

Mental Capacity in the (Civil) Law: Capacity, Autonomy, and Vulnerability

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Article abstract

This paper examines mental capacity as a medico-legal social construct and concludes that, while the construct works reasonably well in the contexts of property-related transactions and health-treatment decisions, it is deeply problematic and is a source of dysfunction in the context of guardianship and guardianship-type interventions. There is nothing natural, compelling, or necessary about the concept of mental capacity, and the author proposes an alternate construct more consistent with the purpose of guardianship and guardianship-type interventions: vulnerability. As the capacity construct is deeply enmeshed with a traditional liberal theory of autonomy (the capacity-autonomy equation or paradigm), so the vulnerability construct described here is more consistent with a theory of relational autonomy. The author contends that the conceptual framing provided by the capacity-autonomy paradigm in the guardianship context has precluded the coherent theorization of vulnerability, and she suggests a more coherent framework for doing so by drawing on theories of equity and relational autonomy.

MENTAL CAPACITY IN THE (CIVIL) LAW: CAPACITY, AUTONOMY, AND VULNERABILITY

*Margaret Isabel Hall**

This paper examines mental capacity as a medico-legal social construct and concludes that, while the construct works reasonably well in the contexts of property-related transactions and health-treatment decisions, it is deeply problematic and is a source of dysfunction in the context of guardianship and guardianship-type interventions. There is nothing natural, compelling, or necessary about the concept of mental capacity, and the author proposes an alternate construct more consistent with the purpose of guardianship and guardianship-type interventions: vulnerability. As the capacity construct is deeply enmeshed with a traditional liberal theory of autonomy (the capacity-autonomy equation or paradigm), so the vulnerability construct described here is more consistent with a theory of relational autonomy. The author contends that the conceptual framing provided by the capacity-autonomy paradigm in the guardianship context has precluded the coherent theorization of vulnerability, and she suggests a more coherent framework for doing so by drawing on theories of equity and relational autonomy.

Ce texte examine la capacité mentale comme construction sociale médico-légale et conclut que, bien que cette construction fonctionne raisonnablement bien dans les contextes liés aux transactions relatives à la propriété et aux décisions de traitement en santé, elle est très problématique et constitue une source de dysfonctionnement dans le cadre de la tutelle et des autres interventions de ce type. Il n'y a rien de naturel, de convaincant, ou de nécessaire relativement au concept de capacité mentale. L'auteure propose une autre construction plus conforme à l'objet de la tutelle et des autres interventions de ce type : la vulnérabilité. Comme la construction de la capacité est intimement liée à une théorie libérale traditionnelle de l'autonomie (l'équation ou le paradigme capacité-autonomie), la vulnérabilité décrite ici est une construction plus cohérente avec une théorie de l'autonomie relationnelle. L'auteure affirme que le cadre conceptuel fourni par le paradigme des capacités d'autonomie dans le contexte de tutelle a empêché la théorisation cohérente de la vulnérabilité et elle suggère un cadre plus cohérent pour le faire en s'appuyant sur les théories de l'équité et de l'autonomie relationnelle.

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Introduction

Mental capacity¹ is a social construct clothed in the naturalizing language of a biological fact. Like all social constructs, mental capacity persists and is used because it works as an effective mechanism for achieving a valuable social purpose or, more precisely, set of purposes. Mental capacity is an especially useful mechanism in the adult guardianship context, allowing for the (apparent) reconciliation of socially valuable, but ideologically inconsistent, purposes: the legally enforced and legally enforceable protection of individual autonomy² and the realization of important social policy goals that seem to require interference with that autonomy.³ This dual function is especially useful where the subject of the guardianship inquiry is an older adult who was previously considered to possess mental capacity, in which case the loss of autonomy is put in issue. These cases will almost always involve a diagnosis of dementia, itself a contested construct, and the simultaneously authoritative and mystifying language of biomedicine will play a crucial role in the “finding” of mental capacity—or incapacity—conferring a particular quality of “out-there-ness”⁴ or truth.

Mental capacity is neither natural nor inevitable, however, and the incoherence of mental capacity in the primarily medical, embodied settings where capacity is substantively evaluated (an evaluation that is subsequently relied on for the purposes of legal action) is a source of significant confusion and dissatisfaction. That incoherence, I suggest, makes the assessment of abstract mental capacity that is required by adult guardianship legislation—perhaps especially by modern, decision-specific adult guardianship legislation—substantively impossible, fuelling the endless search for the perfect “capacimeter” and the tensions between the medical professionals charged with finding capacity and the legal professionals who wring their hands at medicine’s apparent inability to get it right. That inability, most often attributed to the avowed paternalism of the

¹ The word “capacity” is used in this article as synonymous and interchangeable with “competence” and “capability”. This is consistent with both general or everyday usage and legal usage, and is adopted for that reason, although a distinction has traditionally been drawn between mental capacity as a clinical assessment and competence as a legal determination: see e.g. Alec Buchanan, “Mental Capacity, Legal Competence and Consent to Treatment” (2004) 97:9 *Journal of the Royal Society of Medicine* 415 at 415.

