a participant undergoing a medical examination in a doctor's surgery, compared to that which may be conducted on a hospital ward.²⁵ He argues that the former would invoke a 'particularly strong' expectation of privacy, whereas the latter, due to its more public nature, may not do so to the same extent.²⁶ While we accept that the applicability of Article 8 (1) is very much fact-specific, given the evolving nature of the jurisprudence, we suggest that nowadays a strong argument could be advanced in favour of Article 8 (1) of the ECHR being engaged in both of the above scenarios, and indeed in many more observational research settings.²⁷ The fact that any observation takes place in a more public environment, in our view, would not automatically render Article 8 (1) redundant. It has been recognised that 'there is a zone of interaction of a person with others, even in a public context, which may fall within the scope of "private life"'.²⁸ Expanding upon this, Bartlett alludes to common examples of observational research in healthcare settings that could invoke a reasonable expectation of privacy, such as observations in hospital wards, care homes, surgeries and a patient's own home.²⁹ This list is not exhaustive and could be

²³ Human Rights Act 1998, s 6 (1). See also Article 8 (1) of the European Convention on Human Rights.

²⁴ Article 8 (2) of the European Convention on Human Rights states that there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

²⁵ Bartlett (n 12) at 88.

²⁶ Ibid.

²⁷ See *Peck v United Kingdom* App No 4464/98 (ECtHR 28th January 2003); *Perry v United Kingdom* App No 63737/00 (ECtHR 17th July 2003).

²⁸ See *P.G. and J.H. v United Kingdom* App No 44787/98 (ECtHR 25th September 2001) at [56]. For discussion see Nicole V Moreham, 'The Right to Respect for Private Life in the European Convention on Human Rights: A Re-examination.' (2008) *European Human Rights Law Review* 44.

²⁹ Bartlett (n 12) at 88.

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1 developed to include observations of focus group discussions, behaviour of inhabitants of
2 specific communities, and communications between individuals in institutions and places of
3 work. These are all environments in which a ‘zone of interaction’ of a person with others could
4 be present, causing notions of what is public and private to intersect.

5 It thus seems likely that a certain amount of observational research conducted by an
6 NHS body would at least engage the Article 8 (1) rights of a capacitous participant if it were
7 to be conducted without her consent and would, therefore, *prima facie* fall within the MCA’s
8 definition of intrusive research if the same were to be performed on an incapacitated
9 participant.³⁰ To make a final determination on breach, the question of whether any
10 interference with her right was legitimate under Article 8 (2) would then need to be addressed.
11 It is conceivable that some observational healthcare research could be justified on the grounds
12 that is necessary in a democratic society for public safety or to protect health and morals and
13 that, provided it was done in accordance with the law, any interference with the right could be
14 justified under Article 8 (2).³¹ If this held sway, the research would not be unlawful and so
15 would fall outside the definition of intrusive research for the purposes of the MCA. However,
16 it will not be possible to justify all research on these grounds, especially where it is a smaller
17 and more concentrated project that does not have the scope to benefit society more widely.
18 Where interference is incapable of such justification, the research would be unlawful and thus
19 correspond with the MCA’s definition of intrusive research. Considering matters through the
20 lens of Article 8, the overall conclusion as to which types of observational research would be
21 caught by the definition is far from straightforward. Yet, it does appear that some of it would,
22 which may well be beyond the initial contemplation of the MCA’s research-targeted
23 provisions.³²

24 Further methods of research that remain contentious are interviews and questionnaires.
25 Where, for instance, a university researcher wishes to involve incapacitated participants in her
26 project, would her work fall within the MCA’s definition of intrusive research and thus require
27 her to comply with the additional regulatory requirements by gaining specific MCA REC
28 approval? Where is the rule of law that would deem such activity unlawful should it be
29 performed on a capacitous participant, without her consent? If a participant was interviewed
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31 Above (n 27) and (n 28).

32 See, for discussion, *Uzun v Germany* App No 35623/05 (ECtHR 2nd September 2010).

33 Above (n 18).

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and the conversation then taped and transcribed, if any findings were published and it became possible to identify her as a result, assuming she had not consented, it seems likely that her Article 8 (1) rights would be engaged.³³ However, this overlooks the fact that interview research is often not conducted in this way and that transcriptions are, not infrequently, anonymised.³⁴ The same is true of the majority of data collected in questionnaires.³⁵ It is stretching things to suggest that privacy is threatened by interview or questionnaire findings that are not linked in any way to one particular individual, and which safeguard participant anonymity throughout. To conduct either an anonymous interview or a questionnaire on a capacitous participant without her consent may well be unethical, but to say that it would be unlawful on the basis of an infringement of Article 8 seems much less convincing. It is therefore less likely that this would fall within the definition of intrusive research for the purposes of the MCA 2005.

It is important to acknowledge as well that developments in data protection law may provoke arguments about the lawfulness of research on non-consenting capacitous participants which sit distinct from any Article 8 considerations. If, say, research data was gathered and processed from a capacitous participant as part of an observational or questionnaire study, under data protection legislation would it be unlawful for that to happen without her consent? If so, arguably, it could then fall within the meaning of intrusive research for the purposes of the MCA, if it were to be performed on an incapacitated participant. While we have insufficient space here to provide a thorough analysis of the impact of the General Data Protection Regulation (GDPR), for the present purposes it suffices to say that, while consent is one potential ground for lawful processing of data, it is not the only one.³⁶ Some research data could potentially be lawfully processed without consent on the basis that it is necessary for the

³³ See *Smith and Grady v United Kingdom* App Nos 33985/96 and 33986/96 (ECtHR 27th December 1999). In this case it was held that were detailed investigations took place, including interviews of a sensitive and intimate nature, where any findings were then made public and individuals could subsequently be identified, a violation of Article 8 occurred.

³⁴ Barbara DiCicco-Bloom and Benjamin F Crabtree, 'The Qualitative Research Interview' (2006) 40 *Medical Education* 314.

³⁵ Ann Bowling and Shah Ebrahim (eds), *Handbook of Health Research Methods: Investigation, Measurement and Analysis* (1st edn, OUP 2005).

³⁶ Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (Text with EEA relevance), [2016] OJ L 119/1. See also Data Protection Act 2018.

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purposes of a legitimate interest.³⁷ This particular ground is the most flexible and thus provided any research data collected and used was then processed in accordance with the data protection principles, it would not automatically be unlawful by virtue of the absence of consent.³⁸ As such, it should not be assumed that data protection laws will impact upon the MCA's definition of intrusive research in every case, particularly in the context of methods which anonymise data, because the relevant legislation then no longer applies.³⁹ Ambiguities are undoubtedly rife, but nonetheless in our view the majority of research involving incapacitated participants seeking to employ interview and/or questionnaire methods would fall outside the MCA's definition of intrusive research, meaning that strictly speaking researchers should not be bound to follow the rest of the authorisation provisions. Whether or not this is recognised in practice is a moot point.

Regardless of the correct position of the lawfulness or otherwise of certain types of observational, interview and questionnaire research without consent, the MCA Code of Practice (COP), and other associated professional regulatory guidelines, have sought to provide further guidance on the meaning of intrusive research. The COP, at various junctures, seems to hedge its bets by suggesting that interview and observational research *could* be intrusive research in certain circumstances,⁴⁰ whereas the guidance from the Health Research Authority (HRA) is a little more forthright. It states that intrusive research includes non-interventional research where consent is legally required.⁴¹ The guidance then proceeds to give examples of the administration of questionnaires, interviews or observations.⁴² There is nothing inaccurate about that, but the guidance lacks sufficient depth and clarity on the examples it provides of

³⁷ Above (n 36). Article 6 (1) (f). It should be noted that if any research data related to health, it would be classed as 'special category data'. Alongside the legitimate expectation ground, a further justification would also be needed for the lawful processing of this data. In a research context, this is most likely to be founded under Article 9, (j), in which processing is necessary for achieving purposes in the public interest, and scientific or historical research.

³⁸ For the data protection principles, see (n 36), Article 5 (1) (a) – (f). For information on the wide interpretation of the legitimate interest ground, see <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/legitimate-interests/> <accessed 22nd Feb 2019>.

³⁹ Anonymised data falls outside the definition of 'personal data', contained in (n 36) Article 4 (1). For older English authority on this point, see *R v Department of Health, ex p Source Informatics Ltd (No.1)* [2001] QB 424.

⁴⁰ Mental Capacity Act 2005: Code of Practice, para [11.15] and [11.18].

⁴¹ NHS Health Research Authority, Mental Capacity Act: <https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/mental-capacity-act/>. <Accessed 21st February 2019>.

⁴² Ibid.

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non-intrusive research. The danger here is that researchers may be inclined to read this and to think that every project utilising questionnaires, interviews and observations involving incapacitated participants will automatically fall within the scope of the MCA and must therefore comply with the regulatory requirements for research approval.

