

*Decision-Making
for Persons with
Impaired
Capacity A
Background
Paper*

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help make
better laws.**

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Executive Summary

Impairment of capacity occurs for a number of reasons. These range from intellectual disabilities to mental illness and include acute illnesses, brain injuries and conditions such as dementia, affecting persons of old age. While the ability to make decisions about one's life is usually taken for granted, this presumption gets disturbed in the context of persons with impaired capacity who may need support and, in a few cases, even requires others to make decisions on their behalf. Laws governing capacity and decision-making become relevant in this context.

Such laws, however, represent great complexity at both the conceptual as well as design level since they involve difficult decisions about determining when decision-making interventions become necessary due to lack of capacity. Not allowing decision-making when a person may possess the capacity to make a decision or allowing decision-making when the person does not possess capacity for a particular decision are both ethically fraught matters. In this paper, we analyse the concept of decision-making capacity, where capacity is contextual and decision-specific. This is distinct from legal capacity which refers to the law's recognition of personhood and its related rights and obligations. All persons are ordinarily recognised as possessing legal capacity even though they may not possess decision-making capacity, with the lack of decision-making capacity necessitating decision-making interventions. Determining decision-making capacity, however, is complex and in the past has often resulted in the discriminatory denial of legal personhood to individuals. Distinguishing between legal capacity and decision-making capacity is, however, necessary if laws on capacity and decision-making are to truly further the rights of persons with impaired capacity.

The right to individual autonomy provides the principled basis for recognising the decision-making capacity of all persons. However, in determining the scope of laws on capacity and decision-making, values of well-being and distributive justice must also be considered. Decision-making approaches for persons with impaired capacity range from supported decision-making where the person is the ultimate decision-maker even though they may be supported in various ways in reaching a decision, to substituted decision-making where the decision is taken by a surrogate or is based on advance directives. Different jurisdictions with laws on capacity and decision-making emphasise the importance of realising the autonomy of persons with impaired capacity while adopting diverse approaches for doing so.

The Indian legal framework on capacity and decision-making is scattered and fragmented since it comprises a number of population-specific laws and judicial decisions that try to fill the gap in these laws. A holistic approach to the problem of capacity is lacking. Further, it does not go into sufficient detail regarding the rights of all persons with impaired capacity and lacks various conceptions of decision-making that are well-recognised in both academic literature and in developed jurisdictions. Therefore, it does not fully promote the rights of persons with impaired capacity and often leaves them vulnerable. This calls for reform.

The key features of an Indian legal framework on capacity and decision-making which policy-makers should consider include:

- a. Identifying Target Population Groups and the Nature of Decisions
- b. Guiding Objectives
- c. Approach to Decision-Making Capacity
- d. Approach to Decision-Making
- e. Safeguards to Prevent Abuse

Chapter 1: Introduction - Impairment of Decision- Making Capacity and the Law

A. Context

From the time we wake up in the morning to the time we go to bed at night, our days are consumed with decisions that we make about how to live our lives. In their ubiquity, these everyday decisions perhaps come second only to breathing. They can be as trivial as deciding the time we wake up, what we eat for breakfast or what we wear to work, to complex ones, such as deciding how much money we want to spend or how we want to invest what we save and may include potentially life-altering decisions about whether we want to refuse invasive life-sustaining treatment when it does not further the vision of our lives. Most people take their ability to take such decisions for granted. After all, our belief in our ability to steer the course of our lives is what makes us human. From a legal perspective, this ability is an intrinsic aspect of our rights to individual autonomy, equality and dignity, which international human rights law and most liberal constitutional democracies recognise.

However, often due to a combination of reasons, our capacity to make decisions about our lives and to communicate them may get diminished. Reasons may range from certain developmental disabilities to mental health issues and include the onset of dementia in older persons and unconsciousness resulting from brain injuries. In all these situations, an individual's capacity to take daily decisions may get impaired. It would, however, be erroneous to assume that all such situations lead to a total loss of decision-making capacity. In fact, in most situations, with appropriate support mechanisms, individuals are fully able to take decisions about their lives. In a few instances, however, the person may simply lack the capacity to take decisions, and interventions that allow decision-making on their behalf become essential.

This report contextualises the issue of decision-making for persons with impaired capacity for an Indian audience and sets out the role that a legal framework on capacity and decision-making plays in this regard. This introductory Chapter looks at the different population groups who are affected by impaired capacity, the kinds of decisions that become essential and the role a legal framework on capacity and decision-making plays in this context. The second Chapter analyses the theoretical concepts of autonomy and decision-making capacity as well as the different approaches to decision-making for persons with impaired capacity. The third Chapter critically analyses the existing legal framework on capacity and decision-making in India and argues that it currently falls short since it lacks conceptual clarity and does not sufficiently protect the rights of persons with impaired capacity, thereby leaving them vulnerable. The fourth Chapter gives a brief snapshot of international best practices from jurisdictions with developed legal frameworks on capacity and decision-making. The last Chapter delves into the elements of a potential legal framework for capacity and decision-making in India.

B. Loss of Capacity and the Populations Groups Which Are Disproportionately Affected

Persons with impaired capacity may lose capacity to take decisions for a number of reasons. Historically, impaired decision-making was often expressed through terms such as “lunacy” and “insanity”. However, advances in science have made our understanding of capacity far more nuanced. One of the major acknowledgements has been about

how contextual decision-making capacity can be. It may vary with time, situations and our immediate surroundings. For instance, an otherwise competent person's capacity may become impaired when they face stressful situations or find themselves in unfamiliar settings. Similarly, being called upon to take instantaneous decisions may also momentarily affect a person's ability to reason coherently. Moreover, our relationships may also impact our autonomy and consequent decision-making capacity (This is discussed in more detail in Chapter 2, where we expand on relational autonomy, developed as a critique of autonomy). However, while our more nuanced understanding of capacity in itself requires a general review of the existing law on capacity and decision-making, from a policy perspective, it is certain population groups who are disproportionately affected. It is indeed these groups who are often the primary target of laws relating to capacity and decision-making.

The UK National Health Service identifies persons in the following situations as needing decision-making interventions:¹

- Dementia
- Severe learning disability
- Brain injury
- Mental health illness
- Stroke
- Unconsciousness caused by an anaesthetic or sudden accident

The Law Commission of Ontario, on the other hand, identifies the following:²

- Persons with acute illness
- Older persons developing cognitive disabilities later in life
- Persons with developmental or intellectual disabilities
- Persons with mental health disabilities
- Persons with acquired brain injuries

This indicates that there are broadly four categories of persons who are likely to face issues of impaired capacity:

1. Persons with developmental or intellectual disabilities

In India, the National Mental Health Survey 2015-16 indicates that intellectual disabilities are prevalent in 0.6% of the population amounting to 4 million persons.³ The 2011 census, which used the term "mental retardation", pegged numbers at 870,898.⁴ Persons with developmental and intellectual disabilities, especially those with high support needs, may often need life-long support and care. In India, this function is often performed by families as there are limited support facilities.⁵

2. Persons with mental illness and resulting psychosocial disabilities

According to the 2011 census, the number of persons with mental illness was pegged at 415,758.⁶ Mental illnesses, however, lie across a spectrum and capacity may not be impaired in all situations. The term 'psychosocial disabilities' is used for persons who face barriers in interacting with their surroundings due to mental illnesses and may particularly face issues with regard to decision-making capacity.

¹ National Health Service, *Mental Capacity Act, 2005* <<https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/>> accessed 15 January 2021.

² Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Final Report* (Toronto March 2017), 32.

³ National Mental Health Survey of India, 2015-< <http://www.indianmhs.nimhans.ac.in/Docs/Summary.pdf>> accessed 15 January 2021, 22.

⁴ Disabled Population in India as per census 2011 (2016 updated) <<https://enabled.in/wp/disabled-population-in-india-as-per-census-2011-2016-updated/>> accessed 15 January 2021.

⁵ Satish Chandra Girimaji, 'Intellectual Disability in India: The Evolving Standards of Care' *International Psychiatry* Volume 8 No. 2 (2011), 29-30.

⁶ Disabled Population in India as per census 2011 (2016 updated) <<https://enabled.in/wp/disabled-population-in-india-as-per-census-2011-2016-updated/>> accessed 15 January 2021.

3. Persons of advanced age who may experience loss of cognitive functions in situations including dementia

The Alzheimer's Association estimates that more than 4 million people in India have some kind of dementia.⁷ According to the 2011 census, the prevalence of dementia was reported to be around 2.7%⁸ in a population of 65 million people above 65 years of age, which constitutes 5.5% of the total population.⁹ This is significant, since the prevalence of dementia increases with age and 20% of people above the age of 80 are estimated to have dementia.¹⁰ Further, the WHO predicts that India is likely to see a very high increase in the prevalence of dementia in the coming decades due to a significant rise in population of people aged above 60 years.¹¹ In fact, the Longitudinal Ageing Study in India predicted that persons above the age of 60 years are likely to be 20% of the Indian population by 2050.¹² This represents a significant percentage of the population who may suffer dementia and therefore, may face capacity issues.

4. Persons of any age who may either face acute illness and may suffer periods of incapacity or more permanent situations such as stroke or suffer brain injuries

This category of persons is hard to quantify but would include adults in all age groups who may have their capacity impaired due to acute illness or due to brain injuries. It may include persons who may have become permanently unconscious or may be in a persistent vegetative state. In fact, some of the recent High Court decisions in India have been concerned with decision-making for persons in a comatose state.¹³

Although the above categories are not exhaustive, they indicate population groups who are likely to be vulnerable to impaired capacity and may therefore need decision-making interventions. While arriving at accurate numbers of affected groups may need well-designed large-scale empirical studies, the above estimates indicate the significance of decision-making interventions in India.

C. Types of Decisions

Decision-making issues for persons with impaired capacity often occur in intimate, informal settings. In such situations, more often than not, there is little interaction with the law or State machinery and families or caregivers often support such persons in making their own decisions or end up taking decisions on their behalf. Issues often arise when the law requires a decision by the person with impaired capacity and they are unable to make it. For instance, recent cases in Indian High Courts were concerned with situations where family members had to access the financial resources of the person with impaired capacity, to continue caregiving activities and support other family members.¹⁴ The law would ordinarily require the authorisation of the person with impaired capacity in accessing their financial resources, but the fact of such impaired capacity required family members to approach the Courts instead. Often decisions may be more complex such as the continuance of life-sustaining treatment which was the issue before the Supreme Court in the tragic case of Aruna Shanbaug, who was in a persistent vegetative state following a violent sexual assault many decades ago.¹⁵ The Court had to consider whether someone other than the patient who was not in a position to take the decision, could decide on their behalf. Such situations necessitate decisions, since medical treatment decisions cannot be made without the consent of the

⁷ Alzheimer's and Dementia in India <<https://www.alz.org/in/dementia-alzheimers-en.asp> > accessed 15 January 2021.

⁸ Dementia, National Health Portal < <https://www.nhp.gov.in/disease/neurological/dementia>> accessed 15 January 2021.

⁹ *ibid.*

¹⁰ *ibid.*

¹¹ Shyamal Das *et al*, 'Dementia: Indian Scenario' *Neurology India* Volume 60 Issue 6 (2012), 618-624.

¹² Rhythma Kaul, 'About 75 Million Elderly in India suffer from some chronic disease: health ministry study' *Hindustan Times* (6 January 2021).

¹³ See generally *Sairabanu Mohammed Rafi v State of Tamil Nadu* 2016 SCC OnLine Mad 8091; *Philomena Leo Lobo v Union of India* 2017 SCC OnLine Bom 8836; *Shobha Gopalakrishnan v State of Kerala* 2020 SCC OnLine Bom 880.

¹⁴ Rosy Sequeira, 'Bombay HC allows wife to be guardian of husband in comatose state' *The Times of India* (28 August 2020) <<https://timesofindia.indiatimes.com/city/mumbai/bombay-hc-allows-wife-to-be-guardian-of-husband-in-comatose-state/articleshow/77795050.cms>> accessed 15 January 2021.

¹⁵ *Aruna Shanbaug v Union of India* (2014) 5 SCC 338.

patient, while decisions regarding financial resources or property and living arrangements are necessarily encountered as part of the law's interaction with the business of living.

Buchanan and Brock classify decisions as falling under the broad heads of healthcare, finance or property, living arrangements, and participation in medical science research.¹⁶ While many of these decisions, for instance, transferring an elderly relative to institutional care, may be taken informally, they may end up affecting an elderly person's sense of autonomy and dignity.¹⁷ Therefore, the need for decision-making is both a practical necessity and may often also be required by law, while also deeply affecting the rights of the individual.