² As understood within the liberal paradigm and ideology, in terms of liberty and self-rule.

³ Mental capacity in the context of health care decision making plays a very different role, consistent with the roots of the health care consent requirement in the ancient tort of trespass to the person. See the discussion below.

⁴ Jonathan Potter, *Representing Reality: Discourse, Rhetoric and Social Construction* (London, UK: Sage, 1996) at 150.

medical profession, necessarily flows from the mental capacity construct itself.

Furthermore, I suggest, the ideological paradigm in which the capacity construct is situated and of which it is an essential part—the liberal autonomy ideal—is itself, in this context, deeply problematic and even cruel. If we agree with William James that “[t]ruth *happens* to an idea,”⁵ the idea of mental capacity, for the purposes of adult guardianship, should no longer be treated as a real or true description of the world and its workings, allowing instead for the construction of a new and more workable truth in this context.⁶

I. Autonomy and the Sovereign Self: The Role of the Mental Capacity Threshold

Despite the ubiquitousness of autonomy talk across discourses, “[a]bout the only features held constant from one author to another are that autonomy is a feature of persons and that it is a desirable quality to have.”⁷ So what does autonomy mean in, and for, the law? Martha Fine-

⁵ For James and other pragmatic philosophers such as John Dewey, cited below, an idea “becomes true, is *made* true” (William James, *Pragmatism*, ed by Bruce Kuklick (Indianapolis: Hackett, 1981) at 92, cited in Cornel West, *The American Evasion of Philosophy: A Genealogy of Pragmatism* (Madison, Wis: University of Wisconsin Press, 1989) at 65) through the “active and ongoing reconstruction of experienced situations” (Larry A Hickman, “Dewey’s Theory of Inquiry” in Larry A Hickman, ed, *Reading Dewey: Interpretations for a Postmodern Generation* (Bloomington, Ind: Indiana University Press, 1998) 166 at 167).

⁶ John Dewey described this process of truth revision and construction as “warranted assertibility”, an evolution of the true and the real in response to the environment, which should be understood as analogous to evolution in the natural world:

If ideas, meanings, conceptions, notions, theories, systems are instrumental to an active reorganization of the given environment, to a removal of some specific trouble and perplexity, then the test of their validity and value lies in accomplishing this work. If they succeed in their office, they are reliable, sound, valid, good, true. If they fail to clear up confusion, to eliminate defects, if they increase confusion, uncertainty and evil when they are acted upon, then are they false. Confirmation, corroboration, verification lie in works, consequences. ... By their fruits shall ye *know* them (*Reconstruction in Philosophy* (Boston: Beacon Press, 1948) at 156).

⁷ Gerald Dworkin, “The Concept of Autonomy” in John Christman, ed, *The Inner Citadel: Essays on Individual Autonomy* (New York: Oxford University Press, 1989) 54 at 54-55 [Dworkin, “Concept of Autonomy”; Christman, *Inner Citadel*]. Dworkin notes:

It is used sometimes as an equivalent of liberty (positive or negative in Berlin’s terminology), sometimes as equivalent to self-rule or sovereignty, sometimes as identical with freedom of the will. It is equated with dignity, integrity, individuality, independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one’s

man has identified autonomy, defined in terms of freedom from interference by others, as one of the foundational myths of the American legal and political system, reflected in the *Declaration of Independence*, the US Constitution, and the US *Bill of Rights*.⁸ As an idea associated with liberty, freedom from interference, and self-control, the Supreme Court of Canada has found a “degree of personal autonomy over important decisions intimately affecting [one’s] private li[fe]” to be included in the right to life, liberty, and security of the person protected by section 7 of the *Canadian Charter of Rights and Freedoms*.⁹ Autonomy as personal liberty is also fundamental to the common law and to the personal rights to non-interference protected by the torts of trespass to the person, trespass to property, and false imprisonment.

Autonomy has a very specific meaning and function, as it relates to the legal idea of mental capacity. Capacity, in law, serves as the effective threshold of autonomy, dividing the autonomous, on the one side, from the non-autonomous, on the other, on the basis of an individual’s ability to engage in the process of rational (and therefore autonomous) thought, explained as the ability to exercise one’s will to reflect upon, and choose between desires, and to adopt those chosen as one’s “own”.¹⁰ On neither side of the threshold is the law formally concerned with the *substantively* autonomous quality¹¹ of the individual’s thought or action. Evaluating the

own interests. It is related to actions, to beliefs, to reasons for acting, to rules, to the will of other persons, to thoughts and to principles (*ibid* at 54).