As it is probable that researchers will often consult the COP and HRA guidance first, we suggest that addressing the uncertainties associated with the central definition of intrusive research, which is crucial to how the remainder to the MCA research provisions operate, is a matter that needs to be clarified to a greater extent than is currently the case. It is not unusual for primary legislation to remain sufficiently broad to allow some scope for development and adaptation.⁴³ This may well have been the intention underpinning the MCA's definition of intrusive research and there may well have been merit in that drafting technique, for adopting that approach has allowed the law to remain flexible and capable of adapting to changes in legal and social attitudes towards human rights, and research.⁴⁴ Delegating the finer points to supplementary guidance from the COP and HRA therefore confers a number of benefits on the MCA in the sense that the former documents not only complement, but also elaborate upon, the more general framework provided by the latter. Nevertheless, if the guidance contained in those documents remains opaque, little will be done to obviate some of the problems encountered by those involved in research practice. If the legislation, and the guidance from the COP and HRA, are fostering a belief amongst researchers that every type of interview, questionnaire and observational study is automatically intrusive research, then that belief is not only legally incorrect, but also creates a further practical problem.

If the practice is now to refer every project that adopts interview, questionnaire or observational methods to MCA RECs for approval as a matter of course, this may be an unnecessary drain on already scarce resources.⁴⁵ Consider, for example, a university researcher who wishes to conduct interview or questionnaire research involving incapacitated participants who are not NHS patients, but who are drawn from a wider cross-section of society. In this scenario, McHale suggests that 'an alternative approach would be to allow some forms

⁴³ See, for example, the Human Fertilisation and Embryology Acts of 1990 and 2008, which are supplemented by the Human Fertilisation and Embryology Authority: Code of Practice (v9 2018).

⁴⁴ See HL Deb 01 Feb 2005, vol 669, cols 132-135: https://api.parliament.uk/historic-hansard/lords/2005/feb/01/mental-capacity-bill-37-pm#S5LV0669P0_20050201_HOL_123 <Accessed 26th February 2019>.

⁴⁵ A key component of the ASSENT Project at UEA is to assess how many applications MCA REC actually receive in respect of incapacitated participants.

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of research concerning persons lacking capacity to be referred for approval to committees other than NHS research ethics committees, such as university research ethics committees'.⁴⁶ This argument has merit, for often a university research ethics committee may be better placed to review certain projects. In some areas, such as social sciences, they may have a wider and more localised pool of expertise to conveniently draw on. Whatever the solution, as things stand, the contours of the MCA remain poorly defined and the COP and HRA guidance do little to alleviate this uncertainty.

ii) Operating from the Wrong Basis

Alongside the scope of the legislation remaining ambiguous, there are further aspects of the requirements for approval that provide cause for concern. As a corollary of its apparent emphasis on medically-invasive research, the MCA also adopts a limited view of what research has to be connected with when dealing with incapacitated participants.

In order to meet the requirements for approval, the research must be connected with an impairing condition affecting the participant, or its treatment.⁴⁷ An impairing condition is one that is attributable to, or which causes or contributes to, the impairment of, or disturbance in the functioning of, the mind or brain.⁴⁸ It thus portrays a heavily medicalised model of what is deemed valuable in research, which is wedded to the belief that research should only be allowed to proceed if the activities are directly related to improving knowledge of the causes or treatment of the condition that an incapacitated participant is *herself* suffering from, which is impinging on *her* capacity. This neglects to consider that, provided there is adequate support to help her, an incapacitated participant may remain capable of not only adding value to certain types of research that may be wholly unconnected to her medical condition, but also of communicating a desire to become involved in such work.⁴⁹ Here the terms of the MCA arguably focuses the mind on the wrong line of inquiry. When confronted by a participant who lacks capacity, but who is nonetheless able to express and communicate a desire to become

⁴⁶ McHale (n 5) at 67. McHale's reference to 'NHS research ethics committees' is what we have labelled MCA RECs throughout this piece.

⁴⁷ Mental Capacity Act 2005, s 31 (2) (a) and (b).

⁴⁸ Mental Capacity Act 2005, s 31 (3).

⁴⁹ Mabel Stevenson and Brian J Taylor, 'Involving Individuals with Dementia as Co-Researchers in Analysis of Findings from a Qualitative Study' (2019) 18 *Dementia* 701; Julie Calvey, 'Including Adults with Intellectual Disabilities who Lack Capacity to Consent in Research' (2012) 19 *Nursing Ethics* 558; Ruth Bartlett, 'Modifying the Diary Interview Method to Research the Lives of People With Dementia' (2012) 22 *Qualitative Health Research* 1717.

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involved in research, the emphasis should not really be on ‘allowing’ someone else to make a decision to include that participant once certain conditions are met. It should be more about the researcher and the participant working together in order to create a culture of supported decision-making. Where adequate support is provided, it will often be possible for both parties to mutually identify where and how an incapacitated participant could add value to a project, which in no way should be limited to just medical value connected to impairments of capacity.

By way of illustration, consider a general research project conducted by local government aimed at exploring society’s perceptions of how local amenities could be improved. Researchers involved in the project recognise that the study would almost certainly benefit, to the extent that it is possible, from input from incapacitated participants. After reading the HRA guidance, and COP, the researchers assume that their methods would amount to intrusive research and would thus need to satisfy the research provisions of the MCA. Leaving aside the rights or wrongs of that interpretation of intrusive research, a creative reading of the other legislative provisions would still be required to justify her inclusion, which jars with any notion of empowerment. It is actually left to the COP to clarify that treatment is not confined purely to medical treatment, but even then it still states that research can only be authorised if it is linked in some way to the condition affecting an incapacitated participant herself, or to others who suffer from the same or a similar condition.⁵⁰ This misses the point; the hypothetical research project above should not have to be justified on the basis that the contribution of an incapacitated participant may improve matters from her perspective as the sufferer of a mental impairment, or indeed that it may help others with similar or related conditions. It should be justified by recognition that she is a member of the public herself, who may be capable of communicating valid input into any research for the benefit of other individuals in society whose capacity is not compromised. The fact that wording the MCA does not encourage matters to be viewed from this broader perspective paves the way for a restrictive outlook to take shape, which permeates throughout the remainder of the MCA’s research framework.

A similar attitude is fostered in relation to the ground for approval that requires consideration as to whether research of comparable effectiveness could be carried out on a capacitous person.⁵¹ This stems from a wider ethical concern that incapacitated participants

⁵⁰ Mental Capacity Act 2005: Code of Practice, para [11.16].

⁵¹ Mental Capacity Act 2005, s 31 (4).

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should not be used in research simply out of a matter of convenience, which is an admirable position to adopt in one sense.⁵² Nevertheless, its phrasing may cause a researcher to always begin by asking herself the question: ‘can I answer this research question without involving incapacitated participants?’ This may subconsciously encourage a researcher to err on the side of exclusion and if this attitude gains traction it creates a distorted impression of the value that an incapacitated participant may be able to bring to research in her own right. Just because research of comparable effectiveness *may* be capable of being achieved by using only capacitous participants, it does not automatically mean that incapacitated participants should be completely omitted from a project. Perhaps a more suitable way to phrase the condition would be to impose on a researcher an obligation to ‘provide reasonable evidence to support that she has given appropriate consideration as to why and how any research project will derive value from the inclusion of incapacitated participants’. Provided value is broadly conceived, this construction removes any comparative element, which may project a stronger recognition from the law that both sets of participants may be capable of contributing something of equal worth to research.

It has been argued by some that the more general terms of MCA conflict with the renewed emphasis on supported decision-making endorsed by the UNCRPD.⁵³ The particular demand for a comparative assessment of capacitated versus incapacitated participants in the sphere of research is a paradigm example of the MCA failing to recognise what supported decision-making is actually about.⁵⁴ Rather than promoting an attitude of exclusion, the legislation should aim not only to focus on the ways in which it can recognise the valid contribution that incapacitated participants bring to research, but also on how its provisions could effectively accommodate and facilitate their involvement in the process. It should seek to maximise avenues of support for a participant in research and, where possible, to assist her

⁵² Bartlett (n 12) at 89; George F Tomossy and David N Weisstub, *Revival: Human Experimentation and Research* (1st edn, Routledge: Taylor and Francis 2003). For an interesting historical account of the enduring ethical issues see Rebecca Dresser, ‘Mentally Disabled Research Subjects: The Enduring Policy Issues’ (1996) 276 *Journal of American Medical Association* 67.

⁵³ Clough (n 3); Donnelly (n 1); Donnelly (n 2).

⁵⁴ Loomes (n 5); Clough (n 3). See also Ciara Shiggins *et al.*, ‘Towards an ASSET-Based Approach to Promoting and Sustaining Well-Being for People with Aphasia and their Families: An International Exploratory Study’ (2018) *Aphasiology* 1, doi: <https://doi.org/10.1080/02687038.2018.1548690>; Natalie Joseph-Williams *et al.*, ‘Implementing Shared Decision Making in the NHS: Lessons from the MAGIC Programme’ (2017) 357 *BMJ* 1744; Treena Jingree, ‘Duty of Care, Safety, Normalisation and the Mental Capacity Act: A Discourse Analysis of Staff Arguments about Facilitating Choices for People with Learning Disabilities in UK Services’ (2015) 25 *Journal of Community and Applied Social Psychology* 138.