The nature of decisions also has a bearing on how we understand capacity, since different decisions may require different levels of capacity; a concept we discuss in greater detail in the decision-making capacity section of Chapter 2. For example, in healthcare decision-making, standards of capacity are usually such that do not exclude persons with lower degrees of impairment and therefore allow the greatest number of persons to participate in healthcare decision-making. This is because of the value that decision-making in healthcare places on individual autonomy. Further, decision-making capacity in such instances is always decision-specific i.e. capacity is always determined relative to a particular treatment decision and not for all healthcare decisions. In contrast, decisions relating to finances and property, such as banking transactions and contracts usually involve global determinations of capacity since third parties usually have an interest in the consistency of such decisions as they have to rely on them.¹⁸ This means that capacity is usually determined for all financial decisions rather than for specific ones.

On the other hand, there are certain decisions such as marriage, sexual relations, electoral decisions where decision-making interventions, especially substituted decision-making, may not be appropriate, thereby effectually preventing persons with impaired capacity from taking such decisions at all. However, there is a very thin line between disallowing certain people from being able to take decisions and discriminating against them. In fact, the enactment of the United Nations Convention on the Rights of Persons with Disabilities ("UNCRPD") was in response to discrimination against persons with disabilities who were often denied their legal capacity due to oppressive guardianship regimes in various jurisdictions. This translated to barring their participation from public life as well as the denial of private rights such as inheritance. Therefore, the linked questions of the kinds of decisions and the capacity they require are significant and often controversial.

D. Law of Capacity and Decision-Making

The law of capacity and decision-making becomes relevant in this context. Such law governs when a person may be said not to possess the capacity to make decisions about their lives and what processes should govern decision-making in such situations. Therefore, it regulates some of the most intimate aspects of our lives and involves the balancing of weighty considerations such as individual autonomy and well-being of the individual. Further, since decision-making is such an intimate act, cultural as well socio-economic factors, such as the cultural practices of different communities or the manner in which power differentials operate, also influence the way in which decisions are made in practice. These factors make this area of law incredibly complex in both its design and implementation. In common law jurisdictions, minors are considered to lack all capacity, therefore the area of law that this paper is concerned with relates solely to questions of decision-making for adults with impaired decision-making capacity.

Traditionally, the State and by extension, the Courts, possess *parens patriae* jurisdiction, which allows them to take decisions for the welfare and care of adult persons who may suffer from impaired capacity and are unable to take decisions for themselves.¹⁹ This has traditionally been done through the appointment of a guardian who takes

¹⁶ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 19-20.

¹⁷ *ibid.*

¹⁸ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 47.

¹⁹ Norman Cantor, 'The Bane of Surrogate Decision-Making: Defining the Best Interests of Never-Competent Persons' (2005) 26 *J Legal Med* 155, 155.

decisions on behalf of the person. Guardianship orders can, therefore, result in the effective civil death of the individual since they cease to possess the ability to take their own decisions in the eyes of the law.

However, with our evolving understanding of the nuanced nature of decision-making capacity as well as developments in the rights discourse, most notably the UNCRPD, jurisdictions across the world have come to emphasise the autonomy, equality and dignity of persons with impaired capacity. Incorporating these developments into this area of the law, however, has also meant greater complexity and further debate about the design of such laws so that decision-making arrangements impose the least restriction on the rights of such persons. Thus, concepts such as the dignity of risk, which allows persons to take reasonable risks and make their own mistakes have been emphasized by disability-rights activists. At the same time matters may get complicated due to the variety of population groups who may be affected by impaired capacity. For instance, the concerns of persons with congenital disabilities who have important stakes in ensuring that they are facilitated in living their life to their full potential may be different from the concerns of the elderly and persons in an unconscious state. This raises questions about the suitability of common approaches for these diverse population groups. Additionally, while in theory, decision-making approaches should promote the rights of autonomy and liberty, there is inadequate empirical basis for evaluating the autonomy-enhancing potential of different approaches. All these factors pose distinct challenges in designing an alternative legal framework to guardianship.

Chapter 2: Autonomy, Decision-Making Capacity and Approaches to Decision- Making

One of the privileges of ability is that we often take our capacity to take day-to-day decisions for granted. This often finds resonance in the legal recognition of an adult individual's right to autonomy and self-determination. However, as Chapter 1 demonstrated, this assumption is often displaced when either aging or a variety of other situations may result in impaired decision-making capacity among different population groups. This immediately requires us to consider whether the situation calls for supported decision-making or whether decisions should be taken on behalf of such persons. Such interventions also involve defining the appropriate threshold for decision-making capacity post which decision-making interventions become necessary.

This Chapter analyses the concept of individual autonomy which is the basis for decision-making capacity, then goes on to analyse the concept of decision-making capacity itself along with the associated concept of legal capacity, and, lastly, traces the two dominant decision-making approaches that become relevant in the context of decision-making for persons with impaired capacity.

A. Individual Autonomy

I. Autonomy and Decision-Making Capacity

In liberal thought, all individual adults are considered autonomous. This implies that they are thought of as capable of taking decisions about their lives. According to the Stanford Encyclopaedia of Philosophy, "*put most simply, to be autonomous is to be one's own person, to be directed by considerations, desires, conditions, and characteristics that are not simply imposed externally upon one, but are part of what can somehow be considered one's authentic self.*"²⁰ In contrast, to be denied the ability to be one's authentic self is to be oppressed or be subjected to paternalism. It is important to note that autonomy and the resultant decision-making capacity, "*is of non-derivative value, independent of the content of those decisions.*" This implies that the moral worth, or for that matter the worthlessness, of our decisions have nothing to do with our capacity to take those decisions, and one's autonomy or decision-making capacity cannot be denied merely on the basis of subjective evaluations of what is good. This is because liberal values that underscore the notion of autonomy, in their approach to political power and social justice, focus on the principle of rights, independent of any conception of the good, thereby allowing for the pluralism of moral conceptions.²¹

Legal philosopher Ronald Dworkin's integrity view of autonomy offers a coherent way of understanding the link between autonomy and decision-making capacity. He points out that valuing autonomy implies valuing not the welfare but the integrity of the individual.²² In this integrity view of autonomy, its value lies in the "*scheme of*

²⁰ John Christman, 'Autonomy in Moral and Political Philosophy' in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2020 Edition), <<https://plato.stanford.edu/archives/fall2020/entries/autonomy-moral/>> accessed 15 January 2021.

²¹ *ibid.*

²² Ronald Dworkin, 'Autonomy and the Demented Self' *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 4-16, 8.

responsibility it creates: autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction and interest.”²³ Thus, rather than individual decisions, each decision contributes to the picture of life and conception of character and achievement which the individual wishes to create, which must be allowed its own integrity.²⁴ Here again, Dworkin emphasises that the integrity-view of autonomy is not concerned with the consequences of individual decisions. Therefore, a person may take decisions that may not always benefit them or that may even be rational, for instance a decision to smoke by an otherwise health-conscious person. Thus, the recognition of an individual’s autonomy is linked to their capacity to direct their lives in accordance with their chosen values in a manner that displays integrity and authenticity.²⁵

In theory, therefore, individuals who have the capacity for integrity and authenticity in their decisions are considered autonomous and capable of exercising decision-making capacity.

II. Valuing Precedent or Prospective Autonomy

While respecting the autonomy of persons who are competent to take decisions is obvious, Dworkin argues that an integrity-based conception of autonomy necessarily implies the recognition of precedent or prospective autonomy of persons who may lack capacity in the present.²⁶ This implies respecting their exercise of autonomy in the past, even though currently, due to the situation they are in (conditions such as dementia etc.), they are incapable of exercising this capacity. Thus, their decisions taken at a time when they had the capacity for integrity and authenticity should be respected even if their current desires contradict their past decisions. Not doing so would violate the integrity-view of autonomy since an autonomous person would be concerned with how they are treated when they lose the capacity to take decisions. Therefore, artificially prolonging the life of a person through life-sustaining treatment may compromise the character of one’s life if they had expressed a desire for withholding or withdrawing such treatment through advance directives when they had the capacity to take such decisions.

Recognising precedent or prospective autonomy has significant implications for decision-making, since wishes and preferences expressed in the past when the individual had the capacity for autonomy, become determinative instead of well-being or desires in the individual’s present state. Dworkin also argues that precedent autonomy can only be given recognition when there is clear and explicit evidence of past wishes and preferences.²⁷ Constructing an individual’s supposed wishes and preferences through mere evidence of their convictions etc., is an imprecise exercise and can only be considered as part of determining their objective well-being or best interests but may not be concerned with their autonomy *per se*. This view, however, may be considered too high a standard for establishing an expression of autonomy and many authors also consider the construction of past wishes and preferences, in the absence of explicit evidence of past decisions, as giving effect to autonomy.²⁸

III. Legal Recognition of Autonomy and Decision-Making Capacity

Laws generally presume the autonomy and decision-making capacity of all individuals. This presumption of autonomy, however, only extends to adults who are considered to have the capacity to take such decisions. In Indian law, persons below the ages of 18 are considered below the age of majority and therefore are presumed to not have capacity.²⁹ This necessitates a legal framework that facilitates decision-making on behalf of minors. Provisions of the Guardians and Wards Act, 1890 and other religion-specific family laws currently provide for guardianship for minors. Such guardians are usually considered to have the authority to take a wide variety of decisions including decisions regarding the minor’s person and property. In some limited contexts, however, minors are accorded limited autonomy and their capacity to participate in decision-making is recognised. For

²³ *ibid.*

²⁴ Ronald Dworkin, ‘Autonomy and the Demented Self’ *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 4-16, 8.

²⁵ *ibid.*, at 9.

²⁶ *ibid.*, at 13.

²⁷ *ibid.*, at 14.

²⁸ For a general discussion, see Allen Buchanan and Dan W. Brock, ‘Deciding for Others’ *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94.

²⁹ See The Majority Act, 1875.

instance, regulations on ethical practices in clinical research apart from consent of the legal guardian/parent also require the participation of minors possessing the requisite level of maturity in assenting to clinical trials.³⁰

The right to decisional autonomy for adults has been held to be a part of the right to privacy by the Supreme Court of India. In its judgement in *Justice KS Puttaswamy v. Union of India*,³¹ the Supreme Court held that the right to privacy was a fundamental right and was part of the right to liberty and dignity enshrined in Article 21 of the Constitution. In his plurality opinion, Chandrachud J., observed that, “[p]rivacy safeguards individual autonomy and recognises the ability of the individual to control vital aspects of his or her life. Personal choices governing a way of life are intrinsic to privacy.”³² The Court specifically included the preservation of “personal intimacies, the sanctity of family life, marriage, procreation, the home and sexual orientation”³³ as part of the right. Since *Puttaswamy*, the Supreme Court has recognised the right to individual autonomy in various specific instances, such as the right to choose a partner,³⁴ health autonomy and the right to refuse treatment³⁵ and sexual orientation.³⁶ In fact, in *Common Cause v. Union of India*,³⁷ by recognising advance directives in the context of withholding and withdrawing of life-sustaining treatment for terminally ill patients, the Court recognised the concept of precedent autonomy in healthcare as well.

Therefore, the right to autonomy and the consequent ability to take decisions regarding important aspects of one’s life is well-recognised in Indian constitutional law. Moreover, the constitutional rights of dignity and equality also provide an important basis for thinking about the equal recognition of capacity in all persons.³⁸ This approach specifically accounts for the historical denial of equal capacity to various population groups such as persons with disabilities. It is for this reason, that in line with the UNCRPD, Section 13 of the RPWD recognises that persons with disabilities should enjoy legal capacity on an equal basis with all others.³⁹

The concept of autonomy in healthcare, however, is of older vintage. Patient autonomy and the consequent right to refuse treatment, now considered the cornerstone in the practice of western medicine, came to be well-recognised in common law over the course of the twentieth century.⁴⁰ Patients’ informed consent is said to have corrected the “imbalance of knowledge within the physician-patient relationship.”⁴¹ Cases in the United States have therefore stressed not only on consent to a particular procedure but also on the relaying of the facts necessary to make the decision.⁴² Similarly, in the United Kingdom, cases such as *Montgomery v. Lanarkshire Health Board*⁴³ have stressed that information cannot be withheld from patients on the basis that such withholding is in the best interests of the patient. Further, disclosure of all risks and patient-specific disclosure of information is necessary to respect patient autonomy.⁴⁴ The legal recognition of patient autonomy and consent also correspond to ethical shifts in thinking about doctor-patient relationships – from a beneficence-centred conception, where the practice

³⁰ See Third Schedule, New Drugs and Clinical Trial Rules, 2019.

³¹ *Justice KS Puttaswamy v Union of India* (2017) 1com0 SCC 1.

³² Conclusions Part T(F), *Justice KS Puttaswamy v Union of India* (2017) 10 SCC 1.

³³ Conclusions Part T(F), *Justice KS Puttaswamy v Union of India* (2017) 10 SCC 1.