⁸ Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (New York: New Press, 2004) at 18. Fineman states:

Self-government (autonomy) is the ideal and defines the individual subject of liberal political discourse. ...

... Individual liberty interests are what are protected—autonomy entails being left alone to satisfy our own needs and provide for our own families without undue restraint (*ibid* at 18-19).

⁹ *R v Morgentaler*, [1988] 1 SCR 30 at 171, 44 DLR (4th) 385, Wilson J, concurring (the majority agreed with Justice Wilson on this point); *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, reprinted in RSC 1985, App II.

¹⁰ See Harry G Frankfurt, “Freedom of the Will and the Concept of a Person” (1971) 68:1 *The Journal of Philosophy* 5 at 6-7; Gerald Dworkin, “Autonomy and Behaviour Control” (1976) 6:1 *The Hastings Center Report* 23 at 25; Dworkin, “Concept of Autonomy”, *supra* note 7 at 54.

¹¹ Described by Gerald Dworkin as embracing the qualities of dignity, integrity, individuality, independence, responsibility, self-knowledge, self-assertion, critical reflection, freedom from obligation, absence of external causation, and knowledge of one’s own interests: *ibid*. It has been argued that the problem of socialization—what N. Stoljar has described as the “feminist intuition”—dictates against an idea of autonomy without the indicia of substantive autonomy: see Natalie Stoljar, “Autonomy and the Feminist Intuition” in Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist*

substantive choices and actions of those who have capacity is conceptualized as actively undermining their now established autonomy,¹² while actions and choices on the other side of the threshold can never be autonomous, whatever their content. Understood in these terms, the autonomous thought process parallels the dominant medical paradigm of cognitive capacity, in which the physically healthy and unimpaired brain is taken to possess the capacity for rational (and therefore autonomous) thought, which may then be impaired by disease or injury or, in some cases, may be “impaired” from birth.¹³

Recognizing and locating autonomy in the process of self-rule making, rather than in the content of the rules made, avoids assigning social value to particular choices and ways of living, thereby limiting the “tyranny of the majority” and paternalistic interference by the state.¹⁴ Indeed, so long as the decision-making process is “autonomous”, the protection of individual autonomy *requires* a value-neutral stance in relation to the substance of choices and behaviours. Public, and even private, indifference to the substantively non-autonomous, private choices and behaviours of others is conceptualized as essential to the protection of individual autonomy. The characterization of a matter as public works to change this dynamic; the characterization of children and their protection from harm as matters of public interest justifies the scrutiny and evaluation of the substantive decisions and actions of their caregivers, for example. This characterization

Perspectives on Autonomy, Agency, and the Social Self (New York: Oxford University Press, 2000) 94; Paul Benson, “Autonomy and Oppressive Socialization” (1991) 17:3 *Social Theory and Practice* 385; Sarah Buss, “Autonomy Reconsidered” (1994) 19 *Midwest Studies in Philosophy* 95; Sigurdur Kristinsson, “The Limits of Neutrality: Toward a Weakly Substantive Account of Autonomy” (2000) 30:2 *Canadian Journal of Philosophy* 257.

¹² And so, substantively self-destructive choices (e.g., staying with an abusive spouse; signing over your house to a new acquaintance; living in squalor) may be read as “autonomous” *because* of their opposition to social norms and values, as expressions of self-interest that need not be explicable to anyone outside of the self (consistent with “autonomous man’s” self-definition in *opposition* to the social). “The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake” (*Koch (Re)* (1997), 35 OR (3d) 71 at 76 (available on CanLII) (Gen Div), Quinn J).

¹³ And autonomy is now the transcendent value in medicine, as in law: see Paul Root Wolpe, “The Triumph of Autonomy in American Bioethics: A Sociological View” in Raymond DeVries & Janardan Subedi, eds, *Bioethics and Society: Constructing the Ethical Enterprise* (Upper Saddle River, NJ: Prentice Hall, 1998) 38.

¹⁴ The problem of values and value judgment for theories of autonomy is crucial to the idea of theoretical autonomy, codified as legal rights, as an effective counterweight to what J. S. Mill referred to long ago as the “tyranny of the majority”: John Stuart Mill, *On Liberty*, ed by Edward Alexander (Peterborough, Ont: Broadview Press, 1999) at 46-47. See also Ronald Dworkin, “Liberalism” in Stuart Hampshire, ed, *Public and Private Morality* (Cambridge, UK: Cambridge University Press, 1978) 113 at 127-28.

is also essential to the criminal law, in which matters that are deemed criminal, and therefore subject to the state's criminal law power, are those that are identified as harming public morality and public safety. (And so, while my self-ruling autonomy is undeniably abridged by the criminal prohibition on polygamy, for example, that restriction is theoretically justified by the threat my actions would pose to public order.)¹⁵ Mental capacity, in contrast, remains private; legal interference is justified only where self-rule is, or has become, factually impossible. In the void, the state has a responsibility to act.

