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Best interests and relationality in reproductive healthcare

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Introduction

Choices about health care are some of the most important, challenging and emotive decisions we make. For many, decisions about reproductive healthcare specifically can be life-changing, for example deciding to terminate a pregnancy[1] or refusing interventions during childbirth. In making healthcare decisions, many of us draw on our familial relationships and wider networks for advice, support and guidance. As many other chapters in this edited collection have identified, a mother is often instrumental in steering her daughter through pregnancy and childbirth, as well as wider reproductive decisions. In this way, one of the prospective grandparent's roles is to draw on their own experience to support their child in this process. However, as other chapters in this collection also demonstrate, a grandparent's relationship with their grandchild may, in some instances, create legal rights and duties of its own which leapfrog the parent, or at least come into conflict with the parents' rights. While some in this collection are supportive of giving grandparents procedural or even substantive rights in relation to their grandchildren, I express some caution about how this could play out in healthcare law, an area with links to, but distinct from, family law. The complex and interwoven relationship between grandchild, child and grandparent requires careful consideration before we permit any expansion of legal rights for the grandparent.

This chapter explores these intergenerational relationships in a particular social context. It specifically focuses on relationships between women and their own mothers as they become, respectively, mothers and grandmothers. This gender dimension of the social aspect of parenthood and

[1] That is in no way to suggest that decisions about terminations are necessarily exceptional or distressing, merely that they can change the direction of a person's life.

grandparenthood is important, partly because reproduction remains a gendered phenomenon which impacts upon mothers to a greater extent than fathers due to the biological realities of pregnancy and childbirth. The evidence is overwhelming that women most often turn to their mothers for support, rather than their fathers or other family members, during pregnancy and following childbirth and so the special and particular nature of the relationship between child, mother and grandmother is worthy of focus in this chapter.[2] However, the gender dimension is also a relevant factor in the cases that arise in both the disciplines of healthcare law and family law.[3] For example, we know that maternal grandmothers are more likely to be involved in kinship care, whether informally or formally through care proceedings.[4] Therefore under both a social and legal analysis, the focus on child, mother and grandmother is justified.

In addition to the gender dimension, the substantive scenarios I consider in this chapter concern cases where the daughter has a disability or impairment and therefore raise issues of mental capacity. Sometimes these women are referred to as 'vulnerable',[5] which can be hugely stigmatising, notwithstanding attempts by feminists to adopt a more nuanced and inclusive conception of it.[6] In light of this, the chapter draws on the jurisprudence of the Court of Protection (CoP), the court that deals with cases that arise under the Mental Capacity Act 2005 (MCA). Where a person is found to lack the

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[2] S Winterburn, and M Jiwa, and J Thompson, 'Maternal Grandmothers and Support for Breastfeeding' (2003) 17 *Journal of Community Nursing* 4; R Negron, A Martin, M Almog, A Balbierz EA Howell, 'Social Support During the Postpartum Period: Mothers' Views on Needs, Expectations, and Mobilization of Support' (2013) 17 *Maternal Child Health J*ournal 616; I Nenko, SN Chapman, M Lahdenperä, JE Pettay and V Lummaa 'Will Granny Save Me? Birth Status, Survival, and the Role of Grandmothers in Historical Finland' (2021) 42 *Evolution and Human Behavior* 239.

[3] For further analysis of the gendered dimension of these areas of law, see L Pittman, 'Doing What's Right for the Baby: Parental Responses and Custodial Grandmothers' Institutional Decision Making' (2014) 2 *Women, Gender, and Families of Color* 32; K Cook and K Natalier, 'Gender and Evidence in Family Law Reform: A Case Study of Quantification and Anecdote in Framing and Legitimising the 'Problems' with Child Support in Australia' (2016) 24 *Feminist Legal Studies* 147; S Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Abingdon, Routledge, 2016).

[4] P McGrath and L Ashley (2021), Kinship Care: State of the Nation Survey 2021, available at: https://kinship.org.uk/kinship-annual-survey-2021/, 14, 16.

[5] J Herring and J Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act', (2015) 35 Legal Studies 698; J Lindsey, 'Developing Vulnerability: A Situational Response to the Abuse of Women with Mental Disabilities', (2016) 24 *Feminist Legal Studies* 295; B Clough, 'Disability and Vulnerability: Challenging the Capacity/Incapacity Binary' (2017) 16 *Social Policy and Society* 469; L Pritchard-Jones, 'The Good, the Bad, and the 'Vulnerable Older Adult'', (2016) 38 *Journal of Social Welfare and Family Law* 51; J Herring, *Vulnerable Adults and the Law* (Oxford, Oxford University Press, 2016).

[6] Lindsey, Clough, ibid; C Mackenzie et al, 'Introduction: What Is Vulnerability and Why Does It Matter for Moral Theory?' in Catriona Mackenzie and others (eds), *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford, Oxford University Press, 2014).

capacity to make a decision for themselves, the decision must be taken in accordance with the persons' best interests. For the purposes of this chapter, I focus on decisions about reproductive healthcare, most typically caesarean sections, termination of pregnancy, contraception and sterilisation. These cases explicitly, and almost exclusively, concern women. The chapter further concerns cases where a child either has not yet been born, or, where there is a desire to prevent pregnancy. In this respect I am discussing the appropriate role of *prospective* grandmothers in influencing legal determinations that impact upon their daughter and unborn grandchild.

The context of intergenerational relationships in reproductive decision-making is used to illustrate a wider concern about the adoption of a relational approach to the concept of best interests, something which has wider implications beyond mental capacity law, for example in family law too. This contributes to academic and practitioner interest in the concept of best interests, as it is applied across legal jurisdictions.[7] Drawing on autonomy theory in the chapter, I show how the courts have tread a delicate balance between the competing interests of the grandchild, daughter and (prospective) grandmother in their analysis of best interests; acknowledging the primacy of the daughter's autonomy while accepting the relational value of the intergenerational network. The value of drawing on theoretical insights into autonomy throughout the chapter is twofold. First, I highlight that, on a relational autonomy[8] approach, the courts could use the wishes of the grandmother to override the wishes of the daughter, which raises concerns about whose interests are really being protected. Second, I highlight the wider risk in incorporating a strong relational approach through the law through analysis of the wider context in which best interests decisions are made in family law. The relational nature of human interaction certainly requires that her wider network is drawn upon for evidence in any weighing up of best interests. However, I argue that the courts should draw on the prospective grandmother's

[7] M Donnelly, 'Best Interests, Patient Participation and The Mental Capacity Act 2005', (2009) 17 *Medical Law Review* 1; J Herring, 'Forging a Relational Approach: Best Interests or Human Rights?', (2013) 13 *Medical Law International* 32; HJ Taylor, 'What are 'Best Interests'? A Critical Evaluation of 'Best Interests' Decision-Making in Clinical Practice', (2016) 24 *Medical Law Review* 176; C Kong, *Mental Capacity in Relationship: Decision-Making, Dialogue, and Autonomy* (Cambridge, Cambridge University Press, 2017); C Kong, J Coggon, M Dunn and A Ruck Keene, 'An Aide Memoire for a Balancing Act? Critiquing The 'Balance Sheet' Approach to Best Interests Decision-Making', (2020) 28 *Medical Law Review* 753.