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in making her own decision about participation. While it is desirable to assume that the interests of an incapacitated participant should outweigh the interests of science and society, to view the two interests as always being diametrically opposed may lead to a propensity to overprotect, when the direction of travel should be to place greater emphasis on collaboration between a researcher and a participant to engender empowerment.⁵⁵ The research provisions are ripe for an overhaul of how they visualise the position of incapacitated participants and, based on the excellent recent work of Clough, this may entail a complete reconsideration of how notions of incapacity and its affect upon individuals are thought about.⁵⁶ To clarify, the argument is not that there should be no special protection for incapacitated participants in research; it is that the provisions of the MCA that seek to provide it are inappropriately constructed and overly restrictive, when a more appropriate balance could be struck between protection and empowerment. The opening segments of the MCA epitomise this and begin by asking the wrong questions, which sets a narrow tone for the remainder of the conditions. In any event, if the underlying intention behind the insertion of specific research requirements was to provide special protection, it is not abundantly clear that they have achieved this. As we will now proceed to discuss, the further additional grounds for approval also miss their target

C. An Illusionary Different Threshold for Approving Research?

Best interests occupies a central role in the MCA, providing the lawful basis upon which certain decisions can be made for those who cannot decide for themselves. In theory the test remains objective, yet section 4 of the MCA provides a non-exhaustive list of both objective and subjective factors that must be considered by any decision-maker when deciding what is in an incapacitated person's best interests.⁵⁷ One interesting question surrounds its absence in the arena of research, and there was some early confusion on this point.

In his first edition of *Blackstone's Guide to the Mental Capacity Act 2005*, Bartlett argued that the guiding principles of best interests should apply to research in the same way that they should apply to treatment.⁵⁸ In the later edition, he then changes his position

⁵⁵ Mental Capacity Act 2005, s 33 (3). On the point of collaboration, see *ibid*, and also NICE Guidelines: <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>.

⁵⁶ Clough, (n 3).

⁵⁷ Mental Capacity Act 2005, s 4; Donnelly (n 2); Taylor (n 4).

⁵⁸ Peter Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005* (1st edn, OUP 2005) at 66.

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accurately identifying that the best interests test is not referred to and that the research sections of the MCA ‘introduce their own substantive thresholds’.⁵⁹ It would seem that the omission of best interests was deliberate, because its inclusion in the context of research was perceived by some to be problematic on the basis that research is seldom intended to benefit individual participants *per se*.⁶⁰ Consequently, it was perhaps thought that endorsing a separate approach would provide a more tailored type of protection, but the effectiveness of this is disputable.⁶¹ At the same time, a further aim was to create a regime that was broad enough to facilitate inclusive research, but, once again, it is not obvious that removing reference to best interests has accomplished that.⁶² As we examine in more detail below, the thresholds for authorising research require consideration of a range of factors that are not altogether dissimilar to those which must be considered under a best interests assessment, so little if anything is gained by their insertion. For the purposes of the following analysis, the provisions which we are principally concerned with are sections 31 (5) (a) and 31 (5) (b) of the MCA.

i) Benefits to Burdens Ratio: Considering the Position of the Participant (Section 31 (5) (a))
Under section 31 (5) (a), a MCA REC may not approve a research project unless it is satisfied that the research has the potential to benefit a participant without imposing on her a burden that is disproportionate to the potential benefit. If research cannot be approved under this section, it can nonetheless still be approved under the alternative of section 31 (5) (b), which we discuss under the next heading.⁶³

Focusing now on section 31 (5) (a), one fallout from the MCA’s apparent emphasis on medically invasive research, is that any analysis of the notion of ‘benefit’ may naturally gravitate towards identification of medical advantages.⁶⁴ Medical benefits are frequently considered from an objective evidence-based perspective, yet to confine any examination under

⁵⁹ Bartlett (n 12).

⁶⁰ HL Deb 01 February 2005, vol 669, cols 130 – 132. https://api.parliament.uk/historic-hansard/lords/2005/feb/01/mental-capacity-bill-37-pm#S5LV0669P0_20050201_HOL_123 <Accessed 26th February 2019>.

⁶¹ HL Deb 01 February 2005, vol 669, cols 133 – 138. https://api.parliament.uk/historic-hansard/lords/2005/feb/01/mental-capacity-bill-37-pm#S5LV0669P0_20050201_HOL_123 <Accessed 26th February 2019>.

⁶² Ibid.

⁶³ Mental Capacity Act 2005, s 31 (5) (a).

⁶⁴ Above n 18.

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section 31 (5) (a) of the MCA purely to this is too restrictive.⁶⁵ This is one example of the broad nature of the MCA, and the more detailed nature of the COP, working well together. The COP is helpful as it elaborates on the potential meaning of ‘benefit’, embracing a more expansive approach. Section 11.14 of the COP states that alongside developing more effective ways of treating or managing a participant’s condition, benefit could also mean improving the quality of health or social care that a participant may have access to, discovering the cause of the participant’s condition if she would benefit from that knowledge, and reducing the risk of the participant being harmed excluded or disadvantaged.⁶⁶ The adoption of this broader interpretation is undoubtedly sensible, but it is equally important to acknowledge that these considerations must be targeted at procuring some *direct* benefit to the individual participant *herself*. The subjective circumstances of an individual participant must therefore be considered carefully. Remaining cognisant of this becomes even more important when thinking about potential *indirect* benefits under section 31 (5) (a) of the MCA.

If understood correctly, benefits should encompass social, psychological and emotional factors, which may be specific to the individual position of an incapacitated participant.⁶⁷ There may be some situations in which she may only receive a tangentially-related benefit from any involvement in research, but the fact that this may be of a marginal, non-physical nature should not prevent it from being classified as something that may be of worth to *her*. The COP also usefully recognises this in stating that where ‘the research involves interviews and the person has the opportunity to express their views, this could be considered a real benefit to a particular individual’.⁶⁸ The broader potential benefit of allowing an incapacitated research participant to have her voice heard is, therefore, explicitly recognised. It follows that in order to encourage wider participation and inclusiveness, an expansive meaning must be ascribed to the notion of benefit, which considers a range of both objective and subjective factors. At this point, it becomes evident that the test articulated under section 31 (5) (a) of the MCA does not

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49 ⁶⁵ Matthew J Leach, ‘Evidence Based Practice in Traditional & Complementary Medicine: An Agenda for Policy,
50 Practice, Education and Research’ (2018) 31 *Complementary Therapies in Clinical Practice* 38; Matthew J Leach,
51 ‘Evidence-Based Practice: A Framework for Clinical Practice and Research Design (2006) 12 *International
52 Journal of Nursing Practice* 248; Andrew Miles *et al.*, ‘Evidence-Based Healthcare, Clinical Knowledge and the
53 Rise of Personalised Medicine’ (2008) 14 *Journal of Evaluation in Clinical Practice* 621.

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55 ⁶⁶ Mental Capacity Act 2005: Code of Practice, para [11.14].

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57 ⁶⁷ In *Re A (Mental Patient: Sterilisation)* [1999] 12 WLUK 657; [2000] 1 FLR 549, Dame Elizabeth Butler-Sloss
58 P recognised that considering these factors was crucial to any assessment of best interests, at p.10 of the Official
59 Transcript.

60 ⁶⁸ Mental Capacity Act 2005: Code of Practice, para [11.15].

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represent as radical a departure from the best interests test as some may have envisaged.⁶⁹ The threshold for approval is not in reality raised, because it does not demand proof of a higher objective level of benefit to be present. It simply requires that a balancing exercise is undertaken which necessitates a comparative weighing of benefits versus burdens.⁷⁰ Provided there is some potential benefit to a participant, and provided any associated burden is not disproportionate to that benefit, the standard will be satisfied.⁷¹ The correct approach is, thus, to consider both objective and subjective considerations in this assessment and, where this is acknowledged, the balancing exercise performed in the assessment of research under section 31 (5) (a), and the factors that should be included therein, is closely aligned to the manner in which best interests assessments should be performed.⁷²

22
ii) Recognition of Wider Societal Benefits (Section 31 (5) (b))

23 Where a research project will not confer either a direct or indirect benefit on an incapacitated
24 participant under section 31 (5) (a) of the MCA, it may still nonetheless be approved under
25 section 31 (5) (b).⁷³ Under this section, the emphasis switches to an assessment of whether or
26 not the research is intended to provide knowledge of the causes or treatment of, or of the care
27 of persons affected by, the same or a similar condition to that of the participant.⁷⁴ On the basis
28 that this provision invites some consideration of the impact of the research on individuals other
29 than the incapacitated participant herself, a more visible departure from best interests may
30 initially be apparent here.

31 A conventional best interests decision must be made by reference to what is in the best
32 interests of a particular individual, but section 31 (5) (b) actually requires the opposite.⁷⁵ It
33 distances itself from analysing matters from the subjective perspective of a would-be
34 participant and instructs an assessor to turn her attention to any potential knowledge that could
35 be gained from research that may be useful to wider members of society.⁷⁶ A different mode

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69 Bartlett (n 12).

70 Mental Capacity Act 2005, s 31 (5) (a) and (b).

71 Ibid.

72 *Re A* (n 67); *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33, 55.

