

# Care and Relationality Research Workshop

Thursday 5 June 2014

12:30pm – 5:30pm

**Moot Room, Birmingham Law School, University of Birmingham**

Attendance is free, but places limited. Register at: <https://www.eventbrite.co.uk/e/care-and-relationality-afternoon-research-workshop-tickets-11446307213>

## Draft Programme

**12:30 - 1:00 Arrival/lunch**

**1:00 – 3:00 pm Vulnerability, Care and the Potential of Relationality**

Chair: Dr Rosie Harding

Prof Jo Bridgeman 'From Warren and Rose back to Blood with reference to Yearworth and Evans: could the law regulating assisted reproduction be more caring?'

Sarah Singh 'Criminalising Vulnerability: Protecting "Vulnerable" Children and Punishing Their "Wicked" Mothers'

Kirsty Moreton 'Caring in 'The Middle': Reviving the Best Interests Test for Health-Care Decision-Making in Mid-Childhood'

**3pm - 3:30pm Break**

**3:30 - 5:30 pm Relationality and Capacity: Charting in new frontiers in decision making**

Chair: Dr Sheelagh McGuinness, Birmingham Law School

Dr Rosie Harding 'Care as Relationality: Supported decision making and the end of best interests?'

Dr Mary Donnelly 'Re-Forming Capacity Law as a Relational Endeavour: Promises and Challenges '

Closing Discussion

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## Abstracts

### **From *Warren* and *Rose* back to *Blood* with reference to *Yearworth* and *Evans*: could the law regulating assisted reproduction be more caring?**

Jo Bridgeman, University of Sussex

This paper examines the case law surrounding the storage of human gametes prior to medical treatment likely to cause infertility and the use of human gametes after death; reflecting back from *Warren* [2014] and *Rose* [2014] to *Blood* [1999] with reference to *Yearworth* [2009] and *Evans* [2004]. I argue that these cases demonstrate that in some areas of healthcare law autonomy alone provides an inadequate framework. Decisions about reproduction are intensely personal and individual but they are also inevitably relational. It is argued that the dominance of respect for autonomy, generally in healthcare law, and specifically in the regulation of assisted reproduction requires the presentation and resolution of claims and conflict in abstract, individualistic terms. Whilst judges cannot fail but to appreciate the relational nature of claims around reproduction, it is necessary to consider other accounts provided by those using assisted reproductive technology to understand the context and the relational interests surrounding reproductive material and potential. Until the legal framework admits articulation of relational interests, decisions cannot be made about the nature of relational interests deserving of legal protection. Relational interests need to be recognised to make the law, and decisions about reproductive material and potential, more caring.

### **Criminalising Vulnerability: Protecting “Vulnerable” Children and Punishing Their “Wicked” Mothers**

Sarah Singh, Liverpool John Moores University

This paper explores the imposition of relational responsibility on vulnerable women. Looking at the Domestic Violence, Crime and Victims Act (2004) (as amended), a statute initially intended to strengthen legal protection for victims of domestic violence, this paper specifically considers s.5 which introduced the offence of ‘failing to protect a child from serious harm’. I argue that this provision paradoxically criminalises mothers who are themselves victims of domestic abuse.

Drawing on Fineman’s (2008) notions of ‘inevitable’ and ‘derivative’ dependency this paper will explore how this offence seeks to protect the ‘inevitable’ (and thus worthy) dependency of infants whilst punishing derivative dependency, that of the battered mother. Fineman also argues that vulnerability is both *universal* and *particular*. This paper will extend that argument suggesting that particular vulnerability is criminalised in order to protect vulnerable institutions, namely the Criminal Justice System and the Social Services.

Through the lens of a case study, *R v Green & Critchley* [2013] (Unreported) I explore how gendered tropes of motherhood both exaggerate and diminish the relationality between mother and child. Presently, the relationship between mother and child is emphasised to justify the imposition of criminal responsibility (and ultimately punishment) but is also obscured in that it ignores that their interests (namely to live a life free from abuse) are obviously intertwined. Section 5 is a coercive tool which seeks to exploit the vulnerabilities of the mother to encourage her to testify against her violent partner. If she refuses to do so, her vulnerability is then further exploited as any incidences of domestic violence perpetrated against her are cited by the prosecution as, in this context of this offence, they 'prove' that the harm to the child was foreseeable and that the mother consequently had a duty to remove the child from harm. In essence, the frequency and severity of violence suffered by the mother increases her criminal responsibility for her child's death.