³⁴ *Shafin Jahan v Asokan K.M.*, 2018 SCC OnLine SC 343; *Shakti Vahini v Union of India* 2018 (7) SCC 192.

³⁵ *Common Cause v Union of India* MANU/SC/0232/2018.

³⁶ *Navtej Singh Johar v Union of India* (2018) 10 SCC 1.

³⁷ *Common Cause v Union of India* MANU/SC/0232/2018.

³⁸ Article 14 of the Indian Constitution recognises the right to equality, while the Supreme Court has interpreted the right to dignity as being part of the right to life in Article 21 of the Constitution. See *Common Cause v Union of India* Writ Petition (Civil) No. 215/2005.

³⁹ Section 13(2), Rights of Persons with Disabilities Act, 2016.

⁴⁰ Justice Cardozo’s famous statement in *Scholendorff v Society of New York Hospitals* 211 N.Y. 125, 105 N.E. 92 (1914), “Every human being of adult years and sound mind has right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages” is said to have laid down the foundation for the informed consent doctrine in healthcare. Also see, Jonathan F Will, ‘A Brief History and Theoretical Perspective on Patient Autonomy and Medical Decision Making’ *Chest* 2011 Jun;139(6):1491-1497.

⁴¹ *ibid.*

⁴² *Salgo v Leland Stanford Jr University Board of Trustees* 154 Cal. App. 2d 560.

⁴³ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁴⁴ *ibid.*, Also see, Justice KT Desai Memorial Lecture 2017 on Law of medicine and the individual: current issues What does patient autonomy mean for the courts? by The Rt Hon Lady Justice Arden DBE.

of benevolent deception or deliberate withholding of information from patients was acceptable, to an autonomy-centred conception.⁴⁵

In India too, the Supreme Court in *Samira Kohli v. Dr Prabha Manchanda*,⁴⁶ has recognised the necessity for consent for any treatment, including surgical interventions. Further, legislations such as the Mental Healthcare Act⁴⁷ and the HIV-AIDS Act⁴⁸ define “informed consent” in the context of specific treatments. The decision in *Samira Kohli* has since been followed in cases of medical negligence and has been understood to imply that adequate information regarding the treatment should be furnished by the doctor to the patient before their consent can be considered valid.⁴⁹ Therefore, while the standards for consent may vary across jurisdictions, the concept of patient consent for treatment is well-recognised.

IV. Critiques of Autonomy

While conceptions of individual autonomy have dominated liberal thought, feminist scholars have pointed out various situations where autonomy may be restricted due to social conditions such as in the case of women who internalise oppression and therefore do not make free choices.⁵⁰ The concept of “relational autonomy” therefore stresses on the role, “*that relatedness plays in both persons’ self- conceptions, relative to which autonomy must be defined, and the dynamics of deliberation and reasoning.*”⁵¹ In simpler words, this implies the effect of our relationships and social dynamics on the exercise of our autonomy and decision-making. This philosophical focus on relatedness, therefore, sheds light on how often decision-making and the consequent exercise of autonomy plays out in real-life settings. For instance, in the context of healthcare decision-making, Jonathan Herring, by relying on the notion of relational autonomy, argues for the need to account for caregiver interests in medical decision-making.⁵² Therefore, he points to the need of an “ethics of care” approach which views people not only as individuals but also through the lens of inter-dependent relationships.⁵³

These critiques are philosophically significant since they highlight the many factors which contribute to decision-making in everyday settings and while they may not replace the pre-eminence of self-determination, they can suitably inform legal and policy responses in specific settings.

B. Understanding Decision-Making Capacity and Legal Capacity

Laws often deny legal personhood to individuals on grounds of “unsoundness of mind” and “lunacy”. The meaning of these terms either depends on tests laid down in various laws or on judicial interpretation. As a result, there is often a conflation of the concepts of “decision-making capacity” and “legal capacity”. The precise meanings of capacity and its various uses is therefore hard to pin down. This is because different disciplines including medicine, law, ethics and philosophy offer unique perspectives to our understanding of capacity. Further, setting a definitional standard has far-reaching consequences for the concerned individual, since a finding of incapacity can lead to severe deprivation of rights in terms of potential loss of legal personhood. In fact, the association of incapacity with persons suffering mental illnesses or developmental disabilities has led to severe discrimination, stigmatization and resultant marginalisation of such communities. As a result, many laws on capacity and decision-

⁴⁵ Jonathan F Will, ‘A Brief History and Theoretical Perspective on Patient Autonomy and Medical Decision Making’ *Chest* 2011 Jun;139(6):1491-1497.

⁴⁶ *Samira Kohli v Dr Prabha Manchanda* 1(2008) CPJ 56 (SC).

⁴⁷ Section 2(1)(i), Mental Healthcare Act, 2017.

⁴⁸ Section 2(n), The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2019.

⁴⁹ *Suresh Chandra Mytle v United India Insurance* 2016 Indlaw NCDRC 799; *Nizam Institute of Medical Science v Prasanth S. Dhanankha* 2009 Indlaw SC 1047.

⁵⁰ John Christman, ‘Autonomy in Moral and Political Philosophy’ in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2020 Edition), <<https://plato.stanford.edu/archives/fall2020/entries/autonomy-moral/>> accessed 15 January 2021.

⁵¹ *ibid.*

⁵² Jonathan Herring, ‘Caregivers in Medical Law and Ethics’ 25 *J. Contemp. Health L. & Pol’y* 1 (2009), 10.

⁵³ *ibid.*, at 35.

making contain explicit anti-discrimination guarantees.⁵⁴ However, on the other hand, attributing capacity to persons who may otherwise not possess the requisite mental faculties, and subsequently making them legally responsible for their actions is not only ethically vexed but also opens up the possibility of abuse. The question of capacity is therefore an ethically complicated one.

This section first discusses the theoretical meaning of decision-making capacity and second explains the distinction between decision-making capacity and legal capacity.

I. Elements and Assumptions of Decision-Making Capacity

At the heart of the laws relating to capacity and decision-making is the concept of decision-making capacity. Determining the threshold of capacity has far reaching implications for the rights of individuals. For instance, once a determination has been made that a person lacks decision-making capacity and therefore the competence to take certain decisions, they virtually lose their ability to exercise their legal rights associated with that decision. Further, there may sometimes be a distinction between how capacity is understood in the law and purely medical determinations of capacity. For our purposes, however, we are only concerned with the legal definition of decision-making capacity. In law, the notion of capacity is often traced to the principle of individual autonomy and self-determination, as discussed above. However, laws relating to capacity and decision-making often also try to balance autonomy with the need to advance individual well-being or welfare in their approach to decision-making capacity.⁵⁵

In discussing the concept of capacity, scholars have forwarded different definitions and stressed on diverse aspects, thereby highlighting its complexity. Most of this literature, however, has been concerned with healthcare decision-making. While the concept of capacity in other contexts such as financial decisions, contracts and property transactions, may be based on similar principles as well, external considerations such as the interests of third parties may also influence approaches to capacity for such decisions.

Jennifer Hawkins and Louis Charland outline some of the key elements and assumptions of capacity which find broad consensus in literature on healthcare decision-making.⁵⁶ In terms of the elements of capacity, they identify: 1) Choice, 2) Understanding, 3) Appreciation, and 4) Reasoning as key basic elements of decision-making capacity. Choice refers to the ability to express and communicate choice and at its most basic level simply means the ability to express a decision. Understanding refers to the most basic mental requirement of understanding the facts involved in making a decision. Appreciation refers to the individual's ability to appreciate the nature and significance of the decision and the facts involved in making it. Lastly, reasoning refers to the ability to reason and use the facts which the individual has understood and appreciated to reach a decision. These four elements are considered necessary for a person to possess capacity, however, as Hawkins and Charland point out, attributes such as emotions, values and the authenticity of individuals' choices have also been forwarded as elements of capacity by some theorists.⁵⁷ However, since they usually do not represent the minimum attributes, we are not detailing them further.

In terms of assumptions of capacity, Hawkins and Charland identify the following assumptions which are broadly agreed upon in the context of healthcare decision-making:

- **Inclusivity** – implies that whichever notion of capacity we adopt, it should allow the maximum number of persons to exercise decision-making in pursuance of their right to individual autonomy.

⁵⁴ See Section 21, Mental Healthcare Act, 2017.

⁵⁵ *ibid.*

⁵⁶ Jennifer Hawkins and Louis C. Charland, 'Decision-Making Capacity' in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2020) <<https://plato.stanford.edu/archives/fall2020/entries/decision-capacity/>> accessed 15 January 2021.

⁵⁷ *ibid.*

- **Decision Relativity** – stresses on the fact that capacity should be determined relative to decisions, at a particular time, and in particular contexts. This means that capacity is always for a specific decision and therefore the term “decision-making capacity” which acknowledges that different decisions may require different levels of capacity. Further, even for a single individual, capacity may vary over time and in different contexts, thereby making global determinations of capacity for all kinds of decisions inappropriate.
- **All-or-Nothing Assessment** – while capacity may be decision-specific, once capacity is determined, it becomes what Buchanan and Brock refer to as a ‘threshold concept.’⁵⁸ This implies that once a person is determined to lack decision-making capacity for a particular decision, there is no question of allowing the person to make the decision anymore and decision-making is left to appropriate decision-making interventions.
- **Value Neutrality** – implies that once individuals are determined to possess decision-making capacity, they should be able to make whatever decision they want to, irrespective of whether such decisions are unpopular or disapproved of by others. This means that their decisions should not be scrutinised subjectively.
- **Independence from Diagnosis** – implies that a person cannot be held to lack decision-making capacity merely on the basis of a medical diagnosis and instead capacity will have to be determined for specific decisions. This aspect specifically addresses issues of persons with mental illness and cognitive impairments who have long been discriminated against due to a denial of capacity based on diagnosis.
- **Risk and Symmetry** – implies that decision-making capacity may also depend on the risks associated with certain decisions. This can be understood in two ways. First, the risks of consenting to and refusing a treatment are often not the same. For instance, if a person is refusing a simple, but otherwise life-saving treatment, then their decision may have grave consequences for them, including death, as opposed to merely consenting to a specific treatment. At a more general moral level, Buchanan and Brock argue that if our understanding of decision-making capacity is informed by the conflicting moral concepts of individual autonomy and welfare, a process of determining the threshold of decision-making capacity is an attempt at balancing these concepts.⁵⁹ Thus, if a certain decision poses a higher risk to welfare, then the threshold for allowing the individual to exercise their choice becomes higher and vice versa.⁶⁰

Decision-making capacity is therefore an extremely nuanced concept which seeks to set thresholds for decision-making intervention. The elements and assumption of capacity both define the concept and set its standards. In most instances, determining capacity or the lack of it may not be problematic. For instance, a person who is unconscious or in a persistent vegetative state simply cannot make decisions. On the other hand, most persons with mental health illnesses and cognitive impairments can make decisions. It is the cases of borderline incompetence that pose challenges to policymakers and raise difficult questions. Apart from the question of a threshold of decision-making capacity, issues of who determines capacity and what are the exact processes through which decision-making capacity should be assessed also become significant.⁶¹

⁵⁸ Allen Buchanan and Dan W. Brock, ‘Deciding for Others’ *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 27-28.

⁵⁹ The values of autonomy and well-being have been analysed in detail in Chapter 2. Allen Buchanan and Dan W. Brock, ‘Deciding for Others’ *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 30.

⁶⁰ Jennifer Hawkins and Louis C. Charland, ‘Decision-Making Capacity’ in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2020) <<https://plato.stanford.edu/archives/fall2020/entries/decision-capacity/>> accessed 15 January 2021.

⁶¹ Allen Buchanan and Dan W. Brock, ‘Deciding for Others’ *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 22.

While the elements and assumption(s) of decision-making capacity have largely been defined in healthcare contexts, as Buchanan and Brock argue, they are broadly applicable to decision-making capacity in other contexts such as finance and personal welfare as well.⁶² However, they also point out three key differences when the concept of capacity from a healthcare context is applied elsewhere.⁶³ First, in contexts such as finances and personal welfare, there is often a conflict of interest in letting capacity-determinations being undertaken in informal situations. This is because unlike healthcare, where it is physicians who determine capacity, allowing family members, who may have a direct interest in financial decisions, to determine capacity may not be appropriate. Second, different decisions may pose unique risks of harm associated with them which may prompt different standards of capacity and lead to greater complexity. For instance, while determining capacity usually involves balancing autonomy and objective well-being, determining capacity for decisions such as research participation may also involve completely unrelated interests such as maintaining public confidence in such research.⁶⁴ Third, for financial contexts, there are often external interests in ensuring reliability and consistency in decision-making which a decision-specific approach to capacity may not always contribute to. For instance, financial transactions with bankers would require that banks have reasonable assurance that the decision-making is going to be clear, consistent and reasonable over a period of time. Similarly, contractual transactions would also imply reasonable expectations of contractual performance. It is for this reason that financial decisions often involve court-monitored global capacity determinations.