73 Mental Capacity Act 2005, s 31 (5) (a) and (b).

74 Mental Capacity Act 2005, s 31 (5) (b).

75 Per Holman J in *An NHS Trust v MB and Others* [2006] EWHC 507 (Fam); [2006] 2 FLR 319 at [16] [v].

76 Mental Capacity Act 2005, s 31 (5) (b).

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of thinking is, at first blush, required than that which would typically be expected of a decision-maker under a standard best interests examination. Casting the net wider in this way has the capacity to facilitate a more inclusive and permissive approach, but where any inquiry must look beyond individual benefits, and where a participant is particularly vulnerable, it would not be unreasonable to expect a more stringent test in order to justify any research. Section 31 (5) (b) does not actually provide this. Given that under this section the research must be intended to provide knowledge of causes, treatment or care of a condition, there may be an inclination to think that it should be judged against a higher level of evidence-based criteria, but its wording is prone to mislead. Section 31 (5) (b) only demands that the research must be *intended* to provide knowledge; there is no requirement for it to be objectively proved that any research *will actually* produce such knowledge. As most credible research projects will be underpinned by at least an intention to develop a deeper understanding of a particular problem to help society in a broader sense, the reality is that the test under section 31 (5) (b) may be easier to meet than some may imagine. To mitigate against this, the legislation attempts to provide a protective counterbalance.

Where section 31 (5) (b) is engaged, section 31 (6) states that there must also be reasonable grounds for believing that the risk to the participant from taking part in the project will be negligible, and that anything done to, or in relation to the participant, will not interfere with her freedom of action or privacy in a significant way, or be unduly restrictive.⁷⁷ This directs the examination away from balancing out the risks and benefits, towards ensuring that an incapacitated participant is prevented from being exposed to anything greater than a low-level risk when partaking in research designed solely to benefit of others. Those who believe that the definition of a negligible risk is something that can be calculated with precision though are operating under a misapprehension. Any categorisation of a risk as being beyond negligible may depend on a number of factors; emphasis could be given to percentage rates of occurrence, whereas elsewhere it may be placed on the severity of consequence should that risk materialise. Equally, it is subject to differing interpretations. For some, the mere existence of a remote risk, no matter how slight, may be sufficient to classify it as something beyond negligible, thereby ruling out any authorisation of the research. This could lead to a problematic situation in which

⁷⁷ Mental Capacity Act 2005, s 31(6). As Brazier and Cave note, this is a less onerous test than is applied under the Medicines for Human Use (Clinical Trials) Regulations 2004. Under Sch 1, Part 5, para 9 of the Clinical Trials Regulations, the research must either benefit the patient or produce *no risk at all*. See Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, Manchester University Press 2016) at 490. Analysis of the Clinical Trials Regulations is beyond the scope of this piece.

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certain participants may be prevented from taking part in some research projects because of problematic risk appraisals associated with vague definitions. The COP, for example, equates ‘negligible’ with ‘minimal’ and proceeds to state that a participant should suffer ‘no harm or distress by taking part’.⁷⁸ Properly understood, minimal risk should not be taken to mean no risk at all and so perhaps the COP is too restrictive on this point. It is certainly possible to interpret the meaning of negligible more liberally in order to recognise that certain incapacitated participants may be capable of withstanding a greater level of risk in order to legitimise their involvement in research.

This feeds into a further important point; any examination of the magnitude of a risk associated with a project needs at least some consideration of how a prospective participant may view it.⁷⁹ It is therefore sensible to be explicit about the fact subjective considerations also have a role to play in the assessment of research justified on the grounds of wider societal benefits. Where a participant is able to express enthusiasm for involvement in a project, it may colour any assessment of what amounts to a negligible risk; a risk may exist which to some reviewers would appear more than negligible, but from the perspective of a potential participant it may not be viewed in the same way.

The other protective measures under section 31 (6) are also plagued by ambiguous phrases that are very much dependant on an individual. Ensuring that anything done will not amount to a ‘significant’ interference with privacy needs at least some evaluation of a participant’s position and personal circumstances, because what amounts to a significant interference may vary greatly.⁸⁰ Similar complications are associated with the requirement not to do anything that is unduly invasive or restrictive. The meaning of ‘unduly’ is subject to the specifics of the type of research in question and how it may impact upon a range of participants in potentially different ways.⁸¹ Accordingly, a pattern emerges which belies the notion that section 31 (5) (b) demands a wholly objective examination when assessing any potential wider

⁷⁸ Mental Capacity Act 2005: Code of Practice, para [11.18].

⁷⁹ See J Richard Eiser *et al.*, ‘Risk Interpretation and Action: A Conceptual Framework for Responses to Natural Hazards (2012) 1 *International Journal of Disaster Risk Reduction* 5.

⁸⁰ Recently, the Supreme Court stressed the importance of the need to consider things from the *particular patient’s* perspective. What amounts to a significant invasion of privacy could, for example, depend on cultural beliefs and different perceptions of privacy. See *Montgomery v Lanarkshire* [2015] UKSC 11; [2015] AC 1430.

⁸¹ See Victoria Shepherd, ‘Research Involving Adults Lacking Capacity to Consent: The Impact of Research Regulation on ‘Evidence Biased’ Medicine (2016) *BMC Medical Ethics* <https://doi.org/10.1186/s12910-016-0138-9>; Herbert C Kelman, ‘Privacy and Research with Human Beings’ (1977) 33 *Journal of Social Issues* 177.

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12 societal benefits stemming from research. Operating in tandem with the additional protective
13 mechanisms under section 31 (6), it is clear that both objective and subjective factors need to
14 be considered in a manner that is again not entirely inconsistent with the section 4 best interests
15 approach.

16 ***iii) The Bespoke Research Provisions: Justified Abandonment of Best Interests?***
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19 While the requirements for approval of research under sections 31 (5) (a) and (b) of the MCA
20 are phrased differently, in reality they operate in much the same way as the best interests
21 standard. There is a significant amount of replication between the nature of the factors that
22 must be considered under both approaches, so it is difficult to discern where the bespoke
23 research principles add benefit. On the contrary, the research provisions are so opaque in places
24 that they become difficult to translate into a working model of assessment and therefore
25 frustrate, rather than facilitate, research. Arguably the only thing they have accomplished is to
26 create a sense of confusion amongst those who have to apply them, and a lack of consistency
27 between different aspects of the MCA, where it may have been more effective for the
28 legislation to remain more streamlined across all areas of treatment, finances and research.
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30 Instead of incorporating a separate set of substantive thresholds, it may have been
31 simpler and more effective to require both researchers and MCA RECs to undertake a best
32 interests assessment when assessing the validity of participation in research. First, those
33 involved in working with individuals who lack capacity – whatever type of decision is at stake
34 – may be more accustomed to the best interests test. Applied to research, it may therefore be
35 more easily understood, because the minds of consultees and MCA REC member assessors
36 may be more attuned to considering the wider range of factors that are now commonly accepted
37 as having to form part of a holistic balancing process, which may make evaluations more
38 rounded.⁸² Secondly, interpreted in an expansive manner, the concept of best interests is
39 sufficiently malleable so as to be capable of achieving a fairer balance between protection and
40 empowerment in research. It would still allow the specific interests of a participant to be
41 prioritised, while at the same time remaining able to consider, and accommodate, the wider
42 interests of society. Insofar as the latter is concerned, some will no doubt point out a problem
43 we alluded to earlier; what is in the best interest of an individual can never be answered by
44 considerations pertaining to what is in the best interests of others. A significant departure
45 would accordingly be required to allow research to proceed where it would only benefit society.
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⁸² Donnelly (n 1); Donnelly (n 2).

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8 Where a broader view is adopted, this is not necessarily the case, particularly if the question is
9 asked: how would an incapacitated feel about her involvement in research that may not
10 necessarily help her, but which could help others?

11 This is where best interests' explicit endorsement of the need to consider things from
12 the subjective perspective of an incapacitated individual under section 4 of the MCA sends a
13 much stronger and important message than is currently conveyed by sections 31 (5) (a) and (b).
14 When determining the question of best interests, section 4 (6) of the MCA instructs a decision
15 maker to consider, so far as is reasonably ascertainable, the person's past and present wishes
16 and feelings (and, in particular, any relevant written statement made by him when he had
17 capacity),⁸³ the beliefs and values that would be likely to influence his decision if he had
18 capacity,⁸⁴ and the other factors that he would be likely to consider if he were able to do so.⁸⁵
19 Under section 4 (7), provided it is practicable and appropriate to consult them, the views of
20 anyone named by the person as someone to be consulted on the matter in question or on matters
21 of that kind should also be taken into account,⁸⁶ as should the views of anyone engaged in
22 caring for the person or interested in his welfare.⁸⁷ While best interests does not in a general
23 sense provide a complete panacea to English law's current incompatibly with the notion of
24 supported-decision making, these sections do help to give an incapacitated person a voice,
25 which could be beneficial if applied to research.

34 It is often assumed that an incapacitated participant will be unable to communicate her
35 preferences for any involvement in research, but that is often not so.⁸⁸ There will be
36 circumstances where she remains capable of expressing a desire to become involved and so it
37 will be possible to identify a benefit to her own personal development and sense of worth, from
38 contributing to something that may be of value to others.⁸⁹ Even where she cannot
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⁸³ Mental Capacity Act 2005, s 4 (6) (a).