In the context of property-related transactions, donor autonomy has an ideologically potent, but effectively symbolic, role. The idea of unfettered individual liberty to dispose of one's property as one wishes, whether wisely or foolishly, is a fundamental—even sacred—tenet of Anglo-Canadian law.¹⁶ The individual autonomy at stake in these cases is, however, very different in kind and quality from autonomy as it is engaged in the other contexts considered here. Unlike those other contexts, the decision in question is past—there is no question of future constraint—and there is no continuing or potential physical impact on the person in question. Furthermore, the donor in the majority of cases involving discrete property transactions will not be an actual participant in the proceedings; he or she will be dead or incapable, and the real contestants will be those who benefit from the transaction and those who *would* benefit were it set aside. Autonomy, here, is symbolically important but, in fact, of no real value to the absent donor.

In the context of health care decisions, by contrast, the subject of the capacity finding is very much present, and the decision whether to proceed with a particular course of treatment will have the most direct impact on that individual. Autonomy, in this context, is bound up with those physical-integrity interests that have long been protected by the trespass torts, which, prior to legislation in this area, created and enforced the requirement of consent to health treatment. As the Supreme Court of Canada explained in *Starson v. Swayze*:

Ordinarily at law, the value of autonomy prevails over the value of effective medical treatment. No matter how ill a person, no matter how likely deterioration or death, it is for that person and that person alone to decide whether to accept a proposed medical treatment.

¹⁵ This is the rationale for the prohibition on polygamy in the *Criminal Code*, RSC 1985, c C-46, s 293.

¹⁶ See e.g. Sheena Grattan & Heather Conway "Testamentary Conditions in Restraint of Religion in the Twenty-First Century: An Anglo-Canadian Perspective" (2005) 50:3 McGill LJ 511 at 516, citing Philip Hoser, "Family Provision for Non-spouse Dependents" (1984) 14 Fam Law 171 at 171 ("[t]estamentary freedom has been described as the 'corner-stone' of the common law").

However, where the individual is incompetent, or lacks the capacity, to make the decision, the law may override his or her wishes.¹⁷

Autonomy is significantly more problematic in the context of guardianship, which necessarily—as required by the very purpose of guardianship and guardianship-type interventions—proceeds from a finding of *projected, ongoing* loss of capacity, concerning ongoing, non-particularized courses of activity—as opposed to the ascertained and discrete decisions, past and pending, at issue in the property and health contexts. These are necessary features of guardianship interventions derived from their underlying purpose, a purpose which has not changed (because it cannot change) during the last fifteen years of guardianship reform and the introduction of co-decision-making models: to provide a social response to the needs of some individuals for ongoing assistance in order to prevent the loss of assets—and the hardships attendant on impecuniosity in old age—and physical harm.

Formally, of course, the loss of personhood is no longer considered to follow a finding of incapacity for guardianship purposes in law or in medicine. At the more pervasive social level, however, the taken-for-granted embodiment of autonomy—the rational, independent, and self-maximizing figure of the “autonomous man”—necessarily and automatically works to depersonalize the post-capacity individual. A person found to lack capacity now and for the projected future is effectively and necessarily positioned as a non-person, a failed (and not merely misruled) state.¹⁸ Exhortations to recognize personhood, identity, and value in per-

¹⁷ 2003 SCC 32 at para 7, [2003] 1 SCR 722, McLachlin CJC, dissenting. The issue in the *Starson* case was whether the Ontario Capacity and Consent Board had acted unreasonably in finding that Mr. Starson was incapable of consenting to medical treatment. The majority found that the board had allowed their perception of Starson’s best interests to improperly influence their finding; the dissent found that the board had not done so, and had properly confined its inquiry to the question of capacity. The essential premise, as eloquently explained by Chief Justice McLachlin in the passage cited, underlies the reasons of both majority and dissent.