[8] C Mackenzie and N Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford, Oxford University Press 2000); SJ Khader, 'The Feminist Case Against Relational Autonomy', (2020) 17 Journal of Moral Philosophy 499; J Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford, Oxford University Press 2011).

evidence to contextualise the person at the heart of the case rather than considering the wishes and/or interests of the prospective grandmother herself. That is, to understand what the *woman's own* wishes and feelings are. This is an important distinction, which, I argue, is blurred by various relational approaches to law.

I start with an overview of the relevant legal frameworks governing mental capacity law, specifically in the domain of reproductive decision-making. I then move on to my focus on the concept of autonomy, comparing liberal and relational interpretations. The chapter shows how both liberal and relational conceptions of autonomy are implicitly invoked in judgments to balance best interests, as well as highlighting links with the best interests concept in family law. Finally, I show how the courts must be careful in incorporating relational autonomy-based reasoning into their judgments, because it risks placing primacy on the wishes of the wider family network rather than prioritising the wishes of the individual.

The Legal Context

Not all adults are permitted by law to make their own decisions in life. For example, where they are found to lack the mental capacity to make certain decisions, they can be made on the person's behalf in their best interests.[9] In those cases, the views of a person's wider network can be hugely influential, notwithstanding that the concept of 'next of kin' has no legal effect because the application of the MCA means that the person with capacity, or the relevant best interests decision-maker where they lack capacity, has decision-making authority.[10] As other chapters have identified, many cultures and societies would see the influence of family and wider networks as both inevitable and positive. However, the appropriate role that grandmothers ought to play is contested, with concerns about them overstepping the boundaries and taking a malignly maternalistic approach towards their children and grandchildren.

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[9] Mental Capacity Act 2005 (MCA), s 4. See also discussions of legal personhood, which can impact upon decision-making, N Naffine, *Law's Meaning of Life: Philosophy, Religion, Darwin and the Legal Person* (Oxford, Hart Publishing, 2009).

[10] Note that there are exceptions to this, for example, where a family member (or another person) has been granted a power of attorney or deputy to deal with the incapacitated adult's affairs, see MCA, ss 5, 9, 14 and 24 in particular.

Turning to the requirements for decision-making under the MCA, the legislation requires that unwise decisions are not treated as incapacitous decisions. Simply because a prospective grandmother views her daughter's wishes as unwise, for example, by refusing a caesarean section and putting her unborn grandchild at risk, that does not mean that the grandmother has any legal recourse to override her daughter's wishes. The legal test under the MCA for whether a person has the mental capacity to make decisions about healthcare has two stages. It requires that the person has an impairment or disturbance in the functioning of their mind or brain[11] and that, as a result, they are unable to make a decision because they cannot understand information relevant to that decision; cannot retain that relevant information; cannot use or weight it; or cannot communicate their decision.[12] Further, it requires that a person understands the reasonably foreseeable consequences of the decision.[13] In the context of medical treatment, the issue typically turns on what information is relevant to the decision. For example, whether it extends to the impact of the treatment decision on one's family or friends or the impact on the fetus. The case law on these points is well established; the information relevant to medical treatment decisions is narrowly drawn to include a 'broad, general understanding'[14] of the risks and benefits of the treatment in question. This may include some general understanding of the availability of alternative options and their comparative risks and benefits, but the person need not all options available to them in detail. The more complex the healthcare decision, the more likely it is that incapacity will be proven. For example, a decision to consent to a sterilisation procedure is likely to be more complex than a decision to consent to contraception, with the latter being having fewer long term consequences than an irreversible procedure such as sterilisation.

The CoP has, mostly successfully, emphasised that it is a capacitous person's right to make any decision they like, for any reason at all and the importance of respecting unwise decisions through a clear statutory statement within the MCA should not be underestimated.[15] However, once a person is found to lack the mental capacity to make a decision, a decision can only be made on that person's

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[11] MCA, s 2.
[12] MCA, s 3(1).
[13] MCA, s 3(4).
[14] *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342.
[15] Ibid.

behalf if it is in their best interests to do so.[16] What is in a person's best interests extends beyond their medical interests to include a much wider range of factors.[17] This is set out in the legislation, which states that in determining best interests the following must be considered:[18]

> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
> (c) the other factors that he would be likely to consider if he were able to do so.

The factors considered under the best interests test are subject to analysis throughout this chapter. In particular, I argue that some CoP decisions demonstrate a very fine line between the best interests of the person herself and the interests of her wider network. For example, anyone involved in caring for the person must also be consulted on her best interests.[19] Of course, the statutory legal position is clear that others are to be consulted to help determine the best interests of the person herself. Yet, on a deeper analysis, it is not always clear that it is how the law is interpreted in practice.

Liberal or Relational Autonomy: Competing for Best Interests

Analysis of relevant CoP case law shows that the courts have, in some instances, tried to uphold the concept of autonomy as self-determination, even where the person at the centre of the decision has been found to lack the capacity to make the relevant decision. They have mainly done this by prioritising the wishes of the person through interpretation of the best interests test. Autonomy is a complex concept, which is not always used or applied consistently through this (or other) areas of law, meaning that the

[16] There is also the more challenging scenario where a person may be found to have capacity to make the decision but is subjected to the inherent jurisdiction of the High Court instead to justify intervention, for further analysis in this context see Halliday (n3).
[17] See for example *Re Y (Mental Patient: Bone Marrow Donation)* [1996] 2 FLR 787.
[18] MCA, s 4(6).
[19] MCA, s 4(7).

courts invoke different ideals of autonomy, and not always overtly, depending on the case before them. There are various interpretations of it, ranging from individualist/liberal, to relational understandings.[20] In very general terms, use of the word 'autonomy' connotes an ideal of self-determination: that a person can and should be able to make their own decisions about their own lives. This is often not the form of autonomy that is upheld in the CoP as a person's express wishes can be, and often are, overridden.[21] Skowron explains that, in the CoP, '[j]udges tend to use whatever ideas about personal 'autonomy', a word that is not legally defined, best suit their rhetorical needs in the immediate case, whether or not their usage can coherently account for the law as a whole.'[22] I agree and take his analysis further in the section below by contrasting how the liberal and relational interpretations of autonomy can both be seen in CoP judgments. For the most part, the CoP has balanced the competing intergenerational interests in these cases to respect the primacy of the woman's autonomy while acknowledging the importance of relationships to achieving autonomy. However, there is emerging evidence that the best interests of the person at the heart of the decision is unjustifiably displaced by the wishes of her relational network. For the purposes of this chapter, I focus on the wishes of the (prospective) grandmother and her views in relation to best interests. I suggest that analysing the best interests test through a lens of relational autonomy can result in the person's own interests being relegated to those of their wider network, something which may only increase if the rights of grandmothers (or grandparents more generally) are expanded. I further consider how this problem might develop in family law cases too, with the aim of showing how the difficulty arises when we interpret the best interests concept relationally beyond the specific context of this edited collection.