Approaches to the concept and threshold of decision-making capacity are thus extremely context-specific and are intrinsically linked to the decisions in question. Jurisdictions with laws on capacity and decision-making follow unique approaches. For instance, the Mental Capacity Act in the UK prescribes a common test to determine the “inability to make decision”⁶⁵, a similar approach to defining “decision-making capacity” exists in the State of Victoria in Australia as well.⁶⁶ The different interests or risks associated with different kinds of decisions are addressed by allowing or disallowing various decision-making approaches in these laws. For instance, in the UK, advance directives are only available in the form of advance decisions to refuse healthcare treatment⁶⁷ while surrogate decision-makers may be appointed for personal welfare and property decisions through lasting powers of attorney.⁶⁸ In contrast, decision-making laws in the province of Ontario in Canada prescribe different tests for decisions in different domains and different statutory methods for determining capacity.⁶⁹ What, however, is common across modern laws on capacity is the focus on defining it in a functional sense and focusing on the decision-specific nature of the concept. This ensures that the determination of decision-making capacity remains context-specific and is not affected by factors such as medical diagnosis and any status-based discrimination.

II. Decision-Making Capacity and Legal Capacity

The UNCRPD lays down the various human rights obligations that State Parties owe to persons with disabilities. Article 12(2) of the UNCRPD specifies that State Parties recognise the legal capacity of persons with disabilities on an equal basis in all aspects of life.⁷⁰ Paragraphs 3 and 4 of the same Article further oblige State Parties to provide “support” to persons with disabilities to exercise their legal capacity and ensure that no abuse occurs in the process. The General Comment on Article 12 further sheds light on the concept of legal capacity and views legal capacity in a person with disability as both legal standing i.e. to be a rights holder and to be recognised as a legal person, and legal agency i.e. to have one’s actions recognised by the law.⁷¹ The General Comment further draws a distinction between legal capacity and mental capacity, calling the latter a more controversial concept

⁶² Allen Buchanan and Dan W. Brock, ‘Deciding for Others’ *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 44-47.

⁶³ *ibid.*

⁶⁴ *ibid.*

⁶⁵ Section 3, Mental Capacity Act, 2005 (UK).

⁶⁶ Section 4, Guardianship and Administration Act, 2019 (State of Victoria, Australia)

⁶⁷ Section 25, Mental Capacity Act, 2005 (UK).

⁶⁸ Section 9, Mental Capacity Act, 2005 (UK).

⁶⁹ Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Final Report* (Toronto March 2017), 15.

⁷⁰ Article 12(2), United Nations Convention on the Rights of Persons with Disabilities.

⁷¹ General Comment No. 1, Committee on the Rights of Persons (2014), Paragraphs 12-15.

due to its context-specific nature.⁷² Instead, it emphasises on the need for support for persons with disabilities to exercise their legal capacity and consequently make decisions that are legally recognised.⁷³

The UNCRPD represented a fundamental shift in thinking about the rights of persons with disabilities and was the outcome of strenuous work by disability rights activists. However, the language of the convention has specifically been questioned by academics such as Malcolm Parker who have pointed to conceptual confusions in the UNCRPD.⁷⁴ He particularly highlights the conflation of “legal capacity” and “decision-making capacity” which often result in unimplementable legal and policy approaches, thereby undermining the rights and freedoms of those they seek to protect in the first place. He points out that decision-making capacity is essentially the mental capacity to take decisions, while legal capacity requires recognition of a person’s actions in the law. While the General Comment calls for a shift from mental capacity to legal capacity, this becomes harder to implement in domestic laws and policies on decision-making. This is because the two concepts have different but well-established meanings. Thus, a person who may not possess legal capacity—for instance, persons convicted of crimes are often barred from acting under certain laws—may still possess decision-making capacity.⁷⁵ Conflating the two, which some interpretations of the UNCRPD do, can lead to problems.

Since the UNCRPD proposes the concept of legal capacity for everyone, its decision-making approach also advocates supported decision-making where theoretically everyone can be supported to make their own decisions and there is no determinable point where a person ceases to possess decision-making capacity. It is in this context that the UNCRPD calls for replacing all substituted decision-making such as decision-making by surrogates with supported decision-making. Parker points out that such an approach is a misnomer for persons who lack complete decision-making capacity.⁷⁶ Similarly, over-estimating capacity in certain cases of intellectual disability where capacity has not been conceptually determined may lead to risks of harm. For instance, if individuals are being supported to make decisions, their decisions should ultimately be expressions of their autonomy. However, where individuals simply lack decision-making capacity, supported decision-making may presume that they have exercised autonomy when they may in fact have not.⁷⁷

Parker points out that such an approach also suffers from the initiation problem i.e. if a person always possesses legal capacity, there can be no threshold concept of capacity beyond which they cannot make decisions. However, even while authorising a support person, laws would practically require some assessment of capacity of the individual so that the law recognises the person’s autonomous choice in choosing a support person, thereby ultimately necessitating some threshold concept of capacity in the first place.⁷⁸ Moreover, negating any threshold concept of capacity implies that after a point when the person in fact cannot make their decisions, the support person effectively becomes a surrogate decision-maker, which the UNCRPD otherwise tries to effectively prevent.⁷⁹

Therefore, it is important to distinguish between legal capacity and decision-making capacity. For the purposes of this paper, we use decision-making capacity as the mental capacity to make decisions, while legal capacity has been used to refer to recognition of actions through law. It is in these senses that terms such as capacity and decision-making capacity have been used till now. Thus, a person retains legal capacity even though they may lack the decision-making capacity to make their decisions and such decision-making may take place through an alternative mechanism such as a surrogate decision-maker.⁸⁰

⁷² *ibid.*

⁷³ *ibid.*

⁷⁴ Malcolm Parker, ‘Getting the Balance Right: Conceptual Considerations Concerning Legal Capacity and Supported Decision-Making’ *Bioethical Inquiry* (2016) 13:381–393.

⁷⁵ *ibid.*, 386–388.

⁷⁶ *ibid.*, 386–388.

⁷⁷ *ibid.*, 386–388.

⁷⁸ *ibid.*, 386–388.

⁷⁹ *ibid.*, 386–388.

⁸⁰ Here the question of legal responsibility and accountability, however, also become significant. It is for this reason that the Law Commission of Ontario uses the term legal capacity throughout instead of decision-making capacity since it sees an overlap between the capacity to take a decision and the responsibility for that decision. See Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Final Report* (Toronto March 2017), 84.

C. Approaches to Decision-Making for Persons with Impaired Capacity

While individuals are normally presumed to possess decision-making capacity, as discussed in Chapter 1, this presumption may get displaced in several situations. In such cases, usually the first step is to determine whether they possess decision-making capacity or not. As we detailed above, decision-making capacity is a complex and highly contextual concept. The threshold that laws set for decision-making capacity may also influence the decision-making approach since a lower threshold is likely to allow for greater self-determination as opposed to a higher threshold. Further, a person whose capacity is impaired may not necessarily lack decision-making capacity in a legal sense. This is because decision-making capacity is usually set as a legal threshold while capacity may be impaired across a spectrum. This section deals with two of the dominant decision-making approaches i.e. supported decision-making and substituted decision-making. It also discusses the principles associated with these approaches. These are invoked to guide legal and policy responses to govern decision-making for persons with impaired capacity, including those who may lack decision-making capacity.

While supported decision-making focuses on the support that the law provides a person in making their decisions with the ultimate decision-making resting on the person with impaired capacity, substituted decision-making focuses on decision-making interventions such as advance directives or surrogate decision-makers through which or whom decisions are made on behalf of the person with impaired capacity.

It is important to keep in mind, that the values of autonomy and well-being also inform decision-making approaches like they do with decision-making capacity. While giving regard to autonomy may also contribute to well-being, this may not always be so. For instance, in the context of certain healthcare or financial decisions, it is arguable if following a person's wishes may always contribute to their welfare. Further, in the context of decisions such as those relating to property, consideration of third-party interests may also become relevant. Laws of capacity and decision-making, therefore, are a function of the relative weightage they give these values and interests.

I. United Nations Conventions on the Rights of Persons with Disabilities and Supported Decision-Making

As discussed previously, the UNCRPD represented a fundamental shift in thinking about capacity issues since it called for the equal recognition of legal capacity for all persons with disabilities. In line with its conception of capacity, the convention and the subsequent General Comment on Article 12 further focused on replacing substituted decision-making, i.e. decision-making by a surrogate on behalf of a person, which was represented in traditional guardianship regimes for persons with disabilities, with supported decision-making. This was in line with the shift from the medical to the social model of disability which, instead of focusing on the medical situation of the individual, puts the onus on society to remove barriers and positively support the individual with disability.⁸¹

Such supported decision-making is aimed at realising the wishes and preferences of the individual, whereas substituted decision-making regimes often focus on decisions based on an objective understanding of the best interests of the person.⁸² The General Comment also recognises that “support” here could mean a number of informal and formal arrangements that are specifically aimed at ensuring that the person is able to exercise legal capacity.⁸³ This could range from legally recognising a support person or support from informal community networks who assist the person in question to exercise capacity, to making accommodations to recognise different modes of communication from persons with disabilities.

The UNCRPD therefore views the individual as the ultimate decision-maker and imposes obligations on others to support the individual in making their decisions. Thus, even though an individual may be supported in various

⁸¹ Nandini Ghosh, “Introduction: Interrogating Disability in India” in Nandini Ghosh (ed.), *Interrogating Disability in India: Theory and Practice* (Springer 2016).

⁸² General Comment No. 1, Committee on the Rights of Persons (2014), Paragraph 27.

⁸³ General Comment No. 1, Committee on the Rights of Persons (2014), Paragraphs 17.

ways, ultimately, they are the ones who are deciding. This is conceptually distinct from having a guardian or surrogate making decisions on an individual's behalf even if they are making decisions on the basis of the wishes and preferences of the individual. In emphasising equal legal capacity and supported decision-making, the convention recognises the long history of marginalisation and discrimination which persons with disabilities have faced in exercising their rights due to paternalistic laws that denied their agency.

While the UNCRPD is concerned with persons with disabilities, this paper looks at the issue of capacity and decision-making holistically since it affects various population groups such as elderly persons affected by dementia. Though the principle behind the convention that all persons should be supported in making their decisions to give maximum effect to their self-determination is applicable to other population groups as well, yet it may be impossible to apply it in certain situations such as in the case of persons in a vegetative or comatose state. Similarly, supported decision-making may not be possible in some instances of acute illness where patients may not be lucid. Such instances would necessitate some kind of substituted decision-making.

Moreover, as detailed above, academics such as Parker have pointed out the pitfalls of conflating the concepts of "legal capacity" and "supported decision-making" in interpretations of the UNCRPD. Doing so would be effectively carrying out substituted decision-making in the guise of supported decision-making. There has also been a lack of clarity regarding the design of legal frameworks and associated safeguards to realise supported decision-making.⁸⁴ While it is well-recognised that supported decision-making has the potential of enhancing self-determination, little concrete research exists on how different supported decision-making arrangements work in practice.⁸⁵ Further, without adequate safeguards, in several instances, support persons may end up influencing decisions thereby defeating the point of realising autonomy. Jurisdictions that have tried to implement the mandate of the UNCRPD have often pointed to the "wicked problem" of ensuring that the decision is truly autonomous while creating the conditions of autonomy.⁸⁶

Supported decision-making thus represents a powerful approach to realising the autonomy of a large number of persons with impaired decision-making capacity. The basic premise that individuals who can be supported, should be supported in making their own decisions is uncontroversial and can be the universal starting point of all laws on capacity and decision-making. However, how best to design such frameworks and what kinds of supported decision-making interventions laws should specifically recognise, remain difficult questions. At the same time, it is important to recognise that supported decision-making may not fulfil its purpose of enhancing autonomy in all situations of impaired capacity. In such instances, in order to prevent abuse, laws may have to fall back on appropriate substituted decision-making interventions.

II. Principles of Substituted Decision-Making

While the UNCRPD is perhaps the most significant recent development in thinking about decision-making, there is a large body of literature dealing with substituted decision-making which tackles the problems of deciding for persons with impaired capacity.⁸⁷ Irrespective of the UNCRPD's mandate for supported decision-making, concepts in substituted decision-making remain relevant since they inform legal and policy responses to decision-making generally and necessarily have to be invoked for persons in vegetative and comatose states, who may have obviously suffered a complete loss of decision-making capacity.

Buchanan and Brock offer one of the most comprehensive ways of thinking about the theory of surrogate decision-making.⁸⁸ They offer a series of inter-related principles which provide a conceptual basis for navigating

⁸⁴ Soumitra Pathare and Laura S. Shields, 'Supported Decision-Making for Persons with Mental Illness: A Review' *Public Health Reviews* Volume 34 No. 2 (2012).