¹⁸ Joel Feinberg has distinguished between the exercise of autonomy—“[t]he actual condition of self-government”—and the threshold notion of the capacity for self-government, drawing an analogy between the misruled person and the badly governed state (“Autonomy” in Christman, *Inner Citadel*, *supra* note 7, 27 at 30). The threshold for capacity is defined as the “ability to make rational choices [and] interpreted [so] as to exclude infants, insane persons, the severely retarded, the senile, and the comatose, and to include virtually everyone else” (*ibid* at 28). The misruled person may, in fact, enjoy little substantive autonomy, but “like a badly governed nation, he may retain his sovereign independence nevertheless” (*ibid* at 30). Feinberg suggests that “autonomy”, derived from the Greek for “self” and “rule”, may have originally been used to apply to states and that “personal autonomy” should be understood as a “political metaphor” (*ibid* at 27). Three of the five categories on Feinberg’s list—the insane, the severely retarded, and the senile—are not self-evident but must be *identified* through some process of

sons with dementia (the “senile” and therefore non-self-governing, in the language of Feinberg’s analysis of autonomy and the autonomous) call, in effect, for the transposition of the individual’s ghost as he or she existed in the past onto his or her present, embodied form.¹⁹ The manifestations of “illness” are separated from the “real” person underneath. This is the response required by the terms of the capacity-autonomy equation and is, within those terms, the only means of recognizing some continuing form of personhood, and thereby securing the rights to which persons are entitled, after capacity is lost. In so doing, I suggest that the capacity-autonomy equation effectively precludes a deeper understanding of personhood *as embodied* after capacity is lost.²⁰

One response to the drastic impact of a finding of incapacity in the context of adult guardianship has been to minimize the likelihood that a person will be found to lack capacity, through legislation or through instruments of medical evaluation.²¹ This approach, while theoretically maximizing autonomy, frustrates the fundamental purpose of guardianship: to provide ongoing assistance in order to prevent harm. Another approach has been to articulate more precisely the kind of decision that an individual is expected to need ongoing assistance with, in an attempt to resemble, insofar as possible, the kind of discrete, pending decisions at issue in the health care context.²² In reality, however, persons are unlikely to need guardianship assistance only with certain discrete and singular types of decisions and not with others. At the same time, persons who need assistance only with decision making, and who are willing to accept that assistance, will almost certainly have made private and informal arrangements for doing so without the need for a guardianship order.²³ This phenomenon almost certainly explains the negligible use of the co-

evaluation (although for many, the “senile” will be perceived as constituting a material grouping as fixed and self-evident as infants or the comatose).

¹⁹ See Nuffield Council on Bioethics, *Dementia: Ethical Issues* (Cambridge, UK: Cambridge Publishers, 2009) (“[t]he person with dementia remains the same, equally valued, person throughout the course of their illness, regardless of the extent of the changes in their cognitive and other functions” at 21, box 2.1, component 6).

²⁰ Working against the “personhood in dementia” approach advanced by Tom Kitwood and others: see Tom Kitwood, *Dementia Reconsidered: The Person Comes First* (Maidenhead, UK: Open University Press, 1997).

²¹ See Deborah O’Connor, “Personhood and Dementia: Toward a Relational Framework for Assessing Decisional Capacity” (2010) 5:3 *The Journal of Mental Health Training, Education and Practice* 22 [O’Connor, “Relational Framework”].

²² See Robert Gordon, Simon N Verdun-Jones & Donald J MacDougall, “Reforms in the Field of Adult Guardianship Law: A Comment on Recent Developments” (1987) 6:1 *Can J Fam L* 149 at 152. See also Sarah Burningham, “Developments in Canadian Adult Guardianship and Co-decision-making Law” (2009) 18 *Dal J Leg Stud* 119 at 138-44.

²³ See MB Kapp, “Decisional Capacity in Theory and Practice: Legal Process Versus ‘Bumbling Through’” (2002) 6:4 *Aging & Mental Health* 413 at 414.

decision maker order where it is available, in Saskatchewan, in favour of a more plenary guardianship).²⁴

I suggest another, more radical—but ultimately more effective—approach to the dilemma of the capacity-autonomy equation in the guardianship-intervention context: the removal of capacity as the criteria for intervention. The personhood and *autonomy* (understood through the theoretical lens of relational autonomy, discussed below) of those individuals who fall below the capacity threshold can be given recognition only, I suggest, where the threshold itself is removed.

This suggestion appears less extreme on a close and denaturalizing examination of how the mental capacity construct is found in this context. I will argue that there is nothing inevitable or necessary about capacity—nothing real that must be respected, obeyed, or followed—and that, if the construct in this context is—as I assert—deeply problematic, an alternate construct can, and must, be developed. I suggest that the provision of assistance with kindness (i.e., listening carefully and responding to the thoughts, fears, and wishes of others), and with respect, thoughtfulness, and sophistication regarding the *kind* of assistance that will be most helpful, is most appropriately understood as a social response to *vulnerability*. Accordingly, vulnerability provides a more coherent and workable construct in this context.