Liberal autonomy

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[20] For an overview of the different approaches to autonomy as relevant to the healthcare context and that I draw on here, see: J Coggon and J Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011) 70 *The Cambridge Law Journal*; Khader (n8); J Warriner, 'Gender Oppression and Weak Substantive Theories of Autonomy' in Marina Oshana (ed), *Personal Autonomy and Social Oppression: Philosophical Perspectives* (Abingdon, Routledge 2015); Nedelsky (n8); M Oshana, *Personal Autonomy in Society* (Ashgate 2006); Sherwin, 'A Relational Approach to Autonomy in Health Care' in S Sherwin (ed), *The Politics of Women's Health: Exploring Agency and Autonomy* (Temple University Press, 1998); Mackenzie and Stoljar (n8).

[21] P Skowron, 'The Relationship Between Autonomy and Adult Mental Capacity in the Law of England and Wales' (2019) 27 *Medical Law Review* 32.

[22] Ibid, 33.

Traditionally, English law has adopted a liberal interpretation and application of autonomy. This typically means that people should be free to make their own choices about their own lives without unjustified interference. The liberal approach to autonomy reflects an endorsement of John Stuart Mill's 'harm principle', that a person's choices can only be interfered with to the extent that it protects another from harm.[23] Debates have been extensive in the literature, with particularly interesting issues being raised by feminist legal scholars as to precisely what harm entails in scope and specificity.[24] It is not necessary for the purposes of this chapter to engage in those debates about harm, although the issue could arise where the daughter's wishes are seen by the grandmother as harmful to the grandchild. However, in broad terms, this approach reflects that people should be allowed to make any decisions about their lives unless or until those decisions are harmful to others, at which point some evaluation of the respective value of their decisions/actions may be weighed up.

The law's endorsement of the liberal approach to autonomy reflects a wider concern about freedom and state interference in individual choices. This defence of freedom has been particularly important from a feminist perspective as women have, historically at least, struggled to have their choices respected by the law.[25] While there has been a movement within feminist scholarship in this area away from liberal notions of autonomy, a more circumspect analysis may be helpful to remind us of the extent to which a woman's wishes were previously sidelined in the interests of her child or wider network. For example, *St George's Healthcare NHS Trust v S*[26] represented an important re-statement of the liberal conception of autonomy. The case was an appeal against an out of hours declaration that it would be lawful to carry out a caesarean section on a 28-year-old pregnant woman, S, without her consent. In the period following the initial declaration and the subsequent appeal, S gave birth to the baby by caesarean section against her wishes. The case before the Court of Appeal centred on whether

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[23] JS Mill, (1909) *On Liberty*. Available at: https://ebookcentral.proquest.com/lib/bham/detail.action?docID=435870 (Downloaded: 3 January 2018).
[24] Ce Fabre, *Whose Body Is It Anyway? : Justice and the Integrity of the Person* (Oxford, OUP, 2006); M Fox and Thomson, 'Bodily Integrity, Embodiment, and the Regulation of Parental Choice' (2017) 44 *Journal of Law and Society* 501; R Fletcher and others, 'Legal Embodiment: Analysing the Body of Healthcare Law' (2008) 16 *Medical Law Review* 321; Naffine (n9).
[25] Z Eisenstein, *The Female Body and the Law* (University of California Press 1988); Fletcher et al, ibid; K Moreton and M Fox, 'Re MB (An Adult: Medical Treatment) [1997] and St George's Healthcare NHS Trust v S [1998]: The Dilemma of the 'Court Ordered' Caesarean' in J Herring and J Wall (eds), *Landmark Cases in Medical Law* (Oxford, Hart, 2015).
[26] [1999] Fam 26.

the hospital had acted lawfully in treating her without consent. It was held that S had the requisite mental capacity to refuse a caesarean section and, therefore, the medical procedure was unlawful. This ruling was enormously important for reinforcing the rights of all adults with capacity, particularly women going through childbirth, to refuse any medical treatment for any reason, even where it puts the life of their unborn child at risk.[27] Halliday makes an important and persuasive case that, despite this ruling, women continue to struggle to have their healthcare decisions respected, particularly in the context of pregnancy and childbirth,[28] because this and other rulings turn on the question of capacity. That is, the right to non-interference is not absolute and depends on the individual's internal decision-making abilities.

While the liberal approach to autonomy is often posited as respecting, in absolute terms, an individual's freedom to make their own choices, on some interpretations individuals who are unable to make their own decisions, by whichever criteria adopted, can have those decisions overruled against their wishes.[29] The difficulty with such an approach, then, is, firstly, how we determine whether or not a person is able to make their own decision. More importantly for this discussion though, is whether or not the person still has a degree of autonomy even where they are found to lack capacity. For example, should the person's wishes and conception of the good life still be relevant once they have been found to lack capacity to make the decision. Eldergill J's comments in the case of *Manuela Sykes* are an important reminder that even incapacitated persons still enjoy autonomy, on some accounts at least:[30]

> The importance of individual liberty is of the same fundamental importance to incapacitated people who still have clear wishes and preferences... This desire to determine one's own interests is common to almost all human beings.

[27] Moreton and Fox (n25).
[28] Halliday at n16.
[29] For further discussion on who counts as law's persons, see Naffine (n9).
[30] *Westminster City Council v Manuela Sykes* [2014] EWHC B9, s 10.

In *GSTT & SLAM v R*[31] Hayden J similarly remarked that '[t]he right of all individuals to respect for their bodily integrity is a fundamental one. It is every bit the right of the incapacitous as well as the capacitous.'[32] This is clearly a facet of the liberal conception of autonomy and its underpinning conceptual justification of non-interference. That all of us have some right to determine whether or not our liberty or bodily integrity can be compromised is an important backstop against the state, professionals and others with the power to override our wishes, something which has been brought into stark reality and not always fully protected against during the Covid-19 pandemic.[33] The values of bodily integrity and liberty are intimately linked, something that has been particularly emphasised by feminist scholars highlighting, for example, the medical profession's power over women's bodies.[34] A similar argument can be made in respect of kinship power with the complexities of liberty and bodily freedom within controlling family dynamics.[35] However, it is still the case that adults can have both their liberty and bodily integrity lawfully compromised if they are found to lack the mental capacity to make a decision for themselves, if it is in their best interests to do so, despite Hayden J's comments.