⁸⁵ Nina A. Kohn *et al*, 'Supported Decision-Making: A Viable Alternative to Guardianship' 177 *Penn. St. L. Rev.* 1111 (2013).

⁸⁶ Terry Carney, 'Supported decision-making in Australia: Meeting the challenge of moving from capacity to capacity-building?'. *LiC* [Internet]. 2017Dec.1 [cited 2021Jan.18];35(2):44-3.

⁸⁷ Agnieszka Jaworska, 'Advance Directives and Substitute Decision-Making' in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2017 Edition) <<https://plato.stanford.edu/archives/sum2017/entries/advance-directives/>> accessed 15 January 2021.

⁸⁸ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 49.

decision-making for persons who may lack decision-making capacity and who may therefore not benefit from supported decision-making interventions. Their framework comprises the following four principles:

1. Ethical Values Principles

These refer to the values that should inform decision-making for persons who lack capacity. Buchanan and Brock identify self-determination, concern for individual well-being and distributive justice as the key value principles.⁸⁹ Self-determination or concern of individual autonomy was extensively discussed in the first part of this Chapter. Well-being, on the other hand, refers to what may be considered in the objective interests of the individual, while concerns for distributive justice refer to equitable allocation of resources or balancing the interests of the person who lacks capacity with the interests of others. A conflict between the right to autonomy and well-being may often arise in healthcare contexts where a patient's exercise of self-determination may not always increase their well-being, for instance, a patient may refuse certain kinds of treatment for religious reasons even though such treatments may have beneficial outcomes. Concerns of distributive justice become apparent in financial decisions where decisions by an individual may affect the legitimate expectations of those who are in a contractual relationship with them.⁹⁰

2. Guidance Principles

These principles provide the substantive basis for taking decisions in substituted decision-making. Buchanan and Brock identify the following:⁹¹

- **Best Interests:** This standard seeks to maximise the individual good or well-being of the individual from an objective perspective. This standard is often employed from the perspective of what a reasonable person would want in any given situation and is usually utilised when there is no information available about the person.⁹² It therefore seeks to maximise general values such as freedom from pain and the development of physical or mental capacities.⁹³ In healthcare decision-making, this often involves the balancing of the risks and benefits of a proposed treatment to reach a decision.⁹⁴ This standard furthers the moral principle of beneficence in healthcare ethics.⁹⁵
- **Substituted Judgement:** This seeks to replicate the decision which the individual would have made if they were competent and is therefore, based on the person's supposed wishes and preferences. In contrast to best interests, therefore, substituted judgement especially accounts for the subjectivities of the individual while reaching a decision. This standard therefore, seeks to further the autonomy of the individual.
- **Advance Directive:** This refers to legal instruments such as powers of attorney, living wills etc., which were issued by the person when they had capacity to direct decision-making for a time when they may lose capacity. They are usually based on the concept of precedent autonomy which was discussed in the first part of this Chapter. Advance Directives may range from specific decisions which individuals may have taken for certain foreseeable situations to the appointment of surrogate decision-makers and include the giving of guidance which may inform the surrogate's decision-making. However, commentators have often argued that only specific decisions should be considered as proper advance directives, since reconstructing a person's wishes and preferences, in effect amounts to substituted judgement.⁹⁶

⁸⁹ *ibid.*, at 49-50.

⁹⁰ *ibid.*, at 48.

⁹¹ *ibid.*, at 49.

⁹² Agnieszka Jaworska, 'Advance Directives and Substitute Decision-Making' in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2017 Edition) <<https://plato.stanford.edu/archives/sum2017/entries/advance-directives/>> accessed 15 January 2021.

⁹³ *ibid.*

⁹⁴ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly* Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 49.

⁹⁵ Jonathan F Will, 'A Brief History and Theoretical Perspective on Patient Autonomy and Medical Decision Making' *Chest* 2011 Jun;139(6):1491-1497.

⁹⁶ Ronald Dworkin, 'Autonomy and the Demented Self' *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 4-16.

3. Authority Principles

These principles specify who possesses the authority to make decisions for persons who may lack capacity.⁹⁷ Individuals, through advance directives may often identify persons as surrogates who are authorised to take decisions on their behalf. Often, in healthcare contexts, statutes, policies and laws recognise a statutory hierarchy of near relatives or next friends who end up taking decisions on behalf of a patient in the absence of advance directives.⁹⁸ Often surrogate decision-makers may also be appointed by courts such as the appointment guardians in common law under the court's *parens patriae* jurisdictions. Appointments of such decision-makers may often raise concerns of conflicts of interest, especially for financial decisions.

4. Intervention Principles

These principles guide situations where public authorities such as courts or other regulatory institutions may intervene if decision-making by an authorised person on behalf of a person who lacks capacity affects their important interests.⁹⁹ This also becomes relevant in the context of abuse by the substitute decision-maker.

Buchanan and Brock emphasise the need for distinguishing between these principles to avoid conceptual confusions and practical errors. For instance, principles such as substituted judgment based on which an authorised person may take decisions on behalf of an incompetent person may not apply equally in determining intervention by public authorities (if authorities were to intervene on the ground that a particular decision was not in accordance with substituted judgment), due to the inherent subjectivity in construing wishes and preferences. However, it must be borne in mind that this framework does not provide a straitjacket formula for reaching decisions either. Legal and policy frameworks will have to choose appropriate principles under each of the four heads keeping various considerations in mind, including relative weightage of value principles such as autonomy and well-being, the realities of state-capacity, and the nature of the decisions in question.

Further, specific contexts may throw up unique challenges. For instance, any conception of autonomy may be difficult to ascertain for never-competent patients, i.e. patients who have lacked all decision-making capacity since birth, and even best-interest determinations for such patients may throw up unique challenges.¹⁰⁰ What comprises best-interests, has itself been deeply contested with some arguing for a nuanced interpretation of best-interests which includes an individual's current wishes.¹⁰¹ Even for formerly competent persons, there have been many debates about whether the interests of the person as they now are should be accounted for even though theoretically they may not be considered 'autonomous'.¹⁰² The classic example here is the case of an Alzheimer's patient who due to the progress of the illness may be nothing like their former self but may still have certain wishes and preferences as the person they now are. For instance, they may have valued their intellectual capabilities in the past but may now express pleasure while listening to pop music!

Similarly, in the absence of clear advance directives, any assessment of substituted judgement may be prone to subjectivities and may never really be indicative of the precise wishes of the incompetent person.¹⁰³ With regard to a surrogate decision-maker, in the absence of any clear choice of person, the decision-making often ends up falling back on persons specified in default statutory lists. In the context of the United States, Thaddeus Pope identifies various potential problems with such surrogate decision-making including the lack of knowledge of the

⁹⁷ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 49.

⁹⁸ Thaddeus Mason Pope, 'Legal Fundamentals of Surrogate Decision-Making', *CHEST* 2012; 141(4):1074-1081; See Section 14, Mental Healthcare Act, 2017.

⁹⁹ Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 49.

¹⁰⁰ Norman Cantor, 'The Bane of Surrogate Decision-Making: Defining the Best Interests of Never-Competent Persons' (2005) 26 *J Legal Med* 155.

¹⁰¹ Agnieszka Jaworska, 'Advance Directives and Substitute Decision-Making' in Edward N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2017 Edition) <<https://plato.stanford.edu/archives/sum2017/entries/advance-directives/>> accessed 15 January 2021.

¹⁰² *ibid.*

¹⁰³ For problems with Substituted Judgement, see Allen Buchanan and Dan W. Brock, 'Deciding for Others' *The Milbank Quarterly*, Vol. 64, Supplement 2: *Medical Decision Making for the Demented and Dying* (1986), 17-94, 67-71.

patient's wishes and preferences, impaired capacity of surrogates, failure to follow the patient's preferences, lack of knowledge of the patient's best interests and disagreements amongst surrogates.¹⁰⁴

Further, while many of these principles have been articulated in the context of healthcare decision-making, questions of decision-making may arise in the context of financial decisions or living arrangements too. Different population groups may also have their own unique concerns. For instance, persons with developmental disabilities may have a unique set of concerns as opposed to persons who may lose capacity in old age due to the onset of progressive dementia or Alzheimer's. This is because life's interests are naturally likely to vary between people who have their whole life ahead of them as opposed to someone who is of advanced age and who may reflect on their life with satisfaction. Concerns of persons who have suffered brain injury and therefore end up in a comatose or permanent vegetative state may again be entirely different and perhaps far more complex to determine due to vast differences between the current and former selves. Each of these contexts may give rise to a unique set of concerns which may require tailoring of the above principles. The choice of principles, therefore, requires balancing of various considerations and raises several complex questions.

¹⁰⁴ Thaddeus Mason Pope, 'Legal Fundamentals of Surrogate Decision-Making', CHEST 2012; 141(4):1074- 1081.

Chapter 3: Critically Analysing the Indian Legal Framework

In India, the law on capacity and decision-making is currently scattered. Various population-specific laws in conjunction with the general law govern such questions. There is no uniform approach which considers all questions of capacity together. Thus, on the one hand, we have laws such as The National Trust For Welfare Of Persons With Autism, Cerebral Palsy, Mental Retardation And Multiple Disabilities Act, 1999 (“NTA”), the Mental Healthcare Act, 2017 (“MHA”) and the Rights of Persons with Disabilities Act, 2016 (“RPWD”) which deal with decision-making and capacity questions for specific populations. On the other hand, as a series of recent High Court decisions have pointed out, none of these laws apply to certain groups such as those in a comatose state.¹⁰⁵ High Courts have thus usually relied upon their writ jurisdiction under Article 226 of the Constitution to appoint guardians in such cases. Therefore, the law on capacity and decision-making spans both legislation and judicial decisions.

Moreover, terms such as “incompetence”, “unsound mind”, and “lunacy” are used, often interchangeably, in various laws to deny legal personhood to individuals. For instance, under the Indian Contract Act, 1872 only persons of “sound mind” can enter into a contract,¹⁰⁶ while persons of unsound mind can escape criminal responsibility under the Indian Penal Code, 1860.¹⁰⁷ Similarly, being a person of unsound mind is often a standard disqualification under various laws.¹⁰⁸ These legal standards refer to the various tests of legal capacity (which may or may not overlap with decision-making capacity given how the law defines the standard) in laws across different domains. Such tests occur under four broad thematic sets of laws – (i) healthcare and reproductive rights, (ii) contracts, property and testamentary succession, (iii) marriage and (iv) civil and criminal proceedings.¹⁰⁹ While these laws are bound to interact with any legal framework on capacity and decision-making, since they primarily deal with varying domain-specific tests of legal capacity rather than dealing with decision-making *per se*, we have not included them as part of our analysis in this paper.

This Chapter, first, gives a brief overview of the existing law on capacity and decision-making and, second, critically analyses it to identify gaps.

¹⁰⁵ See *Sairabanu Mohammed Rafi v State of Tamil Nadu* 2016 SCC OnLine Mad 8091; *Philomena Leo Lobo v Union of India* 2017 SCC OnLine Bom 8836; *Shobha Gopalakrishnan v State of Kerala* SCC OnLine Bom 880; *Sherly C.A. & Ors. v State of Kerala* WP(C). No. 37062 of 2018; *Vandana Tyagi v Government of National Capital Territory of Delhi* (GNCTD) 2020 SCC OnLine Del 32.

¹⁰⁶ Section 11, Indian Contract Act, 1872.

¹⁰⁷ Section 84, Indian Penal Code, 1860.

¹⁰⁸ Soumitra Pathare, ‘Widely cited, but still undefined’ *The Hindu* (23 April 2017) <<https://www.thehindu.com/sci-tech/health/widely-cited-but-still-undefined/article18191442.ece>> accessed 15 January 2021.

¹⁰⁹ See Kim D’Souza and Rajashri Seal, ‘The Understanding of ‘Capacity’ and Decision-Making under Indian Law lacks Nuance, Consistency and a Modern Scientific Approach - Part I of a II part series – Legal Capacity and Decision-Making in Health and Family Law’ *Vidhi Centre for Legal Policy* (12 March 2021) <<https://vidhilegalpolicy.in/blog/the-understanding-of-capacity-decision-making-under-indian-law-lacks-nuance-consistency-a-modern-scientific-approach/>> accessed 19 March 2021; Kim D’Souza and Rajashri Seal, ‘The Understanding of ‘Capacity’ and Decision-Making under Indian Law lacks Nuance, Consistency and a Modern Scientific Approach - Part II of a II part series – Legal Capacity and Decision-Making in Contract and Procedural Law’ *Vidhi Centre for Legal Policy* (19 March 2021) <<https://vidhilegalpolicy.in/blog/the-understanding-of-capacity-decision-making-under-indian-law-lacks-nuance-consistency-a-modern-scientific-approach-2/>> accessed 19 March 2021.