II. Conceptualizing the Mental Capacity Construct

As a concept in law and in medicine, mental capacity refers generally to a person's intellectual ability to understand and, on the basis of that understanding, to make a decision. Without the required, underlying mental capacity, a person's apparent choice is conceptualized as not, truly, his or her own and genuine decision. In this way, the lack of mental capacity creates one of a limited number of exceptions to the general legal rule of non-interference with personal choices, however foolish, as a structural guarantor of personal liberty or autonomy. (Indeed, non-recognition *protects* the autonomy of the individual by refusing to enforce or recognize decisions that are not, truly, his or her own.)

Defined in these terms, mental capacity is essentially cognitive, describing the *ability* to make a rational decision²⁵ as a real, interior mental

²⁴ See Doug Surtees, "The Evolution of Co-decision-making in Saskatchewan" (2010) 73:1 Sask L Rev 75 at 91-92 (discussing a review of 446 applications made under Saskatchewan's *Adult Guardianship and Co-decision-making Act* between 2001, when the act came into force, and 2008).

²⁵ See Susanna L Blumenthal, "The Default Legal Person" (2007) 54:5 UCLA L Rev 1135 at 1138-39.

quality, although the mentally capable person may choose not to make a rational decision as a matter of personal preference and expression. The medical profession, therefore, as the designated experts in matters related to cognition, will always play a key and authoritative role in the evaluation of capacity, even where the ultimate purpose of that evaluation is, in the formal sense, *legal* (e.g., appointing a guardian, setting aside a property transaction, deciding who will consent to medical treatment).

The characterization of cognitive mental capacity as a hard and medically ascertainable fact is key to the way in which capacity is found, or not found, in the law. (Although as we shall see, that process works differently in different legal contexts, where the finding of capacity serves different purposes.) The modernizing, decision-based trend in adult guardianship legislation, as opposed to the traditional, diagnosis-based approach to capacity and capacity assessment, retains and refines this core understanding of mental capacity as a scientifically provable “bio-fact”: the modern question is whether an individual has the cognitive capacity to make a particular kind of decision, in contrast to the more global incapacity implied by the dementia diagnosis in the traditional model. Parallel developments in medical approaches to mental capacity assessment, including the assessment of performance in addition to the measurement of decision-domain specific capacities through cognitive testing tools, are similarly presented as providing a more accurate account of the underlying biofact.

From a legal perspective, “X has dementia” appears to provide a satisfying account of the individual’s internal mental process, without the need for ideologically troubling references to the substantive nature of X’s choices and behaviours (e.g., “X is making large cash gifts to a young woman he met online”; “X engages strangers in conversation about his supposed affair with the Queen”). The difficulty lies in the nature of the dementia diagnosis, which unlike, for instance, a cancerous cell on a slide, is arrived at through observation of a person’s speech, actions, and behaviours (e.g., “X is making large cash gifts to a young woman he met online” or “X engages strangers in conversation about his supposed affair with the Queen”). Dr. Y’s diagnosis is the end point of this process of observation and categorization, of which diagnosis is the bare statement. The decisive scientific and objective language of that diagnosis—like the language of the cell on the slide—obscures, to the law’s eye, the nature of the *process* of observation that underlies it. In the language of autonomy, the bare diagnosis asserts a definitive and objective truth about the individual’s ability to engage in an autonomous thought process. The process, of which the diagnosis is the end result, necessarily depends on the diagnosed person’s substantive choices and behaviours, requiring judgment on the part of the observer. This is *not* to say that “dementia” is meaningless; the concept has meaning as a clustering of external indicia that are interpreted as indicating something specific about the brain. But dementia must be under-

stood as a medical construct²⁶ that gathers together and contains these behavioural indicia within a discursive boundary, and through the language of diagnosis, provides for some future action to take place (admittance to a care facility, for example).

Cognitive tests such as the mini-mental state examination (MMSE) and the MacArthur competence assessment tool-treatment (MacCAT-T), where provided to support “mere” diagnosis, work in a similar way. As ostensibly objective, scientific measures, they result in rate-able scores that obscure the evaluative processes behind them. These testing tools have come under criticism from the medical community responsible for implementing them²⁷—while retaining the character of medically ascertainable bio-fact outside of that community—as insufficiently connected to the *kinds* of decision-making capacity under evaluation.²⁸ One response to that criticism has been the identification of a more functional approach to testing,²⁹ including an assessment of performance (through patient and

²⁶ See Bradley A Areheart, “Disability Trouble” (2011) 29:2 Yale L & Pol’y Rev 347 at 350-52; Phil Brown, “Naming and Framing: The Social Construction of Diagnosis and Illness” [1995] Journal of Health and Social Behavior 34 at 36-38; Nancy Harding & Colin Palfrey, *The Social Construction of Dementia: Confused Professionals?* (London, UK: Jessica Kingsley, 1997).