For example, in many cases women have been found to lack the mental capacity to make a decision about childbirth and have had caesarean sections forced on them, even against their express wishes.[36] Hayden J's point is, of course, more subtle. It alludes to the importance that we place on bodily integrity in our social, legal and moral world.[37] Such that just because a person lacks the mental capacity to make a particular decision, that does not mean that they can have their bodily integrity interfered with against their wishes. Even where infringing their bodily integrity would benefit them in some way, for example medically, there is no automatic entitlement to interfere with their bodily integrity as doing

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[31] [2020] EWCOP 4.
[32] Ibid, para 48.
[33] See for example, T Hickman, E Dixon and R Jones, (2020) 'Coronavirus and civil liberties in the UK', available at: https://www.ucl.ac.uk/laws/news/2020/apr/dr-tom-hickman-qc-co-authors-report-coronavirus-restrictions-law; D Studdert and MA Hall, 'Disease Control, Civil Liberties, and Mass Testing — Calibrating Restrictions during the Covid-19 Pandemic' (2020) 383 *New England Journal of Medicine*.
[34] Lord Woolf, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 *Medical Law Review* 1; Fletcher et al (n24); M Fox and J Lindsey, 'Health Law, Medicine and Ethics' in Rosemary Auchmuty (ed), *Great Debates in Gender and Law* (Macmillan International Higher Education, 2018); J Lindsey, 'Psychiatric injury claims and pregnancy: Re (a Minor) and Others v Calderdale & Huddersfield NHS Foundation Trust [2017] EWHC 824' (2018) 26 *Medical Law Review* 117.
[35] V Bell, *Interrogating Incest: Feminism, Foucault and the Law* (Abingdon, Routledge, 1993); J Miles, 'Family Abuse, Privacy and State Intervention' (2011) 70 *Cambridge Law Journal* 31.
[36] Halliday (n16).
[37] Naffine (n9).

so must be in the person's best interests. Case law suggests that for bodily integrity to be interfered with under the best interests test, there must be a proportionate level of justification to the interference.

Returning to the issue of grandparents and the law, the strong wishes of a prospective grandmother in relation to her prospective grandchild must still be couched in terms of the person's own best interests for healthcare decisions. For example, the grandmother cannot simply insert her own wishes to persuade a judge that her daughter's views should be overridden. This is the case even where the daughter is a child, provided that she is *Gillick* competent[38] to make the decision herself or, where she is not, the daughter's best interests still prevail over the grandmother or grandchild. By way of example, in *A Local Authority v K*[39] Cobb J was unwilling to authorise a request from parents for the sterilisation of their daughter, K, on the basis that it was not the least restrictive option at that point in time. K was a 21 year old woman with Down's Syndrome and a learning disability. She lived with her parents and there was a perception that the relationship was generally positive. However, as K was maturing and gaining more independence, her parents believed that there was a risk of pregnancy. They attempted contraception via K's general practitioner, but the hormone implant procedure was distressing for K and, according to her parents, over the following months while on contraception, K became 'difficult to manage'.[40] Following this, K was referred to a Consultant Gynaecologist and Obstetrician who recommended sterilisation, with the support of K's parents. The sterilisation, had it been authorised, would have been non-therapeutic, meaning that it provided no particular health benefits to K; she was not experiencing any pre-menstrual difficulties nor any other specific health difficulties that would be alleviated by sterilisation. Following expert evidence on the issue, which was unsupportive of sterilisation, the court held that, at that point in time, the sterilisation procedure was not in her best interests because it was not the least restrictive option, but it was an issue to which the court was willing to return in the future. This approach, while reflecting that K lacked capacity and, therefore, she did not have full autonomy to make her own healthcare decisions, did at least show some respect to her autonomy conceived as freedom from interference in that she was not forcibly treated against her

[38] See *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112.
[39] *A Local Authority v K* [2013] EWHC 242.
[40] Ibid, para 6.

wishes, showing that any interference at the request of others has to be limited by what is in the best interests of the person themselves.

This approach, I suggest, reflects an invocation of the liberal conception of autonomy; that even where a person, here *K*, is unable to meet the criteria for making her own decisions, her wishes should still be given weight and should not be replaced with the wishes of the prospective grandparents because she still has some right to live a self-determined life not overridden by the views of others, even those who know her best. Given the challenges women face having their healthcare decisions respected through the law (and the application of it), we must be careful in expanding any legal rights of (prospective) grandparents to override the autonomy of their daughters. It was right in this case that the CoP did not concede to the wishes of the prospective grandparents in analysing the best interests test. Doing so would have reduced, or at least reframed, K's best interests according to the interests of others.

A relational approach?

Despite showing some respect for the liberal notion of individual autonomy of the incapacitated adult, the CoP has also implicitly incorporated the concept of relational autonomy in some instances, which leaves open the possibility for greater interference by grandmothers and wider familial networks under the application of the best interests test. Relational autonomy is a theoretical approach developed predominantly by feminist scholars who argue for a more socially constitutive analysis of autonomy.[41] It draws on the concept of relationality, which focuses on the interconnected or 'nested'[42] relations through which people live in the world. This means that being relationally autonomous is not an individualistic position in relation to the world, but a relative position within his or her social context. On a relational approach we do not just analyse the individual decision and measure the extent to which it was rational and self-determining, but we can look to the conditions within which the person made that decision, their ways of thinking and self-reflection, and the influence of those around them.

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[41] Notwithstanding that there are a wide range of interpretations of the concept of relational autonomy with which different relational theorists may themselves disagree, see Mackenzie and Stoljar, Khader, MacKenzie and others, Oshana, Nedelsky, (n20).
[42] Nedelsky (n20).

Relational autonomy general subdivides further between procedural and substantive accounts, with both being evident in the operationalisation of the best interests concept, as explained further below. Procedural approaches to relational autonomy look at the process by which decisions are made by the individual to determine whether or not they are autonomous, but they are neutral regarding the substance of the decision itself.[43] This means that the focus is on the decision-maker, including her competencies and self-reflection abilities, rather than the course of action ultimately decided upon. Diane Meyers, for example, sets out a procedural account of autonomy as 'competency autonomy theory'.[44] In this approach she argues that people are autonomous to different degrees depending on the extent to which they have been able to develop the various competencies necessary for self-determination. Meyers' theory incorporates the relational element too, although writing before Mackenzie and Stoljar's seminal book on the topic, through recognising the importance of social context while requiring only that capacities are developed in an autonomous manner. This means that where a person has the competency to make decisions for herself and has reflected, as an agent, on her own values, then even if what might externally be regarded as oppressive social conditions have become embedded within that person's belief system, on Meyers' account she is likely to still be acting autonomously.[45] This highlights how a procedural account of autonomy, even considered relationally, is fundamentally distinct from liberal and substantive approaches.

In an intergenerational context, a procedural relational autonomy analysis could include considering the impact of the woman's mother on her opportunities to develop decision-making competencies and the extent to which she was facilitated to engage in self-reflection as an individual. For example, if a woman decides to refuse a blood transfusion because she feels under pressure to do so for religious reasons imposed by her own mother, this may be viewed as a non-autonomous decision under a procedurally relational account if the woman was unable to reflect on her own religious beliefs

[43] For further analysis see C Mackenzie and N Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford, Oxford University Press, 2000).

[44] D Meyers, *Self, Society and Personal Choice*, (New York, Columbia University Press, 1989).