A. Indian Laws on Capacity and Decision-Making

The NTA was enacted in the late 1990s in response to the demands of groups of parents of persons with disabilities, primarily intellectual disabilities, who wanted to ensure guardianship for their children after their demise.¹¹⁰ It also sets up the National Trust to act for the welfare of its target population groups. The Act, however, has not kept up with developments such as the UNCRPD and does not capture concepts such as autonomy.¹¹¹ The MHA and the RPWD were enacted post India's ratification of the UNCRPD and were aimed at fulfilling India's international obligations. Their enactment involved extensive stakeholder consultations with concerned civil society and community groups and built on the principles of autonomy and dignity.¹¹² However, in spite of this, the UNCRPD's Committee on Rights of Persons with Disabilities, in its concluding observations to India's initial report on compliance with the Convention noted how Indian laws have not done enough (in terms of a complete transition from guardianship to supported decision-making regimes) to realise the autonomy of persons with disabilities.¹¹³

The following table briefly summarises the relevant provisions of the aforesaid Acts from the perspective of decision-making by persons with impaired capacity:

Key Features	NTA	RPWD	MHA
Target Population Group	The Act applies to a person with disability affected by any of the conditions relating to autism, cerebral palsy, mental retardation or a combination of any two or more of such conditions and includes a person suffering from severe multiple disability. ¹¹⁴	The Act applies to persons with disabilities defined as “a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others” ¹¹⁵	The Act applies to persons with mental illness where mental illness “means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.” ¹¹⁶

¹¹⁰ Dr Amita Dhanda and Gabor Gambos, 'Consultation Paper drafted under the auspices of the National Trust' <<http://www.disabilitystudiesnalsar.org/nt.php>> accessed 20 January 2021.

¹¹¹ *ibid.*

¹¹² For debates around the enactment of the RPWD see Nandini Ghosh, "Introduction: Interrogating Disability in India" in Nandini Ghosh (ed.), *Interrogating Disability in India: Theory and Practice* (Springer 2016); For debates around the MHA see Richard Duffy and Brendan D Kelly, 'India's Mental Healthcare Act, 2017: Content, context, controversy' *International Journal of Law and Psychiatry* (2018) <https://doi.org/10.1016/j.ijlp.2018.08.002>

¹¹³ Paragraphs 26-27, *Concluding Observations on the Initial Report of India, Committee on the Rights of Persons with Disabilities, United Nations Convention of the Rights of Persons with Disabilities* (2019).

¹¹⁴ Section 2(j), National Trust Act, 1999.

¹¹⁵ Section 2(s), Rights of Persons with Disabilities Act, 2016.

¹¹⁶ Section 2(1)(s), Mental Healthcare Act, 2017.

Objective

The main objective of the Act is to create a national body called the National Trust which will act for the welfare of persons with disabilities. These include overall supervision of issues of guardianship and decision-making, apart from socio-economic welfare.

The Act gives effect to the UNCRPD and therefore furthers the rights of autonomy, equality etc., through a range of interventions ranging from non-discrimination provisions, recognition of equal legal capacity and measures for improving access for persons with disabilities. It is a comprehensive code for persons with disabilities in India.

The Act gives effect to the UNCRPD by protecting the rights of persons with mental illness and by making provisions for mental healthcare services in India.

Approach to Decision-Making Capacity

The Act does not define decision-making capacity for persons with disabilities. However, the process of appointing a guardian requires the appointing authority (the Local Level Committee) to consider whether the person with disability needs a guardian.¹¹⁷

In accordance with the UNCRPD, the Act recognises the equal legal capacity of all persons with disabilities.¹¹⁸ Accordingly it does not contain any concept of decision-making capacity. However, it does provide for the appointment of a limited guardian when a person with disability is unable to take a legally binding decision.¹¹⁹

The Act stipulates that a person has the capacity to take decisions regarding their mental healthcare and treatment if they understand the information that is relevant to take the decision, appreciate the foreseeable consequences of the decision and are able to communicate the decision.¹²⁰ Therefore, decision-making capacity has only been defined in the context of mental healthcare and treatment decisions.

Approach to Decision Making

The Act follows the traditional guardianship model but allows the person with disability to choose a person of their choice to act as guardian. The guardian is supposed to be responsible for the care and maintenance of the person with disability and their property.¹²¹ The Act makes no direct reference to decision-making, however, once the guardian has been appointed it is implied that they will act a surrogate decision-maker. Further, it does not lay down principles

Like the UNCRPD, the Act adopts a supported decision-making approach. While no formal provision for such supported decision-making has been made, this is apparent from the Act's general emphasis on supporting persons with disabilities to exercise their legal capacity. Moreover, in spite of adequate support if a person with disability is unable to take a legally binding decision, then upon an

The Act provides for decision-making through a nominated representative¹²³ as well as advance directives.¹²⁴ The nominated representative may be appointed by the person with mental illness (failing which, the Act, in order of precedence, identifies persons who may act as nominated representatives) and is supposed to both support the person in making decisions as well as take decisions on their behalf if the person cannot take their own decisions. In making

¹¹⁷ Section 14(3)(a), National Trust Act, 1999.

¹¹⁸ Section 13, Rights of Persons with Disabilities Act, 2016.

¹¹⁹ Section 14, Rights of Persons with Disabilities Act, 2016.

¹²⁰ Section 4, Mental Healthcare Act, 2017.

¹²¹ Section 15, National Trust Act, 1999.

¹²³ Section 14, Mental Healthcare Act, 2017.

¹²⁴ Section 5, Mental Healthcare Act, 2017.

or standards that are supposed to guide the actions of the guardian.

application to the District Court, a limited guardian can be appointed for such decisions.¹²²

decisions, the nominated representative should, “consider the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness.”¹²⁵ The advance directives can specify how the person may or may not want to be treated for their mental health and can also be used to appoint a nominated representative.¹²⁶ These will only come into effect once the person ceases to possess the capacity to take mental health decisions.

Safeguards

The guardian is required to submit details of the property of the person with disability after appointment and is also subject to annual reporting requirements.¹²⁷ Further, a guardian may be removed for abusing or neglecting the person with disability or for abusing or misappropriating their property.¹²⁸

In the context of supported decision-making, specific provisions have been made prohibiting support persons from providing support in cases of conflict of interest,¹²⁹ on the effect on past third-party transactions after a support person changes¹³⁰ and prohibiting the support person from exercising undue influence.¹³¹ However, there are no detailed provisions or procedures laid down that need to be followed in case abuse or conflict of interest actually occurs.

The Act provides for the establishment of Mental Health Review Boards which have the power to revoke, alter or modify advance directives upon an application being made to them.

B. Judicial Interventions for Appointment of Guardians

Since legislation on capacity and decision-making is population-specific, certain population groups who may face issues of impaired capacity get left out. In India this gap has ostensibly been filled by High Courts exercising their writ jurisdiction under Article 226 of the Constitution which gives the High Court vast jurisdictional powers to issue writs and has been interpreted to allow High Courts to fill gaps or omissions in existing laws.¹³² Traditionally,

¹²² Section 14, Rights of Persons with Disabilities Act, 2016.

¹²⁵ Section 17(a), Mental Healthcare Act, 2017.

¹²⁶ Section 5, Mental Healthcare Act, 2017.

¹²⁷ Section 16, National Trust Act, 1999.

¹²⁸ Section 17, National Trust Act, 1999.

¹²⁹ Section 13(3), Rights of Persons with Disabilities Act, 2016.

¹³⁰ Section 13(4), Rights of Persons with Disabilities Act, 2016.

¹³¹ Section 13(5), Rights of Persons with Disabilities Act, 2016.

¹³² *Shobha Gopalakrishnan v State of Kerala* 2020 SCC OnLine Bom 880.

in common law, courts possess the *parens patriae* jurisdiction which allows them to appoint guardians for incompetent persons. Certain High Courts have referred to the civil court's power to appoint a guardian as a common law remedy,¹³³ however, it is difficult to ascertain whether civil courts are exercising such powers directly since their decisions are not reported in the public domain. As a result, our research was confined to decisions of the High Courts which have been reported by Supreme Court Cases and Manupatra, two leading online legal research databases in India.

We found eight such decisions across five High Courts where guardians have been appointed through judicial proceedings for persons who had otherwise lost capacity. These comprise the High Court of Madras' decision in *Sairabanu Mohammed Rafi v State of Tamil Nadu*,¹³⁴ the High Court of Kerala's decision in *Shobha Gopalakrishnan v State of Kerala*¹³⁵ (along with *Sherly C.A. &Ors. v State of Kerala*¹³⁶), the High Court of Bombay's decisions in *Philomena Leo Lobo v Union of India*,¹³⁷ *Madhu Vijaykumar Gupta v State of Maharashtra*,¹³⁸ *Nitin G. Thakker v State of Maharashtra*,¹³⁹ and *Rajni Hariom Sharma v Union of India*,¹⁴⁰ the High Court of Delhi's decision in *Vandana Tyagi v Government of NCT of Delhi*,¹⁴¹ and the High Court of Allahabad's decision in *Uma Mittal v Union of India*.¹⁴² In all these cases, the courts were concerned with guardianship for persons who were in a comatose or vegetative state and were in such a situation due to a variety of medical conditions. The courts were approached by either family or friends who wanted to access the financial accounts of the person with impaired capacity or to alienate their moveable and immoveable properties to meet their medical as well as other family expenses. In many cases, financial institutions such as banks were in fact parties since they were otherwise preventing the family members from accessing the financial resources of the person with impaired capacity in the absence of the person's explicit authorisation. This highlights the stark practical issues that families and caregivers face when their family members lose capacity, thereby preventing them from utilising the person's financial resources to meet their expenses.

In seven out of eight cases, the courts relied upon their powers under Article 226 of the Constitution. In all these cases, the Courts noted that none of the existing laws including the RPWD, MHA and NTA covered the situation of persons in a comatose or vegetative state. While different decisions go into varying levels of detail in terms of their reasoning, they all broadly conclude that judicial intervention was necessary to fill this immediate legislative gap since the petitioners would otherwise be left without a remedy in their precarious circumstances. The High Court of Bombay, in one of its decisions,¹⁴³ noted that even though the issue before them was essentially private since petitioners wanted to access bank accounts and other properties with financial institutions, the larger question of decision-making in such situations was of public importance, thus necessitating intervention under Article 226. The only outlier in terms of legal reasoning is the High Court of Bombay's decision in *Nitin Thakker*¹⁴⁴ where the guardian was appointed in civil proceedings. In the case the Court reasoned that such a route was available to it under Order 32-A, Rule 1 of the Code of Civil Procedure, 1908 ("**Code**") which deals with proceedings relating to family.¹⁴⁵ In this case, however, the suit was filed by an advocate on behalf on another advocate who was in a comatose state. The court, therefore, read the provision along with its inherent power recognised under Section 151 of the Code to appoint the advocate (who was otherwise not a family member) as the guardian.

¹³³ *Sairabanu Mohammed Rafi v State of Tamil Nadu* 2016 SCC OnLine Mad 8091.

¹³³ W.P. No. 28435 of 2015.

¹³⁴ *Sairabanu Mohammed Rafi v. State of Tamil Nadu* 2016 SCC OnLine Mad 8091.

¹³⁵ *Shobha Gopalakrishnan v State of Kerala* 2020 SCC OnLine Bom 880.

¹³⁶ WP(C). No. 37062 of 2018.

¹³⁷ W.P. (L) No.28269 of 2017.

¹³⁸ MANU/MH/1921/2019.

¹³⁹ MANU/MH/0978/2020.

¹⁴⁰ MANU/MH/1073/2020.

¹⁴¹ MANU/DE/0018/2020.

¹⁴² Writ C-No. – 40096 of 2019 (Judgement dated 15 June 2020).

¹⁴³ *Rajni Hariom Sharma v Union of India*, MANU/MH/1073/2020.

¹⁴⁴ MANU/MH/0978/2020.

¹⁴⁵ Order 32-A Rule 1(2)(c) of the Code of Civil Procedure, 1908 provides for the appointment of guardian for a family member under disability in a civil suit.

In all decisions, the Court relied upon medical expert opinion to conclude that persons with impaired capacity were unable to make decisions. However, the High Court of Kerala's decision in *Shobha Gopalakrishnan* is of particular significance since it lays down general guidelines for the appointment of guardians in such situations, which will have an impact beyond the facts of the immediate case. Kerala's lead has been followed by the High Courts of Delhi and Allahabad who have issued similar guidelines in *Vandana Tyagi* and *Uma Mittal*, respectively. Key aspects of the Kerala High Court guidelines include the requirement to disclose all properties of the person with impaired capacity, verification of the medical condition and capacity of the person with impaired capacity by a medical board, re-verification of the medical condition and verification of all properties by revenue authorities, requirement to make all legal heirs party to such proceedings, limiting the guardianship order to only those properties mentioned in the order and the requirement that decisions taken by the guardians be in the best interests of the person with impaired capacity. The guidelines also include safeguards such as periodic reporting requirements of all transactions to the Registrar General of the High Court, the possibility of reversing the guardianship order in case of misappropriation and abuse and the possibility of random spot inspections by the social welfare officers of the areas where the guardian and person with impaired capacity reside. The guidelines also note that the person being appointed as a guardian should be legally competent and should be a close relative (spouse or child). The Delhi High Court and Allahabad High Court guidelines are based on this template with minor variations.