²⁷ See e.g. Timo Erkinjuntti et al, “The Effect of Different Diagnostic Criteria on the Prevalence of Dementia” (1997) 337:23 New Eng J Med 1667 at 1671-73.

²⁸ See e.g. Lazare Benaroyo & Guy Widdershoven, “Competence in Mental Health Care: A Hermeneutic Perspective” (2004) 12:4 Health Care Analysis 295 at 299-300; Torsten Marcus Breden & Jochen Vollmann, “The Cognitive Based Approach of Capacity Assessment in Psychiatry: A Philosophical Critique of the MacCAT-T” (2004) 12:4 Health Care Analysis 273.

²⁹ “Function”, in this context, refers to a particular decision or decision set (financial decision making, for example), with the assessment focused on the individual’s ability to carry out this kind of decision. Jennifer Moye and her colleagues propose an assessment model structured around six domains: medical condition; cognition; everyday functioning; individual values, preferences, and patterns; risk of harm and level of supervision needed; and means to enhance capacity: Jennifer Moye et al, “A Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship” (2007) 47:5 The Gerontologist 591 at 594-97. See also American Bar Association Commission on Law and Aging & American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* (Washington, DC: American Bar Association, American Psychological Association, 2005) at 9-11 (Jennifer Moye served as editor of this handbook). Guidelines issued by the Public Guardian and Trustee of British Columbia (Public Guardian and Trustee of BC in consultation with physicians and other incapability assessors from throughout BC, *Practice Guidelines for Certificate of Incapability Assessments Under the Patients Property Act* (2005) at 3, online: <[http://www.trustee.bc.ca/pdfs/STA/Certificate of Incapability Package.pdf](http://www.trustee.bc.ca/pdfs/STA/Certificate%20of%20Incapacity%20Package.pdf)> [*Guidelines for Incapability Assessments*]; Public Guardian and Trustee of British Columbia, *Court and Statutory Guardianship: The Patients Property Act and the Adult Guardianship Act (Part 2)* (An Updated Discussion Paper on Modernizing the Legal Framework), (2005) at 14-16, online: <http://www.trustee.bc.ca/pdfs/General/Modernizing_Guardianship_2005.pdf> [*Court and Statutory Guardianship*]) follow a model based on a principle of

collateral interviews), alongside diagnosis and standardized cognitive-screening-tool scoring, as best practice.³⁰ Another is the continuing proliferation of more decision-specific assessment tools.³¹ Importantly, these developments in the medical process of capacity evaluation are presented as providing a more accurate mirror or description of the individual's objective, internal state—the capacity bio-fact. From the law's perspective, however, these medical developments are opaque and ultimately irrelevant; the medical finding of capacity (or the lack thereof) *works* as an au-

mental capacity (or competence) as inherently interactive, in which “the patient's external environment and changing personal skills influence capacity at any point in time. Thus, the patient's use of resources, external and internal, should be considered in determining competency status” (M Donnelly, “Financial and Personal Competency Assessments for British Columbia Seniors” (1996) 38:9 British Columbia Medical Journal 484 at 485).