[45] Discussed further in J Lindsey, Maximising Women's Autonomy in the Regulation of Assisted Reproduction, King's College London 2010.

or given any opportunities to develop her own decision-making competency.[46] In contrast, substantive accounts of relational autonomy require us to look at the content of the decision as an indicator of whether or not it is autonomous.[47] In the example given, this would mean setting aside the influence of the mother on the woman's decision-making abilities throughout her childhood and adolescence, and instead analysing the mother's role in impacting the final decision to refuse a blood transfusion. For example, an outsider could determine whether the decision is substantively autonomous by weighing up whether or not a blood transfusion is in the self-determining interests of the woman and in accordance with her own values in wanting to, for example, protect the life of the fetus. Substantive relational accounts of autonomy in some ways have more in common with liberal accounts of autonomy than procedural accounts because under liberal and substantive approaches, scholars have argued that certain decisions (or people) are not autonomous.[48] The result can mean that individuals who are seen as lacking autonomy can have their choices overruled. Thus, a lack of autonomy also impacts on liberty.[49]

Relational autonomy has been developed particularly as a response to overly individualistic conceptions of autonomy that have permeated legal philosophy, which value higher order reasoning and rationality as necessary conditions for acting autonomously.[50] As Harding has explained 'the subject that law seeks to regulate is often one that is artificially removed from her interpersonal context, especially when individual approaches to autonomy are elevated at the expense of relational

[46] There are many reported cases regarding refusal of blood transfusions by Jehovah's Witnesses, which is perhaps unsurprising given the difficult ethical issues raised by these cases, see *Re T* (*Adult: Refusal of Treatment)* [1992] Fam 95, *Re L (A Minor)* [1998] 6 WLUK 164, *HE v A Hospital NHS Trust* [2003] EWHC 1017, *E&F (Minors: Blood transfusion)* [2021] EWCA Civ 1888. While there are cases that indicate this approach, one difficulty with this area of law remains that reported judgments are relatively limited and often lack detail about the various parties involved, for a critique of reliance on reported judgments in this area see: R Harding, 'The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance', (2015) 78 *Modern Law Review* 945; J Lindsey, 'Testimonial Injustice and Vulnerability: A Qualitative Analysis of Participation in the Court of Protection' (2019) 28 *Social & Legal Studies* 450; J Lindsey, 'Competing Professional Knowledge Claims About Mental Capacity in the Court of Protection', (2020) 28 *Medical Law Review*, 1 .

[47] Oshana (n20).

[48] Coggon and Miola (n20); Herring and Wall (n5).

[49] For more detailed analysis on the different conceptions of autonomy in this context, see C Kong, *Mental Capacity in Relationship: Decision-making, Dialogue and Autonomy* (Cambridge, Cambridge University Press, 2017).

[50] For a useful overview in this context see Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge, Cambridge University Press, 2010).

understandings of decision-making'.[51] While I understand the feminist motivation for emphasising relations in rethinking autonomy, I am less convinced that relationality is necessarily incompatible with liberal autonomy or feminist approaches to legal philosophy, despite the stark debates we see between relational and liberal theorists within healthcare law and beyond.[52] I have written elsewhere that, depending on your conception of rational self-interest,[53] it may be possible to incorporate relational thinking into the liberal conception, without abandoning the value that the liberal conception provides in terms of liberty and non-interference. For example, it can be rationally, morally and legally defensible to act in one's self-interest, where the definition of self-interest goes beyond individual bodily boundaries. This means that it is rationally in one's self-interest to care about the wishes and views of your family, friends and community and that in weighing things up we analyses the variety of influences in our lives to come to a *contextually rational* decision.[54]

This can often be seen in responses to domestic and sexual abuse, something considered in Harwood's chapter in this collection. Where victims remain in relationships, or continue contact, with their abusers, their decisions can be criticised as highly irrational on the face of it. However, there are complex relational factors at work which, in many instances, mean the victim's decision to maintain a relationship at that point in time is an entirely rational one.[55] This argument is particularly acute in the context of intergenerational relationships, which are the subject of this edited collection. Imagine a multi-generational household, consisting of grandparents, daughter and grandchild. A scenario whereby the parents are perhaps controlling of their adult daughter but who, without her own parents' financial, material and social support, would not be able to care as effectively for her own child (their grandchild).

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[51] R Harding, *Duties to Care: Dementia, Relationality and Law* (Cambridge, CUP, 2017), 17.

[52] S Sherwin, 'A Relational Approach to Autonomy in Health Care' in S Sherwin (ed), *The Politics of Women's Health: Exploring Agency and Autonomy* (Temple University Press, 1998); J Christman 'Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves' (2004) 117 *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 143; AC Westlund, 'Rethinking Relational Autonomy' (2009) 24 *Hypatia* 26; C Mackenzie, 'The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability' in C Mackenzie, W Rogers and S Dodds (eds), *Vulnerability: New essays in ethics and feminist philosophy* (Oxford, Oxford University Press, 2014); B Clough, 'New Legal Landscapes: (Re)Constructing the Boundaries of Mental Capacity Law' (2018) 26 *Medical Law Review* 246; Khader (n8).

[53] Lindsey (n5).

[54] A similar argument has been made in different ways by, for example, Khader (n8) who suggests that from the outside it may not be clear why a person is acting in a particular way, but from their standpoint they are making correct judgments based on their social situation.

[55] C Humphreys and RK Thiara, 'Neither Justice Nor Protection: Women's Experiences of Post-Separation Violence' (2003) 25 *Journal of Social Welfare and Family Law* 195.

In that scenario, remaining in the multi-generational household may be entirely rational and self-interested, if only in the short term while the daughter seeks to make alternative arrangements for herself and her child. Relationships are complicated, but taking those relationships outside of the bounds of self-interest and rational deliberation further exceptionalises, rather than normalises, them.

There are different conceptions of relational autonomy, but the core of each is that they reject the rational, atomistic, self-interested decision-maker as the model for being autonomous. Despite the problems with the liberal conception of autonomy, my concern in replacing it with any form of relational approach, substantive or procedural, is that it can operate to justify paternalism by placing too much weight on context and the person's wider network, at the expense of avidly defending individual rights. In the specific context of grandparents it could, as I show below, allow the wishes of a prospective grandmother to outweigh the wishes of her daughter. I make the argument here in respect of CoP proceedings, but if such a theoretical approach takes hold in jurisprudence, there is a risk of cross-fertilisation to other areas too given the close link between the best interests tests in family law and mental capacity law.[56]

Relational autonomy in the courts

We can see a relational approach taking hold in legal scholarship throughout social welfare and family law, predominantly a procedurally relational approach. Jonathan Herring for example has emphasised the value of relational autonomy across family, healthcare and mental capacity law.[57] Most specifically, we can see relationality through the application of the best interests concept, which transcends these otherwise distinct areas of law with some clear overlap in the interpretation and application of the concept. Camillia Kong , for example, has more specifically argued that the MCA and associated law indicates that 'autonomy must assume a much more relational rather than individualistic temper'.[58] To

[56] This is particularly relevant here because most CoP judges are family court judges too or at least have experience in family law. Also see, S Choudhry, 'Best interests in the MCA 2005: What can Healthcare Law learn from Family Law?' (2008) 16 *Health Care Analysis* 240; A Daly, 'No Weight for "Due Weight"? A Children's Autonomy Principle in Best Interest Proceedings' (2018) 26 *The International Journal of Children's Rights* 61.
[57] J Herring, (2013) 'Forging a Relational Approach: Best Interests or Human Rights?' 13 *Medical Law International* 32; J Herring, *Law and the Relational Self* (Cambridge, Cambridge University Press, 2019).
[58] See Kong (n49), 67.

some extent she is making a normative argument, but her statement captures a wider view that mental capacity law does, in fact, incorporate relational approaches to autonomy and she makes this argument specifically in respect of the best interests test.[59] If this is true, which it appears to be in certain interpretations of best interests at the very least, then it raises some concerns which come to the fore when seen in light of the possible expansion of grandparents' rights, but also in relation to best interests assessments more broadly.