⁸⁴ Mental Capacity Act 2005, s 4 (6) (b).

⁸⁵ Mental Capacity Act 2005, s 4 (6) (c).

⁸⁶ Mental Capacity Act 2005, s 4 (7) (a).

⁸⁷ Mental Capacity Act 2005, s 4 (7) (b).

⁸⁸ Benjamin W. J. Spencer *et al.*, 'Unwell in Hospital but not Incapable: Cross-Sectional Study on the Dissociation of Decision-Making Capacity for Treatment and Research in In-Patients with Schizophrenia and Related Psychoses' (2018) 213 *The British Journal of Psychiatry* 484; Mark J. Jayes and Rebecca L. Palmer, 'Stroke Research Staff's Experiences of Seeking Consent from People with Communication Difficulties: Results of a National Online Survey' (2014) 21 *Topics in Stroke Rehabilitation* 443.

⁸⁹ See, for example, Mencap, *Involve Me: Independent Evaluation Report* (Foundation for People with Learning Disabilities 2011).

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communicate a preference, she ought not to be automatically precluded from participating in a project for the wider benefit of society, and the advantage of a best interests approach in the context of research would be explicit recognition from the legislation itself, and not just the COP,⁹⁰ of the need to view that question through the lens of the participant. It may be possible to conclude that she would be stimulated and enthused by a desire to contribute to society by helping others, which would induce a sense of happiness in her. Researchers must be clearly encouraged to explore with any incapacitated participant, to the greatest extent possible, how she may feel about her involvement in any research that may not necessarily help her, but which could help others. Naturally this requires complex concepts to be addressed that sometimes may be outside a participant's comprehension. Therefore, how meaning is constructed with potential participants is absolutely crucial and the research sections of the MCA fall short of addressing this, and arguably the COP does not fare much better.

Making efforts to elicit the views of any potential incapacitated participant may reveal that she has a strong desire to act altruistically and to become involved in a project, a view which has gained traction under best interests reasoning. For instance, it has previously been acknowledged that an incapacitated person's best interests may be served by authorising a bone marrow donation that conferred no direct medical benefit on her, but which would only benefit her sibling. This was because that, in the long run, it was agreed she would gain some emotional, psychological and social benefit from this procedure as it would allow her sister, and indeed her mother, to spend more time with her in the future.⁹¹ In other words, a clear benefit could be identified from helping someone else. This attitude has recently been reiterated by Morgan J in the Court of Protection, where he confirmed that the best interests test does not confine a court to considering self-interest, but could be extended to consider how the potential altruistic wishes of a person could indicate that a course of action ostensibly designed to help others could in fact be in that person's best interests.⁹²

Admittedly, in some instances factors pulling in the opposite direction may be sufficiently compelling to override the above points, but they could also be considered as part of a rounded balancing exercise that is typically performed under best interests. All things being equal, however, where an incapacitated participant is capable of communicating a wish to participate in research in order to help others, it should be highly persuasive in terms of

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⁹⁰ Mental Capacity Act 2005: Code of Practice, paras [11.20], [11.24] and [11.29].

⁹¹ *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam 110.

⁹² *Re G* [2010] EWHC 3005; [2010] 11 WLUK 498.

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sanctioning her involvement. In order to promote this attitude, greater emphasis needs to be placed on ways in which researchers themselves can be encouraged to engage participants with the research concepts and communication process in whatever way each individual is able. At present, the legislation gives the impression that this role should be mainly delegated to a consultee, which carries with it some pitfalls that we explore in more detail below.

We now turn to consider whether other aspects of the MCA could potentially depict the bespoke research provisions in a more favourable light. While a number of other requirements must also be complied with before research can be approved, we argue that these additional measures impose different obligations on different parties. Thus, far from adding clarity, they actually send out mixed messages.

D. Researchers; Consultees; MCA RECs: Mixed Responsibilities

i) Researchers

The question of capacity is the first issue that must be addressed by a researcher, and she must approach this by reference to the general principles contained in the MCA.⁹³ The starting point is that capacity should always be presumed, which acts as a safeguard by ensuring that the burden of disproving capacity rests on the person contesting it.⁹⁴ To rebut that presumption, it must be proven, on the balance of probabilities, that at the material time, a person is unable to make a decision.⁹⁵ Under section 3 (1), a person is unable to make a decision if she is unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate her decision (whether by talking, using sign language or any other means).⁹⁶ This is a decision-specific, functional approach that focuses on the ability of a participant to actually make a decision through understanding, remembering, processing and communicating.⁹⁷ Where a research participant is deemed to have capacity, her decision about participation remains

⁹³ Mental Capacity Act 2005: Code of Practice, para [11.4]; NHS Health Research Authority, Mental Capacity Act: <https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/mental-capacity-act/>. <Accessed 21st February 2019>.

⁹⁴ Mental Capacity Act 2005, s 1 (2).

⁹⁵ Mental Capacity Act 2005, s 2 (1)

⁹⁶ Mental Capacity Act 2005, s 3 (1) (a) (b) (c) and (d); See also *Re C (Refusal of Medical Treatment)* [1994] 1 WLR 290.

⁹⁷ Michael Gunn, ‘The Meaning of Incapacity’ (1994) 2 *Medical Law Review* 8.

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sacrosanct.⁹⁸ If, however, the opposite conclusion is reached, the additional measures of the MCA will be triggered. Where research is concerned, specific difficulties arise not only in relation to who is responsible for performing capacity assessments, but also in respect of the nature of the test itself.

The test for capacity is notoriously difficult to apply in practice, which often leads to inconsistencies in its performance.⁹⁹ Where a decision relates to treatment, a perceived advantage is that medical professionals will usually be involved in at least some stage of any capacity assessment, yet it is a common misconception that they are all trained in assessing capacity, when often they are not.¹⁰⁰ Research has established that in some instances they do not fully understand what the legal test requires of them.¹⁰¹ This is mitigated to a degree by the fact that disputes about capacity in certain treatment decisions may be more likely to be referred to court for scrutiny. Where this happens, expert testimony will be presented before a judge of the Court of Protection by professionals who have extensive experience in assessing capacity by reference to the appropriate legal test. It is not a guaranteed safeguard though, because recent evidence has suggested that the same select group of experts are often called upon to give evidence repeatedly, thereby creating the danger of assessments becoming too formulaic an exercise.¹⁰² Nonetheless, an added layer of accountability still exists that has the effect of ensuring that any query surrounding capacity in delicately poised treatment cases is subject to forensic judicial scrutiny and open to challenge. No such safety measures are ever likely to be activated in research. While theoretically it would be possible to ask the Court of Protection to make a declaration concerning the capacity of a potential research participant, it is highly

⁹⁸ It was stated by Lord Donaldson MR in *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102 that ‘an adult who suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered...This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.’ The same principles would apply to research.

⁹⁹ Mark Jayes *et al.*, ‘How do Health and Social Care Professionals in England and Wales Assess Mental Capacity? A Literature Review’ (2019) *Disability and Rehabilitation* 1. Doi: 10.1080/09638288.2019.157293; Paula Case, ‘Negotiating the Domain of Mental Capacity: Clinical Judgement or Judicial Diagnosis?’ (2016) 16 *Medical Law International* 174; Mary Dixon-Woods *et al.*, ‘Research Involving Adults who Lack Capacity: How have Research Ethics Committees Interpreted the Requirements?’ (2009) 35 *Journal of Medical Ethics* 377.

¹⁰⁰ Jayes (n 99); Daniel Ratcliff *et al.*, ‘Health and Social Care Practitioners’ Experiences of Assessing Mental Capacity in a Community Learning Disability Team’ (2016) 44 *British Journal of Learning Disabilities* 329;
¹⁰¹ Ibid.

¹⁰² Case (n 99).

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unlikely to happen in practice.¹⁰³ Individuals involved in the research approval process will have little incentive to seek such a declaration and, given the extra cost and additional time, the chances are that it will never be pursued. It follows that an important layer of legal scrutiny that exists in regard to certain treatment cases, is effectively lost in the realms of research. The only real safeguard that exists in respect of the capacity question is, therefore, grounded in the overall scrutiny that a MCA REC maintains over a project, but we argue later that this may be an inappropriate forum to oversee this issue.

Following on from this, the problems associated with capacity assessments are likely to be amplified in research, particularly given that the scope of the MCA seems to have been broadened to cover a variety of non-invasive methods.¹⁰⁴ Certain types of researchers involved in certain types of projects may have little if no experience in dealing with capacity assessments. The less exposure a researcher has had to dealing with borderline incapacitated participants who may exhibit difficulty with understanding, problems with speech and language, and poor memory and recall, the more difficult it may become for her to make an accurate determination as to whether recourse to the research provisions of the MCA is necessary. Where a researcher perceives that she may be confronted with such individuals, she may be inclined to avoid any challenging capacity-related questions by simply altering the parameters of her investigation. If there is a propensity to avoid rather than confront these difficult questions, the problem becomes self-perpetuating as researchers will never gain enough experience to become more proficient in assessing capacity and valued participants may continue to be excluded.