Albeit in the context of sex offences Stanko (2014) has proposed that we move away from the problematic issue of the consent, (where all attention is focused on the victim) to vulnerability thus shifting focus to the perpetrators *reaction* to these vulnerabilities. Similarly I argue that the Criminal Justice System needs to respond to the common vulnerabilities of mother and child and battered mother and battered woman rather than deny their relationality and seek to protect one group to the detriment of the other.

### **Caring in 'The Middle': Reviving the Best Interests Test for Health-Care Decision-Making in Mid-Childhood.**

Kirsty Moreton, University of Birmingham

The approach of healthcare law to children is inconsistent. While much has been written both about parental dilemmas surrounding care for young and disabled children, and the scope for competence at the borders of adulthood, the 'middle' has been under theorized in the academic literature and largely ignored in the courtroom. Yet the period of mid-childhood (approx. aged 8 -14 years) reveals profound questions around the nature of vulnerability, the importance of relational identity, the value of bodily integrity and the potential for active participation in decision-making. Neither the current construction of the 'best interests' test, nor the criteria for establishing Gillick competence adequately addresses these issues. Indeed the criticisms oft cited against best interests - that it is poorly defined, atomistic, deferential to medical opinion and absent relational concern, resound more loudly in the context of mid-childhood.

In this paper I will argue that best interests is still the pragmatic choice for healthcare decision-making but I will employ an Ethic of Care as a means of reviving the test. I shall draw upon the 3 guidelines presented by Jo Bridgeman in her 2007 monograph, *Parental Responsibility, Young Children and Healthcare Law* and show how they can be developed into a framework to be used as tool in interpreting mid-childhood best interests. This framework will then be applied to the recent immunization case of *F v F* [2013] EWHC 2683

(fam), which will be used as a case study to demonstrate the potential descriptive and normative efficacy of the Ethics of Care.

### **Care as Relationality: Supported decision making, dementia and the end of best interests?**

Dr Rosie Harding, University of Birmingham

'Best interests' decision making has become a cornerstone of healthcare law, and was embedded as a key principle in the Mental Capacity Act 2005. Yet in April 2014, the Committee on the Rights of Persons with Disabilities confirmed their view that the 'best interests' approach to decision-making for those who lack capacity to make particular decisions is incompatible with Article 12 of the UN Convention on the Rights of Persons with Disabilities. Instead, where it is not possible to support a person to make their own decisions, the relevant decision must be made with reference to the "best interpretation of the will and preferences" of that individual. This paper seeks to explore how a relational approach to law could help to operationalise this shift from 'best interests' decision-making to 'best interpretation of will and preferences' using the case study of caring for a person with dementia. I will argue that taking a relational approach to the legal subject goes some way towards understanding what support means in this context whilst simultaneously seeking to maximise opportunities for autonomy and personal freedom for people with intellectual and psychosocial disabilities. Yet the case study of dementia care also provides an important counterpoint by exploring conceptual and practical limitations of the elevation of supported decision making as a substitute for best interests approaches, including the difficulties inherent in untangling past and present wishes and feelings when making decisions about health and social care needs.

### **Re-Forming Capacity Law as a Relational Endeavour: Promises and Challenges**

Dr Mary Donnelly, University College Cork

Legal approaches to capacity are undergoing profound changes. Within a relatively short time, the conceptual breakthrough in the Mental Capacity Act 2005, which required participative decision-making by persons lacking capacity has been superseded by a much more extensive requirement for supported decision-making in Art. 12 of the United Nations Convention on the Rights of Persons with Disabilities and, indeed by the suggestion that legal differentiation on the basis of incapacity is no longer permissible (Dhanda, 2007). The implications for capacity law, as we know it, are profound.

The paradigm shift in the CRPD (and to a lesser extent that in the MCA) is underpinned by a relational understanding of autonomy (Bach and Kerzner, 2010). Replacing the traditional notion of decision-making capacity as immutable, we see autonomy as something to be achieved in the right context and with the right support. While this conceptualisation of autonomy is clearly more progressive than the traditional view, its deliverability is far from assured. This paper identifies two aspects of the CRPD's approach to legal capacity in which,

it suggests, the CRPD fails to follow through on a relational approach. First, although Art. 12(3) requires States Parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity, there is no indication regarding what this might be and the matter is left undeveloped. A number of models are emerging, including the British Columbia Representation Act and aspects the Irish Assisted Decision-Making (Capacity) Bill, both of which draw on family/caregivers as the primary source of support. Secondly, relationality as conceived by the CRPD is a one-way process. Family or caregivers are presented always as of secondary importance to the person with disabilities. There are, of course, good reasons for this return to individualism (Kayess and French, 2008). However, the individualist approach also means that CRPD-inspired reform of capacity law may well miss out on the potential for more meaningful engagement with the individual in a relational context.