The current approach under the MCA, drawing on several prior family law cases including *Re F (Mental Patient: Sterilisation)*[60] and *Re A (Male Sterilisation)*,[61] has clearly embedded a relational approach. The MCA sets out that regard must be given to the relevant circumstances of the decision[62] and the views of:

> (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
>
> (b) anyone engaged in caring for the person or interested in his welfare,
>
> (c) any donee of a lasting power of attorney granted by the person, and
>
> (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

This means, in practice, that it is a legal requirement to consult those around the person to enable the decision-maker (or the CoP) to make a judgment about what is in the person's best interests. This is a deeply relational approach; it requires, by law, to consult the views of the people around the decision-maker and recognises the importance of relationships to understanding the person themselves. This is not simply a case of information gathering. It is an explicit recognition that the views of those close to us matter. It reinforces our socially constituted existence as humans. Of course, these views are primarily meant to be ascertained for epistemological reasons: to facilitate a better understanding of the

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[59] Ibid.
[60] [1990] AC 1.
[61] [2000] 1 FLR 549 560 F-H.
[62] MCA, s 4(2).

person's best interests, rather than to supplant that with the wishes of the family member. However, this is a fine line and one which is not always clearly drawn by the courts. This highlights the potential risks of taking a relational approach to best interests.

In medical decision-making for example, best interests is not simply about what is in the person's narrow medical interests with the law approving the non-therapeutic donation of bone marrow for example, something that had no medical benefits to the person herself at all.[63] Such an approach might be welcomed for recognising that people do not always, or even primarily, act in their own self-interest but care deeply about the position of those close to them, even in relationships which may be less than positive. While this is clearly an accurate description of decision-making for most of us, it is an approach which has also raised some concerns. For example, such a case highlights the potential conflict not only between children and their parents, but also between differing parental obligations towards different children which might conflict,[64] an issue explored further in the example below. In *AN NHS Foundation Trust v MC* the judge was highly critical of the evidence before him which only referred to the patient's best interests in cursory terms:[65]

> Nowhere is there at the centre of what is being considered either by the treating Trust or the Human Tissue Authority, the best interests of the donor. Ms Gollop for the Trust helpfully referred to me to the passage within the accredited assessor's report and it is right that there is a passage headed 'Best Interests' but Ms Dolan is also right to say that it is cursory.

This is precisely the difficulty where best interests moves away from the individual to be seen in more substantively, rather than procedurally, relational terms. We can clearly see relationality in individual judgments of the CoP too. The judges do not expressly say they are using 'liberal' or 'relational'

[63] See *Re Y (Mental Patient: Bone Marrow Donation)* [1996] 2 FLR 787; *AN NHS Foundation Trust v MC* [2020] EWCOP 33.
[64] For a full discussion of the useful example of so-called 'saviour siblings' see, S Sheldon and S Wilkinson, 'Should Selecting Saviour Siblings be Banned?' (2004) 30 *Journal of Medical Ethics* 533.
[65] Para 21.

autonomy though. Instead, we can infer from the reasoning used how the concept of autonomy is being deployed. There are a number of high profile CoP cases which engage autonomy, including *Wye Valley NHS Trust v B*[66] and *Westminster City Council v Sykes,*[67] but an earlier judgment of the CoP is particularly instructive here. *Re GC*[68] concerned an 82 year old man who had been living with his nephew for a number of years living in squalid conditions. As such, an application was made to the CoP to consider whether or not it was in GC's best interests to live at his home given the poor conditions and level of care he was receiving from his nephew. The CoP held that it was in his best interests to return home to live, despite psychiatric evidence to the contrary. The reason for GC's return home, despite difficulties with the living conditions to which he was returning, were entirely relational – that he valued his familial relationship with his nephew and the 'emotional warmth, emotional security and the commitment of human relationship.'[69] GC did express a desire to return home to the care of his nephew, but this alone appeared not to be determinative of the court's judgment. In *GC* the court actively weighed up what was in his best interests, and explicitly referred to the balance sheet approach to best interests in doing so,[70] which is unusual in reported judgments of the CoP. The use of the balance sheet and the factors considered under the balance sheet approach show that the court did not simply defer to GC's own wishes, which would have reflected a liberal conception of autonomy. Instead, the court used the balance sheet to analyse a number of different factors, including the relational benefits of returning home in terms of the emotional and caring dimensions, and, as a result, found in favour of such a decision, despite the risks to GC.[71] This suggests that the court valued the relational factors in the case and they counterbalanced the other factors present, such as GC's own wishes and the risks of harm to GC. That is not to argue that the court took a paternalistic approach, quite the opposite – a paternalistic analysis would have resulted in the risks of harm as *outweighing* the relational benefits and prohibiting a move home.

[66] [2015] EWCOP 60.
[67] [2014] EWHC B9.
[68] [2008] EWHC 3402 (Fam).
[69] *Re GC* [2008] EWHC 3402 (Fam).
[70] Para 18.
[71] Paras 17 – 21.

Even if the outcome would remain unchanged under a liberal autonomy analysis (i.e., GC would still have returned home), the judicial reasoning for the judgment matters. Firstly, it shows greater respect to the agency of a disabled person if the reasoning for the decision is based upon that individual's own wishes. Furthermore, respecting GC's own wishes under a liberal approach is more closely aligned with the requirements under the United Nations Convention on the Rights of Persons with Disabilities, specifically article 12 which prohibits a substituted decision-making approach for disabled people.[72] Secondly, if judges in the CoP move towards a relationally informed approach to best interests, this poses risks both to the individual and, more widely, for the understanding and development of the best interests concept in other cases. I set out these difficulties in the section below, with analysis of possible consequences and concerns of this approach.