In research, a ‘grey area’ will also often exist. Some projects will be a one-off, but others may necessitate more prolonged involvement from a participant. It is thus possible that if a participant is asked to take part in a project over a sustained period of time, that she may experience fluctuating capacity at various junctures.¹⁰⁵ Moreover, as capacity is technically decision-specific, there may be some components of a research project that a participant may have capacity to agree to, and others which she may not.¹⁰⁶ While there is some legal

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¹⁰³ Mental Capacity Act 2005, s 15.

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¹⁰⁴ See discussion above at (n 46).

¹⁰⁵ In *Re MB (Caesarean Section)* [1997] 2 WLK 313; [1997] 2 FLR 426 it was confirmed that a person could be rendered ‘temporarily’ incapacitated. See also Barton W Palmer *et al.*, ‘Changes in Capacity to Consent over time in Patients Involved in Psychiatric Research’ (2013) 202 *The British Journal of Psychiatry* 454.

¹⁰⁶ *An NHS Trust v MB and Others* (n 75).

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recognition of the possibility of a ‘temporary’ loss of capacity,¹⁰⁷ untrained researchers may be unaware of it and hence be more inclined to view the question of capacity as absolute instead of relative.¹⁰⁸ Therefore, if capacity cannot be evidenced securely, exclusion may follow, which may be unnecessary. If capacity also appears to fluctuate during the course of a project, there may be a greater inclination from a researcher to think that a participant has lost capacity while the research is ongoing, when that assessment may be inaccurate. If a participant is then withdrawn on this mistaken belief, her exclusion from a project may be overly premature and needlessly damaging to the research.¹⁰⁹ Alternatively, the opposite problem may occur in which a mistaken belief that a participant has capacity causes her involvement in a study to continue, where it may be inappropriate and perhaps even harmful to allow it to happen.¹¹⁰ Naturally, it must be acknowledged that capacity related concerns may be only one reason for exclusion. A researcher may operate cautiously because of a perceived fear her own legal exposure, or, worse still, for the sake of administrative convenience. Engaging the mechanisms of the MCA and its associated safeguards carries with it cost, time and resource implications which some may wish to avoid. Whatever the reason though, there is a problem if those who actually remain capable of contributing something of value to a project are unnecessarily discounted, and if those whose capacity is compromised are included without thorough review. It follows that clearer and more specific guidance is required for researchers in terms of how they should approach capacity assessments and what should form part of their decision-making processes when addressing the question of participant inclusion.¹¹¹

¹⁰⁷ Above (n 105).

¹⁰⁸ One of the problems with capacity is that it is often reduced to a binary ‘yes’ or ‘no’ question, when it should be understood as a more fluid concept. For an excellent discussion of some of the problems with the capacity ‘cliff-edge’, and some interesting suggestions for reform, see Emily Jackson, ‘From “Doctor Knows Best” to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions About Their Medical Treatment’ (2018) 81 *Modern Law Review* 247.

¹⁰⁹ The MCA makes provisions for loss of capacity during a project. Should this happen, it would seem that immediate exclusion would not automatically be necessary. See Mental Capacity Act 2005, s 34.

¹¹⁰ Mental Capacity Act 2005, s 33 (4) and (5).

¹¹¹ For a number of interesting suggestions, see Jackson (n 108).

ii) The Consultee

A further obligation placed on the researcher by the MCA is the requirement to appoint a consultee. This individual must be prepared to be consulted by a researcher about whether or not an incapacitated participant should be included within a research project, and to offer her opinion as to what a participant's wishes and feeling would be likely to be about taking part in the project if she had capacity.¹¹² Two different types of consultee are recognised. A researcher must first seek to appoint a 'personal' consultee, which is defined as a person who otherwise than in a professional capacity or for remuneration, is engaged in caring for the participant or is interested in her welfare.¹¹³ If no such person can be identified, the researcher, in agreement with a MCA REC, must then appoint a 'nominated' consultee. This is someone who has no connection with the research, but who is still prepared to be consulted about the potential involvement of an incapacitated participant.¹¹⁴ The rationale behind this system is to ensure that an incapacitated participant is represented by an independent advocate who has no vested interest in the research, and to maximise the potential for her subjective views and beliefs to be heard and respected in decisions about research. This is the archetypal example of the MCA seeking to balance out the aims of protection and empowerment, but whether or not the consultee requirement serves either purpose effectively is open to question.

First, there are some pragmatic difficulties. The system begins by placing an obligation on a researcher to find an appropriate person who has some type of pre-existing personal relationship with a potential participant. Depending on the circumstances, it may actually be very difficult to locate such an individual. The extent of a researcher's duty is to 'take reasonable steps' to locate a personal consultee, but this is ambiguous.¹¹⁵ One advantage is that it provides a degree of flexibility, so that where any proposed research is scheduled to take place in, say, Norwich, it may be deemed unreasonable to impose on a researcher an obligation to make extensive efforts to contact a participant's distant relative in a remote part of Australia. The drawback is that determining what may amount to taking reasonable steps is open to interpretation. The question will be scrutinised by a MCA REC, so the potential for differing interpretations across the spectrum may add to increased anxiety among researchers. An even

¹¹² Mental Capacity Act 2005, s 32 (4) (a) and (b).

¹¹³ Mental Capacity Act 2005, s 32 (2)(a).

¹¹⁴ Mental Capacity Act 2005, s 32 (3) (a) and (b)

¹¹⁵ Mental Capacity Act 2005, s 32 (2).

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greater predicament unfolds where it is not possible to identify a personal consultee. A researcher must then clearly address any arrangements for appointing a nominated consultee when seeking approval from a MCA REC.¹¹⁶ This enables the latter to assess whether or not there is a convincing reason for not appointing a personal consultee, and for it to advise on the suitability of the arrangements that have been installed for appointing a nominated consultee. A MCA REC may recommend a person who could suitably act in this capacity, and in some instances direction on this question may be helpful, yet any guidance may still not remedy the array of problems connected with the notion of a nominated consultee.

Not infrequently, a researcher may have to approach a nominated consultee who is involved in providing professional care or support for a potential research participant.¹¹⁷ Provided they are not connected to the project, this is permissible, but the problem is that a researcher is reliant on the good will of that professional person.¹¹⁸ Professional people, whatever their discipline, will often not have the time to devote to acting as a consultee for an incapacitated participant whose circumstances they may not be hugely familiar with. A number of potential candidates may decline the invitation, not necessarily because they lack altruistic tendencies, but simply because they may be unable to devote sufficient time to discharge the relevant duty appropriately, especially if it becomes an ongoing obligation. It is too gross a generalisation to suggest that all potential nominated consultees will respond in the negative, for there may be some willing volunteers who will make the time for what they perceive to be a valuable social function. However, the greater number of nominated consultees that refuse to participate at the first time of asking, the further removed the eventual appointed person may become from an incapacitated participant. A risk is also apparent as in some cases no one will agree to act as a consultee, which would effectively block the involvement of some potential participants. If researchers consistently encounter complications insofar as identifying and appointing consultees, then this may chill their enthusiasm for conducting research involving incapacitated individuals, especially if it is perceived to be an excessively burdensome obstacle that is capable of causing significant harm to time-sensitive research.

The system is also predicated on a misconception that a consultee will always be able to offer a convincing opinion about the values, wishes, and beliefs of an incapacitated

¹¹⁶ Mental Capacity Act 2005, s 32 (4) (a) and (b).

¹¹⁷ See Department of Health, *Guidance on Nominating a Consultee for Research Involving Adults Who Lack Capacity to Consent* (DOH London 2008) at 8.

¹¹⁸ Ibid.

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participant. A personal consultee, as someone who already knows the participant, may be better placed to advise on these considerations than any researcher or nominated consultee, but it is by no means certain that they will be able to do this effectively in every case. In terms of a nominated consultee, the more remote the relationship between her and a participant, the less chance she has of being able to comment accurately on any personal views that participant may hold. Some proposed nominated consultees may recognise this danger and where they have little or no knowledge of a participant may simply decline to become involved, for proceeding on this basis may cause the system to become artificial, and perhaps even harmful. A natural concomitant of this, however, is that the problems of recruitment identified earlier become amplified.

The notion that the consultee system will promote empowerment by attempting to accommodate the subjective position of an incapacitated participant is, in any event, misleading. Placing emphasis on the personal values, wishes and beliefs of incapacitated individuals is sometimes said to be an autonomy-enhancing type of substitute decision-making, but it will not operate as such in every case.¹¹⁹ A consultee must only offer *her opinion* to the researcher about what she considers would be the likely wishes and feelings of an incapacitated participant about involvement in a project, but it is crucial to note that it often may not be the actual wishes and feelings of the participant herself that are conveyed, but simply a consultee's interpretation of them. The more serious the impairment affecting capacity, and the more detached a consultee is from knowing a participant personally, the more likely it is that the consultee's advice to the researcher will not closely reflect the wishes and feelings of a potential participant. Given these difficulties, it is a challenge for a consultee to identify the precise scope of her duty and what steps she must take to discharge it. Absent any clearer guidance, she may be hesitant to recommend participation. This may sometimes be sensible, but if over-cautious thinking from an untrained consultee prevails, it may lead to her misinterpreting certain signals from an incapacitated participant as objections, when they are actually not. If this happens, it has potentially far-reaching consequences for encouraging wider participation as a consultee effectively enjoys a power of veto if they advise that participation should not go ahead.¹²⁰

¹¹⁹ See *Wye Valley NHS Trust v B* [2015] EWCOP 60; Skowron (n 3); Lucy Series ‘The Place of Wishes and Feelings in Best Interests Decisions: *Wye Valley NHS Trust v Mr B*’ (2016) 79 *Modern Law Review* 1101.