The High Court of Bombay has not issued comprehensive guidelines, and its decisions range from failing to discuss safeguards against potential abuse to introducing specific mechanisms in individual cases. For instance, the Court does not discuss safeguards in *Philomena Leo Lobo* on the one hand, while on the other, in *Madhu Vijaykumar Gupta* it requires the petitioner to submit property documents to the Court once the transactions are complete and in *Rajni Hariom Sharma*, it requires the Maharashtra Legal Services Authority to monitor the functioning of the appointed guardian.

These cases represent both the urgency of the problem of decision-making for persons with impaired capacity and the various judicial approaches that High Courts have adopted in resolving the issue. They also clearly show how certain groups of persons with impaired capacity, mainly persons in a vegetative or comatose state, are simply not covered by existing decision-making laws, thereby necessitating judicial interventions.

C. Why does the Indian Legal Framework fall short?

The Indian law on capacity and decision-making currently comprises legislations such as the NTA, RPWD and the MHA, and the law laid down by jurisdictional High Courts through their decisions. We argue that the current framework falls short since it is highly scattered and fragmented and does not fully promote the rights of all persons with impaired capacity and therefore, leaves them vulnerable. This is because of the following reasons:

I. Concerns with the RPWD

The RPWD primarily outlines and reiterates the various rights of persons with disabilities and entrusts government authorities with the general duty of ensuring these rights, and requires it to perform specific functions to facilitate their realisation. It overrides all other provisions relating to guardianship with the concept of "limited guardianship," but fails to elucidate the features of this type of guardianship (beyond a brief explanation of the term¹⁴⁶), or to provide detailed mechanisms for its functioning. Further, the provision provides for the appointment of a limited guardian when the person is unable to take a legally binding decision, however, at the same time defines the eventual decision as being a "joint-decision." Therefore, it remains unclear whether the ultimate decision is a result of supported decision-making that is made by the person with disability or a substitute-decision that is made by someone else on their behalf. This, in turn, creates uncertainty over the duties and liabilities of the support person or the substitute decision-maker as the case may be. The need for conceptual

¹⁴⁶ See the Explanation to Sub-Section 1 of Section 14 of the RPWD

clarity in laws on capacity and decision-making was emphasised in our discussion of theoretical concepts in decision-making in Chapter 2.

Moreover, while the RPWD rightly lays down supported decision-making as the norm for persons with disabilities, in line with the UNCRPD, it neither clarifies the role of such support persons nor provides for a clear process of appointment. This immediately begs the questions of whether such provisions realistically enhance autonomy and the extent to which they prevent abuse by support persons. Further, as noted above, while the RPWD contains specific provisions on conflict of interest and impact on third party transactions, it does not provide procedures or mechanisms to deal with situations where a conflict may actually occur, and third parties may be adversely affected.¹⁴⁷ This lack of detail is surprising since the RPWD is otherwise an extremely comprehensive law. Further, since the RPWD is a relatively new law, there is also very little evidence of how its provisions have played out in practice and whether models of supported decision-making and limited guardianship have been effectively utilised.

II. Concerns with the NTA

The NTA's stated objective is, among other things, to empower persons with disabilities to live independently and realize their rights of equality and equal participation in society, however it is structured more as a charter for the central and local bodies established under it to promote and protect the welfare of persons with disabilities (as defined in the Act), through the appointment of guardians and supervision of their functioning via self-reporting mechanisms. It does not set out a detailed description of the rights and duties of the guardian and the person with disability with respect to each other or with respect to third parties. Further, while the guardian makes decisions on behalf of the person, the Act does not lay down any clear principles on the basis of which the guardian should be taking such decisions. It also does not expressly prioritise or create systems to facilitate the realization of agency over their lives by the person with disability, as well as equal participation in society as per the objects of the Act.

Moreover, the NTA has not kept up with international developments such as the UNCRPD which recognise the importance of autonomy, and therefore, presume legal capacity for all persons with disabilities. The NTA still operates on a guardianship model rather than attempting to support decision-making by persons with disabilities. The enactment under the RPWD, which is admittedly a more comprehensive law for persons with disabilities, also questions the continuing utility of the NTA. Debates during the enactment of the RPWD indicate opposition to repeal of the NTA by groups of parents with intellectual disabilities who felt that their children may never be able to exercise legal capacity, and therefore, needed legal protection in the form of guardianship.¹⁴⁸ This further indicates the need for greater clarity in utilising concepts such as "legal capacity" and "decision-making capacity" and accounting for caregiver perspectives in doing so. It also demonstrates the need for specifically accounting for the concerns of persons with impaired capacity whose issues with decision-making may be distinct from other persons with disabilities, for example persons with locomotor or visual disabilities.

III. Concerns with the MHA

Of the three Acts, the MHA contains the most detailed mechanisms for the appointment of substitute decision-makers, and for the functioning of supported and substituted decision-making by persons with mental illness. Like RPWD, it also recognizes that persons with disabilities need to be empowered to make their own decisions and act for themselves as far as possible, so that they may exercise agency over their own lives. The MHA does not, however, relate to decision-making in general - it is restricted to mental health and treatment decisions by persons with mental illness. Further, while the MHA provides for advance directives in recognition of the precedent autonomy of individuals, to the best of our knowledge no regulations on how such advance directives should be executed have been issued, thereby making such provisions meaningless in practice.¹⁴⁹

¹⁴⁷ See Section 13, Right of Persons with Disabilities Act, 2016.

¹⁴⁸ Nandini Ghosh, "Introduction: Interrogating Disability in India" in Nandini Ghosh (ed.), *Interrogating Disability in India: Theory and Practice* (Springer 2016)

¹⁴⁹ Draft regulations on advance directives were prepared by the Ministry of Health and Family Welfare, Government of India and were released for public consultation in 2017. However, they have not been enacted yet. See

IV. Concerns with Judicial Decisions

As is apparent from the judicial decisions discussed above, there is a clear gap in the law in respect of persons whose conditions do not fit the definitions of disability or mental illness under the aforesaid Acts, and who, consequently, are constrained to seek the court's intervention to protect their rights. The courts have attempted to bridge this gap by delineating guidelines for the appointment of a guardian for a person in a coma-like state; however, this has been done only in Kerala, Delhi and Uttar Pradesh, thus far. Moreover, these guidelines vest accountability responsibilities on authorities such as Court Registries whose capacity constraints are well-documented, thereby raising questions on their ability to perform such functions and on the overall practicability of such guidelines. Cases arising in the rest of India will still require the matter to be looked at afresh, not only to assess the specific needs in each case, but also to devise a procedure for the appointment and functioning of a guardian for a person in a comatose / coma-like condition.

Moreover, judicial interventions in India can be time consuming and expensive, thereby restricting judicial options only to those who may have the ability to pay for and pursue such proceedings. This makes this option less than desirable for a majority of the population.

V. General Concerns

Apart from these specific issues, the approaches in these legislations are highly fragmented and do not provide individuals with various decision-making options that are now recognised in other comparable jurisdictions. For instance, while the Supreme Court has recognised the concept of advance directives in end of life decision-making in highly circumscribed situations¹⁵⁰ and the MHA recognises such directives for mental healthcare decision-making,¹⁵¹ there is no recognition of such directives for healthcare decision-making in general. This prevents persons from authorising decision-making in advance for a time they may lose the capacity to take decisions. Similarly, individuals do not have a general right to choose a surrogate to make decisions on their behalf once they lose capacity. This may especially affect persons who may lose decision-making capacity during acute illness, such as a comatose state and persons of older age who may be affected by conditions such as progressive dementia. Often, decision-making in such situations is left to members of the heteronormative family which leaves communities such as the LGBTQ+ community particularly vulnerable, since Indian laws do not recognise their relationships.¹⁵² Their chosen families often fall outside traditional heteronormative family structures which are often represented in the default statutory hierarchies of decision-makers who may be authorised by certain laws to make decisions on behalf of a person when they lack capacity.¹⁵³ In fact, in contrast, their families in law are often a cause of stress and violence for such communities.¹⁵⁴

At the structural level, the Indian legal approach to capacity and decision-making remains population-specific rather than looking at the issue of capacity holistically for all persons with impaired capacity, which leads to fragmentation of legal responses, although admittedly, the concerns of different population groups are different. For instance, the aspirations of a person with congenital intellectual disabilities who wishes to experience life in all its vicissitudes may be vastly different from a person of advanced age who is concerned with securing their life's

<https://main.mohfw.gov.in/sites/default/files/Final%20Draft%20Rules%20MHC%20Act%2C%202017%20%281%29.pdf> accessed 25 February 2021.

¹⁵⁰ *Common Cause v Union of India* Writ Petition (Civil) No. 215/2005. Further, the guidelines in *Common Cause* suffer from various practical issues of implementation, see Dhvani Mehta *et al*, 'End of Life Care in India: A Model Legal Framework' *Vidhi Centre for Legal Policy* <<https://vidhilegalpolicy.in/research/end-of-life-care-in-india-a-model-legal-framework/>> (accessed 14 February 2021).

¹⁵¹ Section 5, Mental Healthcare Act, 2017.

¹⁵² For shortcomings in Indian family law and LGBTQ+ inclusion, see Akshat Agarwal *et al*, 'Chapter on Family in Queering the Law' *Vidhi Centre for Legal Policy* <<https://vidhilegalpolicy.in/research/queering-the-law-making-indias-laws-lgbt-inclusive/>> (accessed 20 January 2021).

¹⁵³ See definition of "relative" in Section 2(u) of the The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2019; definition of "near relative" in Section 2(i) of the Transplantation of Human Organs and Tissues Act, 1994 and definitions of "family" and "relative" in Sections 2((1)(h) and 2(1)(za) respectively of the Mental Healthcare Act, 2017. Also, see Response dated 10 July 2018 to Law Commission of India on Uniform Civil Code <<http://orinam.net/lci-response-lbt-2018/>> accessed 15 January 2021.

¹⁵⁴ Response dated 10 July 2018 to Law Commission of India on Uniform Civil Code <<http://orinam.net/lci-response-lbt-2018/>> accessed 15 January 2021.

integrity at the end of life. However, not focusing on the issue of capacity for all inevitably leaves out persons who may need decision-making interventions as demonstrated by the judicial decisions. The difference in aspirations, however, points to the complexities in thinking about appropriate design choices.

The existing law ranges from one end of the spectrum to the other. The NTA errs on the side of caution, adopting a paternalistic approach to decision-making 'for' the person with the disability – hedging against harm to the individual, as well as protecting the world at large from the need to ascertain the competence of the individual with regard to specific actions or interactions. The RPWD ranges on the side of liberty and dignity of the individual, assuming that every individual when provided with adequate support is capable of acting for themselves and should be enabled to do so. This does not, however, account for the practical concerns arising from interactions of the individual and their support person and the world at large, such as mutual obligations and responsibilities and the potential for abuse.

Therefore, India's current approach to capacity and decision-making falls short on various fronts and needs reconsideration to ensure not only that it is conceptually coherent, but also promotes the rights of persons with impaired capacity.

Chapter 4: Brief Overview of International Best Practices

This Chapter gives a brief overview of developed legal frameworks and ongoing debates about laws on capacity and decision-making in foreign jurisdictions. It looks at laws in three countries, the United Kingdom, Canada and Australia. These three countries have been chosen for analysis for three reasons. First, since their laws on capacity and decision-making are well developed and they have seen long-standing and thoughtful debates on the development of such laws. Second, they share the common law tradition and therefore there is a broad similarity with India in terms of legal concepts.¹⁵⁵ Lastly, all three countries have ratified the UNCRPD and therefore, are also obliged to introduce mechanisms for supported decision-making to advance individual autonomy.