In addition to the clear relational dimension for mental capacity law, the case also importantly highlights the similarity in the analysis of best interests under the MCA and the Children Act 1989, despite obvious differences in application, with Hedley J stating:[73]

> [T]he State does not intervene in the private family life of an individual, unless the continuance of that private family life is clearly inconsistent with the welfare of the person, whose best interests the court is required to determine. That is the same principle that governs State intervention under the Children Act 1989, and whilst the Children Act and the Mental Capacity Act deal with quite different problems and must be treated quite separately, in my judgment it is right that the fundamental principle governing the welfare agencies of the State's interventions in private life should be the same.

[72] B Clough, ''People Like That': Realising the Social Model in Mental Capacity Jurisprudence' (2015) 23 *Medical Law Review* 53; A Arstein-Kerslake and E Flynn, 'Legislating Consent: Creating an Empowering Definition of Consent to Sex That Is Inclusive of People With Cognitive Disabilities' (2016) 25 *Social & Legal Studies* 225; A Arstein-Kerslake, *Restoring Voice to People with Cognitive Disabilities: Realizing the Right to Equal Recognition before the Law* (Cambridge, Cambridge University Press, 2017); A Keeling, ''Organising Objects': Adult Safeguarding Practice and Article 16 of the United Nations Convention on the Rights of Persons with Disabilities' (2017) 53 *International Journal of Law and Psychiatry* 77.
[73] Para 14.

This clear overlap between these otherwise distinct areas of family and mental capacity law show that there is at least some degree of cross-fertilisation between these areas which share the concept of best interests. This risks embedding relationality in best interests decision-making beyond the confines of mental capacity law given the close conceptual overlap with family law.[74] For example, as Davey discusses in her chapter on adoption, application of the welfare checklist requires the court to consider before ordering adoption 'the relationship which the child has with relatives'.[75] Davey emphasises the value of grandparents and the benefits of recognising such rights through the law and it is of course important to consider the child's relationship with relatives before something as final as adoption is ordered. However, within family law, analysis of the impact of relationships is too often viewed through the lens of the adults involved, whether that be the family members or professionals. For example, in another chapter in this collection, Fisher-Frank outlines that the child, particularly in private family law proceedings, rarely has her own voice which is directly heard. This means that the child's best interests is analysed through the framing of those adults with the power to do so in proceedings, which in turn can shape the value placed on those relationships by the court. Of course, this is balanced by the expectation that professionals, and ultimately the family court judge, will be able to consider best interests with the child at the centre, but this relies on good evidence gathering and effective representation at court, which is not always present.[76]

A relational autonomy approach to best interests in family law cases could also result in difficulties particularly where there are allegations of domestic abuse. I agree with Harwood's analysis that expanding the role of grandparents in this regard poses significant risks to children. Yet even doing so through the best interests test itself poses risks. By way of example, if the courts are faced with an older child expressing a desire not to have contact with their grandmother, then the court could view this as a substantively non-relationally autonomous decision where there is an inherent assumption that

[74] See also Choudhry, Daly (n56).

[75] Adoption and Children Act 2002, s 1(4)(f).

[76] For critiques of the evidence gathering process in the family court, see AL James, A James and S McNamee, 'Turn down the Volume Not Hearing Children in Family Proceedings' (2004) 16 *Child and Family Law Quarterly* 189; AL James, 'Children, the UNCRC, and family law in England and Wales' (2008) 46 *Family Court Review* 53; A Brammer and P Cooper, 'Still Waiting for a Meeting of Minds: Child Witnesses in the Criminal and Family Justice Systems' (2011) *Criminal Law Review* 925; M Hill, V Welch and A Gadda, 'Contested Views of Expertise in Children's Care and Permanence Proceedings' (2017) 39 *Journal of Social Welfare and Family Law* 42.

kinship care is valuable and beneficial to children. Instead of deferring to the child's wishes, or analysing, procedurally, whether the child is of sufficient competence to make an autonomous decision, the courts could look at the substance of the decision by the child to conclude that it indicates a non-autonomous decision which is not in their best interests.

Examples of this can most starkly be seen in so-called 'parental alienation' cases, a broad term which is difficult to precisely define but typically involves the concern that one parent (often the mother) is trying to alienate their child from another parent (or grandparent) without foundation.[77] This is despite the widespread debunking of parental alienation as a concept since it was first noted by the American child psychiatrist Richard Gardner.[78] A typical example of this arose in *Re H*[79] which concerned H, a 12 year old boy's, contact with his father and paternal family, with Keehan J stating '[t]he father had enjoyed a very good relationship with H up until March of 2018. H also enjoyed a close relationship with his paternal grandparents and paternal relatives. I am satisfied these were mutually loving, fulfilling and beneficial relationships.'[80] Despite H's own wishes to remain living with his mother, Keehan J ordered that H should live with his father due to the mother's parental alienation, meaning a complete and radical upheaval to H's circumstances, including moving to a completely different geographic area, changing schooling and constructing new friendship groups. This decision is characterised by a substantive relational analysis; that the substance of H's decision to prefer the care of his mother indicates that he is not making an autonomous decision because, from a judicial perspective, he is acting under the oppressive influence of his mother and her unfounded views about the father.[81] Instead, respecting the child's own express wishes to remain with his mother, particularly at the age of 12 which is likely to be at the cusp of competence, would provide greater respect to the

[77] See C Bruch, 'Parental Alienation Syndrome and Parental Alienation: Getting It Wrong in Child Custody Cases' (2001) 35 *Family Law Quarterly* 527; JB Kelly and JR Johnston, 'The Alienated Child: A Reformulation of Parental Alienation Syndrome' (2001) 39 *Family Court Review* 249; J Birchall and S Choudhry, '"What About My Right Not to be Abused?" Domestic Abuse, Human Rights and the Family Courts' (Women's Aid, 2018).
[78] Ibid, Bruch.
[79] [2019] EWHC 2723 (Fam).
[80] Para 18.
[81] This is, perhaps, exacerbated by the statutory presumption of parental involvement under Children Act 1989, s 1(2A), albeit such a presumption does not exist in English law in relation to grandparents.

child's autonomy on a liberal account, rather than viewing his best interests in substantively relational terms.

The Risks of Expanding Rights of Grandparents through Relational Approaches

In considering what all of this means more specifically for grandmothers in mental capacity law, I now turn to an example of the type of best interests scenario that has the potential for a harmful relational approach to be incorporated which favours the grandmother's interests over that of the decision-maker herself.

(1) The NHS Acute Trust and (2) The NHS Mental Health Trust v C[82] concerned a pregnant woman, C, who had bipolar disorder and who was also detained under s 2 Mental Health Act 1983. The court heard oral evidence from Ms X, who was C's mother and the prospective grandmother of her unborn child.[83] The CoP proceedings related to C's forthcoming labour as there were concerns that she would be unable to have a natural delivery and her labour would be difficult to manage. It was held that C lacked the capacity to make decisions about medical interventions relating to the birth as she was 'not able to weigh the pros and cons of such interventions, in what was likely to be a dynamic situation with the need to understand and weigh up options at relatively short notice.'[84] C's mother, and the prospective grandmother, gave evidence that '[s]he understood why the application had been made, she would like C to experience some of the birth process but recognised the position needed to be kept constantly under review and, depending on C's state of mind, could see that a caesarean section may be the only option.'[85] It is unfortunate that the grandmother's oral evidence was summarised in only a few lines in this way and I have no doubt that her evidence was much richer than this passage reflects, a problematic phenomenon more generally when considered from a critical perspective.[86] However, the

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[82] [2016] EWCOP 17.