¹²⁰ Mental Capacity Act 2005, s 32(5).

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The lack of clarity may also cause consultees to think that they can actually make a decision for an incapacitated participant by attempting to step into her shoes.¹²¹ This view is misguided, for an opinion cannot be legitimately justified by a claim that it is what a participant would have wanted to happen if she had capacity, when in fact she may never have had it in the first place.¹²² Signs of a confused sense of responsibility begin to emerge here. The consultee does not provide consent for an incapacitated participant, she simply advises. It is actually a researcher who should make a final decision about inclusion, but whether or not this is recognised as being the correct legal position by the various parties involved in the authorisation process is the subject of doubt.¹²³ Technically speaking it is correct to recognise that a consultee has no legal power to consent, but if she is still given the power to advise that participation may be inappropriate, which is then viewed by both researchers and MCA RECs as being determinative, the difference between the power to decide and the mere power to advise effectively evaporates.¹²⁴ The upshot is that consultees may frequently play a defining role in the authorisation of research and this accords to them powers which exceed those initially contemplated by the Act.¹²⁵

The drafting of the MCA adds a further layer of confusion in terms of the obligations it creates. While it is incumbent on a consultee to offer an opinion on an incapacitated participant's wishes and feelings, the Act itself does not specifically direct a researcher to consider things from that perspective.¹²⁶ It is left to the COP to clarify that researchers have a continuing obligation to consider the person's wishes and feelings, but we have already highlighted that is inappropriate where the matter is of such crucial importance.¹²⁷ An impression is thereby created from the terms of the MCA that researchers have no specific duty to consider things from the perspective of the participant, as this is a role that is to be performed exclusively by the consultee. It would be regrettable if this misunderstanding become

¹²¹ In legal terms, this is known as the substituted judgment approach. It has not been endorsed in England, but has been used in some American cases. See *Strunk v Strunk* [1969] 445 S.W.2d 145.

¹²² For an interesting discussion on this point see Shaun D Pattinson, *Medical Law and Ethics* (5th edn, Sweet & Maxwell, 2017) at 149 and 455.

¹²³ Mental Capacity Act 2005, s 32 (4) (a) and (b); Mental Capacity Act 2005: Code of Practice, para [11.27]. It should be noted here that the researcher does not 'consent' for the participant either.

¹²⁴ Above (n 120).

¹²⁵ Mental Capacity Act 2005, s 32 (4) (a) and (b).

¹²⁶ Mental Capacity Act 2005, s 32 (2) – (6).

¹²⁷ Above (n 90).

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widespread, as it is dangerous to rely on the consultee system to fill this void. If researchers inadvertently lose sight of these key elements, or at least attach less importance to them, this is problematic. This is because, more often than not, it is a researcher and not a consultee who may be best placed to consider how aspects of a particular project may impact upon the personal circumstances of an individual, and to provide her with the help and support she needs to make a decision for herself. The MCA's entire system of research regulation needs to emphasise this more explicitly.

We have insufficient space here to provide a comprehensive discussion regarding how to optimise supported decision-making. However, one possible starting point is the judgment of Baker J in *CC v KK*.¹²⁸ One of the issues to be decided in the case was whether the applicant had capacity to make decisions about where she should live. Baker J warned that assessing capacity from a “blank canvas” was inappropriate and stressed that a person under consideration needs to be provided with relevant information and detailed options so that their capacity to weigh up those options can be fairly assessed.¹²⁹ Equally, it is not a requirement that a person has to demonstrate an ability to understand and weigh up every nuance and detail, as long as she understands the salient factors.¹³⁰ If support is provided to help a person achieve this, it may change the outlook of a number of capacity assessments. For example, on the facts, Baker J suggested that some steps that the local authority may wish to consider taking could involve a series of overnight trial visits, with all the necessary support, to enable the applicant to reach a decision about whether she wished to move back home or if she would prefer to remain in a nursing home.¹³¹ Even though *CC* did not concern research, the key message is the same: it is crucial to take all practicable steps to enable a person to make a decision for herself.¹³²

Researchers, then, should be encouraged to provide potential participants with relevant information about a project in a way that is comprehensible to that individual. Tailored steps must also be taken to assist that person to understand the key points of the project, and to encourage her to enter into a dialogue about what the research is intended to achieve. This could include, *inter alia*, techniques such as the provision of easy read materials, visual aids

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¹²⁸ *CC v KK and STCC* [2012] EWHC 2136; [2012] 7 WLUK 861.

¹²⁹ *Ibid* at [68].

¹³⁰ *Ibid* at [69].

¹³¹ *Ibid* at [75].

¹³² *Ibid*.

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3 and flash cards to assist in comprehension. We are by no means claiming that this is a definitive
4 formula to ameliorate the difficulties associated with implementing a supported decision-
5 making model in practice, but what we propose are at least some suggestions that could be
6 employed to assist a person, where possible, to make her own decision about participation in
7 research.
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12 The final question we now address is whether the additional requirement of needing to
13 gain approval from an MCA REC adds anything more of value to the approval process.
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17 ***iii) MCA RECs***

18 A MCA REC retains overall responsibility for the final authorisation of any project involving
19 incapacitated participants and its seal of approval is needed to render any intrusive research
20 lawful.¹³³ This oversight serves multiple functions, such as promoting integrity in research,
21 maintaining high standards of ethical practice and assessing whether or not a researcher has
22 discharged all her obligations under the legislation. A MCA REC may also review any
23 considerations pertaining to capacity, and on occasion provide advice to a researcher on
24 arrangements for appointing a consultee. Given the enhanced vulnerability of incapacitated
25 participants, the need for specialist MCA REC supervision was introduced to inject an
26 enhanced layer of independent objective scrutiny to the approval process.¹³⁴ In theory, this
27 may seem like a sensible attitude, but its effectiveness should not go unchallenged. It has been
28 common practice for some time now to obtain approval from an appropriate ethics committee
29 before any type of research involving human participants takes place, whether capacitous or
30 not.¹³⁵ The NHS has its own ethics committees, so too have other organisations.¹³⁶ With this
31 in mind, imagine hypothetically that the specific provisions of the MCA were not enacted; if
32 that were the case, a university social science researcher proposing a project involving the use
33 of incapacitated participants would still be obliged by her institution to seek approval from one
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49 ¹³³ Mental Capacity Act 2005, s 31.

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51 ¹³⁴ HL Deb 18 June 2004, vol 422, cols 69 - 70: https://api.parliament.uk/historic-hansard/written-statements/2004/jun/18/mental-capacity-bill#S6CV0422P2_20040618_CWS_5. <Accessed 26th February 2019>.

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53 ¹³⁵ See UK Research Integrity Office, *Code of Practice for Research: Promoting Good Practice and Preventing Misconduct* (UK Research Integrity Office 2009).

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55 ¹³⁶ See, amongst others, the Health Research Authority: <https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-committees-overview/>; the British Psychological Society: <https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct>.

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of its own ethics committees before any work commenced, so a natural question to ask is: what extra, if anything, is gained by the MCA's insertion of mandated MCA REC authorisation?

One advantage resides in the nature of the obligation created. While there are some exceptions, the majority of more mainstream research on human participants is referred to ethics committees on the basis of good practice, rather than being a specific legal requirement.¹³⁷ Thus, in the hypothetical scenario presented above, without any legal direction from the MCA, a university researcher wishing to use incapacitated participants in a routine project would only be bound by a professional obligation to seek ethical approval, not a legal one. Admittedly, if she proceeded without it, she may well be subject to professional regulatory sanctions for misconduct in research, but that is different than characterising her conduct as being unlawful. It is here where the benefit of the MCA's insistence on specific approval from a MCA REC becomes apparent, for it sends out a powerful symbolic message in identifying that intrusive research involving vulnerable incapacitated participants is deserved of a special legal status. A possible deterrent effect is as well brought to the fore because the consequences of failing to gain ethical approval are potentially more serious where that omission would lead to not only unprofessional, but also to unlawful, activity. Where a researcher is aware of this, it is perhaps likely to induce a greater incentive to comply with the legal requirement imposed by the MCA, thereby ensuring that projects will be subject to a greater degree of specialist scrutiny. Accordingly, it seems plausible to suggest that the obligation to gain approval from a MCA REC has the potential to positively influence the way people think about research and incapacitated participants, particularly because it signifies that especial measures must be adhered to in the approval process. The theory behind its inclusion therefore may have some merit, but nonetheless there are other concerns.

The insistence upon approval from a specific MCA REC, instead of a more general ethics committee, is presumably based on the fact that the former will have the opportunity to develop specialist expertise in dealing with proposals that seek to involve incapacitated participants. MCA REC members will receive customised training that will assist them in assessing whether the requirements for approval have been adequately met. Nevertheless, the composition of a particular committee may impact upon outcomes. Membership of a MCA REC should include a range of individuals from a variety of different backgrounds, including

¹³⁷ For a list of the types of research that require ethical approval by law, see Health Research Authority, Governance Arrangements for Research Ethics Committees (HRA 2018) at [2.3]. It should be noted that most reputable academic journals require proof of ethical approval where human participants have been involved.