A. United Kingdom

The United Kingdom enacted the Mental Capacity Act, 2005 (“MCA”) to comprehensively deal with questions of decision-making for persons with impaired decision-making capacity. The MCA proceeds on the premise that individuals should be presumed to have capacity and as far as possible, should be assisted in making decisions. This includes the possibility of the individual making unwise decisions. It therefore focuses on giving maximum effect to the autonomy of the individual. However, the MCA does not provide a detailed legislative scheme for supported-decision-making. In 2017, the Law Commission of the UK considered making legislative amendments to introduce such a scheme, but in the absence of detailed empirical evidence on how supported decision-making would work, left the question to regulations under the Act.¹⁵⁶

In case decisions are to be made by someone else, they should be in the individual’s best interests and any treatments and care being provided to a person who lacks capacity should be least restrictive of their rights and freedoms. Interestingly, while a decision in best interests is traditionally understood to incorporate an objective standard, the Act defines a decision in best interests to involve consideration of the individual’s past and present wishes and preferences and their values and beliefs.¹⁵⁷ In fact, in line with the UNCRPD, the 2017 Law Commission Report has further stressed the importance of including the wishes and preferences of the person in question, and has advocated moving towards an interpretive approach in determining the person’s best interests.¹⁵⁸ The Act also allows individuals to make legally binding advance decisions with respect to future refusal of healthcare treatment when they may lack the capacity to consent.¹⁵⁹ These are distinct from advance statements which merely express wishes regarding care and treatment, but may not be binding.

An individual may also appoint another person to take healthcare, financial or other relevant decisions on their behalf through a lasting power of attorney.¹⁶⁰ However, such a surrogate must take decisions in compliance with principles of decision-making including the best-interests standard enshrined in the Act. The MCA further designates the Court of Protection which is specifically tasked to resolve issues with respect to decision-making and appoint deputies to take decisions on behalf of a person.¹⁶¹ Lastly, it creates the Office of the Public Guardian which maintains registers of lasting powers of attorneys and deputies appointed by the Court and is also responsible for the overall welfare of persons who may lack the capacity to make decisions.¹⁶² The Act also has

¹⁵⁵ In Canada’s case the province of Ontario follows common law.

¹⁵⁶ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) 169-170 (UK).

¹⁵⁷ Section 4(5), Mental Capacity Act, 2005 (UK).

¹⁵⁸ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) (UK).

¹⁵⁹ Section 24, Mental Capacity Act, 2005 (UK).

¹⁶⁰ Section 9, Mental Capacity Act, 2005 (UK).

¹⁶¹ Sections 15 & 16, Mental Capacity Act, 2005 (UK).

¹⁶² Sections 57 & 58, Mental Capacity Act, 2005 (UK).

specific protections in place where decisions lead to deprivation of the person's liberty¹⁶³ and excludes decisions relating to family life, intimacy and voting choices from its ambit.¹⁶⁴

B. Australia

Australia has seen significant debates about implementing the UNCRPD, with the Australia Law Reforms Commission's 2014 report ("**ALRC Report**") being a significant starting point on the question of law reform at the federal level. While different states in Australia have their own laws governing issues relating to decision-making, including decisions relating to refusal of treatment and guardianship for financial decisions, the ALRC Report sets out the National Decision-Making Principles which it considers key to law reform. These principles stress on the equal right of all adults to make decisions about their lives, the need for providing support to persons who need such support to make decisions, the need for the will, preferences and rights of persons to guide decisions on their behalf, and the need for safeguards to prevent abuse and undue influence in interventions for persons who require decision-making support.¹⁶⁵

Following up on the UNCRPD's mandate, the ALRC Report therefore stresses on supported decision-making. It recommends the appointment of supporters who may provide various levels of support to persons who need it to make their own decisions.¹⁶⁶ When supported decision-making may not be possible at all and in a very limited set of circumstances, it recommends the appointment of representatives who may make decisions on behalf of the person.¹⁶⁷ In contrast to the UK law, instead of using the best-interests standard, the ALRC Report recommends that the representative should take a decision according to what the will and preferences of the person would have been and if they are impossible to determine, then a decision should be taken in accordance with the person's human rights relevant to the situation.¹⁶⁸ In the UK, while a decision in best interests involves accounting for the person's supposed will and preferences, it is only one of the factors that need to be taken into account in what is otherwise an objective decision. The ALRC Report's recommendations seem to give greater precedence to the will and preferences of the person. In the event these wishes are impossible to determine, and in line with the mandate of the UNCRPD, it advocates a completely new human rights standard to replace best interests as a last resort option.¹⁶⁹ The human rights standard involves consideration of the various rights articulated in the UNCRPD.

While the ALRC Report's recommendations were largely aimed at laws at the federal level, various States in Australia have undertaken law and policy reforms pursuant to the UNCRPD. For instance, New South Wales published a Capacity Toolkit¹⁷⁰ which stresses on supported decision-making and recommends substituted decision-making under the state's guardianship laws as a last resort. On the other hand, the state of Victoria passed the Guardianship and Administration Act, 2019¹⁷¹ which modernises the law and allows for the appointment of supporters termed as supportive guardians and supportive administrators to facilitate supportive decision-making, apart from guardians who undertake substituted decision-making. Individuals can also execute enduring powers of attorney to appoint persons who can take decisions on their behalf once they lose capacity. The general decision-making principles of the Act stress on the person's will and preferences, and also acknowledge the need for consulting relatives and other caregivers in understanding these preferences.¹⁷²

¹⁶³ Sections 4A, 4B & 4C, Mental Capacity Act, 2005 (UK).

¹⁶⁴ Sections 27 & 29, Mental Capacity Act, 2005 (UK).

¹⁶⁵ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124, August 2014) 64.

¹⁶⁶ *ibid.*, at 99.

¹⁶⁷ *ibid.*, at 111

¹⁶⁸ *ibid.*, at 77.

¹⁶⁹ See discussion on will and preference, *ibid.*, Chapter 3.

¹⁷⁰ Capacity Toolkit, New South Wales Government <<https://www.justice.nsw.gov.au/diversityservices/Documents/CapacityToolkit2020.pdf>> accessed 15 January 2021.

¹⁷¹ Guardianship and Administration Act, 2019 (State of Victoria, Australia) <<https://content.legislation.vic.gov.au/sites/default/files/2020-06/19-13aa004%20authorised.pdf>> accessed 15 January 2021.

¹⁷² Section 9, Guardianship and Administration Act, 2019 (State of Victoria, Australia).

However, in the event that is not possible to determine them, then the Act relies on a standard which promotes the individual's personal and social well-being.¹⁷³

C. Canada

Being a federal country, Canada again has province-specific legal frameworks on capacity and decision-making. We specifically focus on the province of Ontario Canada's most populous province, which has a complex and sophisticated legal framework on the issue and has also seen debates on law reform in recent years. Two laws viz. the Substituted Decisions Act, 1992 ("SDA") and the Health Care Consent Act, 1996 ("HCCA") are significant. While the HCCA governs decision-making in healthcare contexts, the SDA governs other contexts such as finance and property. These laws currently do not recognise supported decision-making since they were enacted before the UNCRPD and have not been amended yet. Under the SDA, a surrogate decision-maker can be appointed through a power of attorney made by the person before they lost capacity, or a guardian can be appointed as a statutory guardian through a court appointment process. Under the HCCA, the surrogate decision-maker is appointed through a hierarchical list which privileges persons appointed through power of attorney and then lists members of the individual's family. Individuals may also prepare advance statements indicating their wishes and preferences to guide their surrogate decision-makers. However, advance directives which give specific instructions are not recognised. The office of public guardian and trustee serves as the guardian of last resort under both the SDA and the HCCA.

In 2017, the Law Commission of Ontario suggested reforms to the province's capacity and decision-making laws. It specifically identified persons with disabilities and the elderly as two key population groups who are affected by such laws and articulated separate sets of vision principles for both.¹⁷⁴ The Law Commission further emphasized the need for autonomy-enhancing decision-making practices as well as the need for legal accountability in decision-making law.¹⁷⁵ It also discussed the UNCRPD in detail and concluded that an approach that solely focused on either supported or substituted decision-making may not work. This is because supported decision-making may specifically be unsuitable for older people due to the higher risk of abuse. Additionally, presuming capacity for all people in all circumstances may raise tricky questions of legal responsibility for decisions in instances where capacity is hard to establish.¹⁷⁶

In its approach to decision-making law, the Law Commission therefore underscored the need for correspondence between decision-making and legal accountability for those decisions, taking the least restrictive approach in relation to the rights of the individual, making decisions based on the wishes and preferences of the person, and for a diversity of approaches which address the concerns of specific population groups.¹⁷⁷ On the one hand, subject to extensive safeguards, it recommended the amendment of existing laws, such as the SDA to recognise support authorisations for aid in decision-making and to clarify that substituted decision-making for property decisions should account for the wishes and preferences of the person apart from focusing on well-being. On the other, it also recommended that the Government undertake further empirical studies to identify autonomy enhancing decision-making practices.¹⁷⁸ The Law Commission's approach, therefore, represents a fairly nuanced take on a complex issue and is also indicative of its extensive consultations with different population groups affected by decision-making and capacity laws.

¹⁷³ Section 9(1)(d), Guardianship and Administration Act, 2019(State of Victoria, Australia).

¹⁷⁴ Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Final Report* (Toronto March 2017).

¹⁷⁵ *ibid.*, at 61.

¹⁷⁶ *ibid.*, at 81-82.

¹⁷⁷ *ibid.*, at 84-87.

¹⁷⁸ *ibid.*, at 95-97.

Chapter 5: Conclusion– Key Features of a Legal Framework on Capacity and Decision-Making for India

This paper discussed the context in which the laws of capacity and decision-making become relevant and the various theoretical concepts and dominant approaches which form the backbone of such laws. It analysed the existing Indian legal framework on capacity and decision-making and argued that it currently falls short since it is scattered and fragmented and does not fully promote the rights of persons with impaired capacity, thereby leaving them vulnerable. This highlights the need for law reform in this area. The paper also provided a brief snapshot of such laws in jurisdictions with developed frameworks.

As the discussion in the previous Chapters showed, these laws represent complex design choices and often require policymakers to make difficult decisions about how to facilitate autonomy while balancing values of well-being as well as distributive justice. While this paper does not give concrete recommendations on the exact form which an Indian legal framework on capacity and decision-making should take, we outline the key features which policymakers will have to consider in formulating such a framework:

<i>S.No.</i>	<i>Key Features</i>	<i>Considerations</i>
1.	Target Population Groups and Nature of Decisions	<p>Existing Indian laws are population specific i.e., they target specific groups of persons with impaired decision-making capacity such as persons with disabilities and persons with mental illness. This naturally leaves out population groups such as persons in comatose states or persons of older age who may face conditions such as dementia. While a holistic approach to capacity which includes all potential population-groups is likely to address problems of exclusion, it also makes problems of design more complex since different population groups are likely to have different values and interests. As pointed out previously, for instance, the concerns and interests of persons with congenital disabilities may diverge from persons of older age.</p> <p>A linked question is the kinds of decisions that such a legal framework should cover. Decisions could range from healthcare to those relating to property and may include decisions concerning personal welfare. At the same time some decisions such as electoral choices may be excluded altogether.</p>
2.	Guiding Objectives	<p>While decision-making capacity is itself the embodiment of the right to individual autonomy, the rights of equality and dignity also become relevant in shaping these laws. This is particularly significant since concepts of decision-making capacity and legal capacity have in the past, and continue to be, utilised to discriminate against sections of the population, such as persons with disabilities, by denying them legal personhood. At the same time such laws will also have to balance the right of autonomy with some notion of individual</p>

well-being which comprises a more objective standard of welfare. Concerns of distributive justice which take into account the interests of third parties in their interactions with persons with impaired capacity, such as in the context of financial transactions, will also become relevant.

3. Approach to Decision-Making Capacity

In India currently, while the MHA defines the capacity to take mental healthcare decisions, the NTA and the RPWD do not engage with the concept at all, with the latter assuming that all persons possess equal legal capacity. As has been pointed out in this paper, conflating the concepts of “legal capacity” and “decision-making capacity” can have ethically vexed policy implications by attributing decision-making capacity to persons with impaired capacity who may simply not possess any capacity after a certain point. Further, decision-making capacity is itself a very nuanced and complex concept and setting the appropriate legal threshold will require balancing the ethical principles of autonomy and well-being.
4. Approach to Decision-Making

While supported decision-making appears to be the most intuitive approach to facilitating decision-making to maximise autonomy, it is important that legal design choices ensure that such supported decision-making does in fact lead to the expression of autonomy while minimising the potential of abuse. At the same time, it is important to remember that supported decision-making may simply not be possible once capacity gets impaired beyond a point as well as for persons in a comatose or vegetative state. In such instances, robust and conceptually sound frameworks for substituted decision-making are essential. These mechanisms should provide for mechanisms such as advance directives, nominated or appointed surrogates as well as provide clear guiding principles for decision-making by surrogates.
5. Safeguards to Prevent Abuse

Any legal framework on capacity and decision-making has to ensure that it does not lead to the abuse of the person with impaired capacity or violate their important rights and interests. Such safeguards are also necessary to avoid conflicts of interest with the support person or the surrogate decision-maker. Such laws will also have to provide for nimble procedures to effectively enforce the rights of persons with impaired capacity and prevent abuse.

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