[83] Legally, the status of the child at this point in time is a fetus. However, I use the term 'unborn child' here to indicate that in this scenario the child was born.

[84] Para 8.

[85] Para 6.

[86] The Open Justice Court of Protection Project has provided much greater insights into the realities of CoP evidence, showing that what is summarised in the judgment is rarely a full picture, see https://openjusticecourtofprotection.org/; see also Lindsey (n46); J Lindsey, 'Protecting Vulnerable Adults From

grandmother's wishes (or the judicial framing of them) can be interpreted in two ways. First, it could be seen that the grandmother's wishes are entirely about what is in the best interests of her daughter. That she is concerned for C because, on the one hand she knows that C would want to experience the birth process, but, on the other hand, she knows that it could be harmful to C to have a vaginal delivery. The alternative interpretation is that the grandmother was balancing the interests of C against the interests of the unborn child and, indirectly therefore, her wish to have a healthy granddaughter. These two interpretations are, of course, not mutually exclusive and on a relational analysis, are difficult to separate. However, I suggest that it is essential that we do so otherwise there is a risk of blurring the boundary between what is in C's exclusive best interests, and what is in the interests of others, whether that be her unborn child or her own mother.

C's interests and the interests of her unborn child are, to many people, at least very closely related. In English law, the fetus has no rights until birth[87] and so C's bodily interests, and bodily integrity, must take precedence. Similarly, even from C's subjective perspective, her interests may align with the objective interests of her unborn child, that is, C really wants her baby to have the best chance of survival. Conversely though, if C's wish was to, under no circumstances, have any surgical intervention in her delivery, even if that risks the life of her unborn child, then the imputed wishes of C and the child are in direct conflict. Furthermore, it is not simply C's wishes and her child's that are in conflict, but potentially her interests and those of her existing children, something which particularly strengthens the grandmother's claim if she has existing bonds with her other grandchildren that she wishes to preserve. The potential for sibling conflict is perhaps more akin to the bone marrow donation example above, where we can see that such issues are not always resolved in the strict interests of the individual affected but by reference to her wider network. Drawing such an analogy here might suggest that C's best interests are best served by considering the wider interests of her network, including her

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Abuse: Under-Protection and Over-Protection in Adult Safeguarding and Mental Capacity Law' (2020) 32 *Child and Family Law Quarterly* 157.

[87] For comparison between English law and US and German law on this point, see Halliday (n16). There has been some discussion in a number of English cases regarding overriding the woman's decision-making rights to protect the fetus, see for example *Re T (An Adult) (Consent to Medical Treatment)* [1993] Fam 95. However, so far, English law has only permitted this in the case where the woman lacks the mental capacity to make a decision herself.

own mother's wishes which may be more closely aligned with the court's approach to weighing up the interests of the already living siblings. If the grandmother can provide evidence which is of use to the court in this regard then it may make it easier for a judgment which is not clearly in the mother's own interests to be reached.

Where these different interests come into potential conflict, the courts need to be much clearer about how they are weighing the evidence. The courts have, as outlined above, incorporated a wide range of evidence but with an emphasis on how this illuminates the person's best interests. Yet it is not clear from this judgment for example, whose interests the prospective grandmother's views are supportive of and the opacity of the judgment in this regard is arguably intentional to blur the boundaries of the best interests analysis in favour of a particular outcome. If C's mother is giving evidence about what, based on her relationship with C, she thinks C would want, then that is legitimate. But if C's mother is giving evidence based on her own wishes for her prospective granddaughter, then it is not a legitimate approach. Perhaps it is not so easy to delineate and that is why the courts have not done so, instead obscuring the issues and evidence within the reported judgment. However, it is my contention that they must do so clearly to avoid a risk of restricting, or overriding, the daughter's autonomy. In less mutually supportive mother-daughter relationships, the distinction would be vital to avoid such a risk.

Given the lack of clarity in the reported case law from the CoP, let us imagine a similar scenario to the above, but with some key differences. Imagine that C has a difficult relationship with her mother. They see each other regularly and C values her mother, but C is emotionally dependent on her mother, perhaps due to a history of childhood neglect and periods of her teenage years where C was in care. C also has two other children, who are much loved grandchildren. This scenario is reflective of the more difficult cases that reach the family courts and highlights the complexities of intergenerational relationships for many families. Imagine, then, that during the hearing C's mother gives evidence to the court that she knows her daughter would want a natural birth and would not want any intervention whatsoever. The grandmother goes on to say, though, that on balance, she thinks C should have forced obstetric intervention because, without it, her current grandchildren could suffer and C and the fetus may die. It is the sort of evidence that one might expect to hear in a case such as this, evidence which

would not be particularly unreasonable for a grandmother to give. Yet, how should the court treat this evidence? On a relational analysis of best interests, the grandmother's views do not go to the issue of what her daughter would want, rather they highlight the impact of C's refusal of medical intervention for the grandmother and the existing grandchildren.

A relational autonomy influenced approach has the potential to result in forcibly overriding the wishes of an individual in the name of their best interests as conceptualised by the wishes of another. Even though this is done under the pretext of best interests, in fact it could be the interests of others that are really being prioritised. Such an approach risks undermining individual freedom and bodily integrity under the guise of a seemingly benevolent concept of 'relational autonomy' which ought to be treated with caution here. I have highlighted ways that this might be a particular problem in respect of discourse that expands grandparents' rights, but it also raises wider issues for the application of the best interests test in mental capacity law and beyond, including in family law cases concerning children or where there are allegations of abuse.

Concluding Remarks

I am not rejecting the concept of relationality in this chapter. Nor do I repudiate relationally feminist approaches to autonomy, with which I broadly agree as a descriptor of our social world. Relationality is a more accurate understanding of human existence and reflects the value and significance of intergenerational (and other) relationships to most people. Feminist approaches to autonomy also importantly seek to reject the paternalistic subordination of a woman's will to others. Yet a relational approach to autonomy, substantive or relational, risks doing precisely that. It risks replacing a person's expressed wishes and feelings with the preferences of someone else. I have argued for caution when advocating a relational autonomy approach through the best interests test of the law, given the potential for it to displace the person's own interests with the interests of others and explained how this represents a real risk in the context of expansion of grandparents' rights in particular.

In analysing the role of grandparents and the law, I am concerned that a relational understanding of autonomy can be, and perhaps is being, used to facilitate giving grandparents greater influence than

is epistemologically justified to get to the person's wishes and feelings. In this chapter, I have shown how this has the potential to happen under the best interests test under the MCA. However, it may also impact upon decision-making elsewhere across the Family Division if courts are persuaded that grandparents, for relational reasons, ought to influence the interpretation of best interests.

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