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both professional people and lay representatives.¹³⁸ This inevitably means though that they will have varying degrees of expertise across different fields, depending on the experience of the individuals sitting on them. Experts who have worked in psychiatry and mental health will naturally have an important role to play in sitting on such a specialist committee, but the extent to which each separate committee will include members with significant expertise in assessing capacity by reference to the legal test is somewhat unknown. There is no assurance that this important question will receive the same amount of rigorous scrutiny as it would do in a formal court setting.¹³⁹ This problem is not confined to the question of capacity, because if a particular MCA REC happens to have an experienced lawyer well versed in interpreting statutes amongst its membership, there may well be closer examination of the myriad of different meanings that could be ascribed to the thresholds for approval than would be present in other MCA RECs that do not possess the same personnel.

The logistics of the approval process may also frustrate matters. There are circumstances in which an on-going project will be the subject of periodic review from a MCA REC, but more often than not the approval process is anticipatory and forward-looking in nature. Researchers are not supposed to recruit participants beforehand, so any inquiry by a MCA REC is somewhat limited to exploring the procedures that have been put in place for ensuring that capacity assessments are carried out appropriately, and for securing the appointment of consultees. Within this, a MCA REC will probably want to check a researcher's experience and understanding of assessing such things as capacity, but it is unlikely to be able to assess individually the capacity of each participant for itself. This means that a MCA REC has to put significant faith in a researcher's ability, and we have already demonstrated that some will experience difficulty in dealing with complex issues such as capacity, not through any fault of their own, but because it is a nebulous and participant-specific concept.¹⁴⁰ The disadvantage of forward-looking scrutiny is not exclusive to capacity, but also plagues the further conditions for approval. We have illuminated that many of the factors that fall to be examined under those provisions should be recognised as inherently subjective questions. The potential effect that a project may have on an incapacitated participant must, therefore, be considered from the angle of that individual. Nonetheless, the precise individual

¹³⁸ See HRA Guidance: <https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/become-rec-member/>. <accessed 26th March 2019>.

¹³⁹ Case (n 99).

¹⁴⁰ Gunn (n 97); Palmer (n 105).

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9 is often unidentified at the approval stage and it follows that a MCA REC is precluded from
10 engaging in any rigorous subjective scrutiny.¹⁴¹ Based on this, the dichotomy of responsibility
11 between a researcher and a MCA REC becomes even more pronounced.
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14 The legislation dictates that the ultimate responsibility for ascertaining whether the
15 requirements under section 31 have been met rests with a MCA REC, but prospective
16 researchers would be well advised to carry these requirements in mind when initially designing
17 any project. However, throughout this piece we have demonstrated the multitude of
18 interpretations that could, potentially, attach to the approval requirements and there is no
19 certainty that a researcher and a MCA REC will think about these issues in the same way. Some
20 members of a MCA REC could, for example, treat certain research requirements as being
21 analogous to a best interests standard and review them with that in mind. A researcher, on the
22 other hand, could view them in an alternative way, with more exclusive focus on mitigating
23 risk rather than seeking to highlight any benefits. The potential for inconsistency between the
24 various levels of decision-maker is thereby exacerbated. Similarly, certain MCA RECs may
25 adopt a lenient approach to assessing the criteria for approval, whereas others may embrace a
26 more hard-line stance. This may tempt a researcher to identify what are perceived to be more
27 sympathetic MCA RECs when deciding where to send a project for approval, but if such
28 cherry-picking becomes commonplace it would be unfortunate, as it could undermine the very
29 need to gain ethical approval in the first place.
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32 Very little is actually known about how MCA RECs operate, both in terms of the
33 volume and type of research that they are asked to approve, and of the actual dynamics of their
34 decision-making processes. In the light of this, McHale's assertion is undoubtedly accurate that
35 this is an area in which further empirical research is required to gain a better understanding of
36 how MCA RECs actually function in practice.¹⁴²
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39 **E. Conclusions**
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42 The fact that the MCA sought to address the issue of intrusive research involving incapacitated
43 participants is commendable. Had it overlooked the issue entirely, which was not beyond the
44 realms of possibility, a considerable gap would have continued to exist in the law of England
45 and Wales.¹⁴³ However, some of the problems that we have alluded to may have derived from
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¹⁴¹ Bartlett (n 12) at 90.

49 ¹⁴² McHale (n 5); Dixon-Woods (n 95). See also the details of the ASSENT Project @ UEA, above (n 45).

50 ¹⁴³ HL Deb 10 January 2005, vol 668, cols 17 – 18. <https://api.parliament.uk/historic-hansard/lords/2005/jan/10/mental-capacity-bill>. <Accessed 26th February 2019>.
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the main thrust of the MCA being focused on treatment, welfare and financial decisions as opposed to research.¹⁴⁴ The research provisions operate from the wrong standpoint and arguably continue along a skewed trajectory, perhaps betraying the fact that research was very much an afterthought. Insufficient time seems to have been devoted to identifying clear aims and objectives and to creating an effective regime that would adequately meet them.¹⁴⁵

Certainly, the research sections do not appear to sit comfortably with the other aspects of the MCA and, in places, appear to have been rather restrictively drafted.

Establishing a separate set of substantive tests that must be met in order to gain approval does not, in reality, achieve the objective of providing a fair balance between protection and empowerment. This goal could arguably have been better achieved by assessing the existing objective and subjective factors that must be considered under a traditional section 4 MCA best interests assessment. The additional measures introduced that require the appointment of a consultee and the final approval from a MCA REC are also of questionable effectiveness. The idea that a third-party consultee can act as an effective advocate and thus empower an incapacitated participant by ensuring that her voice is heard is frustrated by its impracticalities. A system that promotes co-operation between a researcher and a participant, with a renewed emphasis on seeking positive assent from a participant, may be a more desirable method of guaranteeing greater emphasis on supported decision-making.¹⁴⁶ Similarly, very little is known about how a MCA REC actually forms its opinion, and about what is at the forefront of the minds of its members when making a decision on a given project. Significant variation in interpretation of the requirements for approval could lead to a pattern of inconsistency between MCA RECs, which has the potential to undermine the perceived value of the system. What is clear, however, is that the manner in which the research requirements have been drafted creates the impression that the researcher, the consultee and the MCA REC are subjective to differing

46 ¹⁴⁴ See the literature cited above (n 4), and also Marcus Jepson *et al.*, ‘Indirect Payments: When the Mental
47 Capacity Act Interacts with the Personalisation Agenda’ (2016) 24 *Health and Social Care in the Community* 623;
48 Marie Poole *et al.*, ‘Going Home?: An Ethnographic Study of Assessment of Capacity and Best Interests in People
49 with Dementia being Discharged from Hospital’ (2014) 14 *BMC Geriatrics* 56; Jill Manthorpe *et al.*, ‘Early Days:
50 Knowledge and Use of the Mental Capacity Act 2005 by Care Home Managers and Staff’ (2011) 10 *Dementia*
51 283.

52 ¹⁴⁵ HL Deb 18 June 2004, vol 422, cols 67-70: [https://api.parliament.uk/historic-hansard/written-
53 statements/2004/jun/18/mental-capacity-bill#S6CV0422P2_20040618_CWS_5](https://api.parliament.uk/historic-hansard/written-statements/2004/jun/18/mental-capacity-bill#S6CV0422P2_20040618_CWS_5). <Accessed 26th February
54 2019>. This Hansard debate discusses the aims of the MCA 2005. Research is only mentioned sparingly.

55 ¹⁴⁶ Shiggins (n 54); Amanda Sibley *et al.*, ‘Developing a New Justification for Assent’ (2016) 17 *BMC Medical
56 Ethics* 1. DOI 10.1186/s12910-015-0085-x; Amanda Sibley *et al.*, ‘Assent is not Consent’ (2012) 38 *Journal of
57 Medical Ethics* 3; Susan Slaughter *et al.*, ‘Consent and Assent to Participate in Research from People with
58 Dementia’ (2007) 14 *Nursing Ethics* 27.

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obligations which all potentially overlap, but which may not necessarily be viewed in that way.
This sense of confusion may cause researchers to become disillusioned with the system of
approval and therefore reluctant to consider incapacitated participants in the future. If the
research provisions of the MCA are having this effect, they are arguably impeding the very
type of activity that they should be seeking to promote and this ought to be recognised as a
problem that needs resolving.

Endnote: This article provides a doctrinal analysis of the law and did not involve human participants. As such, ethical approval was not required for this research. However, the empirical components of the larger scale ASSENT Project at UEA obtained ethical approval from the Social Care REC, London. REC Reference: 18/IEC08/0042; IRAS Project ID: 244132. Professor Rob Heywood was the lead author of this article, and is a Co-Investigator on the ASSENT Project. Dr Karen Bunning is the Principal Investigator on the ASSENT Project. All other authors are Co-Investigators on the ASSENT Project.

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