- ³⁰ See Eike-Henner W Kluge, “Competence, Capacity, and Informed Consent: Beyond the Cognitive-Competence Model” (2005) 24:3 Canadian Journal on Aging 295. Kluge's piece has both a legal and a medical aspect and relevance, like much of the legal literature dealing with mental capacity in civil cases. See also Alister Browne et al, “On Liberty for the Old” (2002) 21:2 Canadian Journal on Aging 283; Terry Carney & David Tait, “Adult Guardianship: Narrative Readings in the ‘Shadow’ of the Law?” (1998) 21:2 Int'l J L & Psychiatry 147; Public Guardian and Trustee of British Columbia, *Incapacity Assessments: A Review of Assessment and Screening Tools* by Deborah O'Connor (Final Report), (2009), online: <http://www.trustee.bc.ca/pdfs/STA/Incapacity_Assessments_Review_Assessment_Screening_Tools.pdf>; Thomas Grisso with Randy Borum et al, *Evaluating Competencies: Forensic Assessments and Instruments*, 2d ed (New York: Kluwer Academic, 2003) at ch 3; Moye et al, *supra* note 29.
- ³¹ See Laura B Dunn et al, “Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments” (2006) 163:8 American Journal of Psychiatry 1323; Grisso with Borum et al, *supra* note 30 at ch 2; Thomas Grisso, Paul S Appelbaum & Carolyn Hill-Fotouhi, “The MacCAT-T: A Clinical Tool to Assess Patients' Capacities to Make Treatment Decisions” (1997) 48:11 Psychiatric Services 1415; A Vellinga et al, “Competence to Consent to Treatment of Geriatric Patients: Judgments of Physicians, Family Members and the Vignette Method” (2004) 19:7 International Journal of Geriatric Psychiatry 645; Edward D Sturman, “The Capacity to Consent to Treatment and Research: A Review of Standardized Assessment Tools” (2005) 25:7 Clinical Psychology Review 954; Vanessa Raymont et al, “The Inter-rater Reliability of Mental Capacity Assessments” (2007) 30:2 Int'l J L & Psychiatry 112; Leo M Cooney, Jr, et al, “Who Can Stay at Home? Assessing the Capacity to Choose to Live in the Community” (2004) 164 Archives of Internal Medicine 357; K Cramer et al, “Measuring Awareness of Financial Skills: Reliability and Validity of a New Measure” (2004) 8:2 Aging & Mental Health 161; Mavis M Kershaw & Lynne S Webber, “Assessment of Financial Competence” (2008) 15:1 Psychiatry, Psychology and Law 40; James M Lai et al, “Everyday Decision-Making Ability in Older Persons with Cognitive Impairment” (2008) 16:8 American Journal of Geriatric Psychiatry 693; James M Lai & Jason Karlawish, “Assessing the Capacity to Make Everyday Decisions: A Guide for Clinicians and an Agenda for Future Research” (2007) 15:2 American Journal of Geriatric Psychiatry 101; Mathy Mezey et al, “Decision-Making Capacity to Execute Health Care Proxy: Development and Testing of Guidelines” (2000) 48:2 Journal of the American Geriatrics Society 179.

thoritative bio-fact, whether contained in the statement “X has dementia” or in a function-based assessment report.

As neither the dementia diagnosis nor the cognitive score is analogous to the paradigmatic bio-fact of the cancerous cell on the slide, nor is the mental capacity construct. A finding of mental capacity is a particular judgment about human beings that is made for one of several distinct purposes, from which distinct and specific consequences flow (despite the ceaseless medical quest for a more perfect, objective “capacimeter”).³² The terms of the judgment will reflect the purposes for which it is made and the consequences that flow from it. By “terms”, here, I mean the *way* in which the judgment will be made, who will make it, and the information that will be recognized as open to consideration, as well as the information that will, in fact, be considered.

III. Capacity in Context: Property, Health, and Guardianship

Three distinct legal contexts in which mental capacity is positioned as a central factor will be considered here: property-related transactions, including wills; consent to medical or health treatment; and guardianship and guardianship-type interventions. All three are civil (as opposed to criminal) law contexts; all three are particularly likely to involve older adults as their subjects, and accordingly, some form of dementia—itself a contested construct—is likely to be involved.

In each of these contexts, mental capacity works to permit an interference with individual decision making (although the language of “decisions” is truly apposite only in the context of property-related transfers and transactions),³³ which would otherwise be unjustified. In this way,

³² Marshall B Kapp & Douglas Mossman, “Measuring Decisional Capacity: Cautions on the Construction of a ‘Capacimeter’” (1996) 2:1 Psychol Pub Pol’y & L 73 at 79: “[t]he idea of a capacimeter ... resonates powerfully with relevant scientific findings and with modern society’s sometimes uncritical faith that human problems can be mastered through quantification. A measure that produced a definitive, objective, numerical readout addressing the ultimate capacity question in any treatment setting would carry understandable (even if ultimately illusory) appeal.”

³³ Unlike mental capacity in the other contexts considered here, capacity in the health care context is fundamentally concerned with *consent*, rather than decision making *per se*. The patient has no right to decide on his or her course of medical treatment (in the way that he or she can “decide” to dispose of property, to bathe or not bathe, or to ask for housekeeping assistance); there is no right to demand a specific course of treatment where the physician does not feel that it would be useful. The ability of the patient that is in question is his or her capacity to consent to bodily interference that would, without that consent, comprise a trespass to the person violating the individual’s absolute right to self-ownership. That common law right is also consistent and resonates with the Supreme Court of Canada’s expansive interpretation of section 7 of the *Canadian Charter of Rights and Freedoms* (*supra* note 9) to include a right to personal autonomy, integri-

and for this reason, mental capacity is often conceptualized as a threshold. The implications of this threshold are most significant in the guardianship context, both on a conceptual and a practical and embodied level (i.e., the projected and continuing oversight of, and engagement in, the day-to-day life of another). The social and ideological identification of capacity with autonomy—and, on that basis, with personhood itself³⁴—charges the finding of an ongoing, projected incapacity in a way that is qualitatively distinct from the other contexts considered here.

A. *Property-Related Transactions*

In contrast to the other two contexts considered here, the capacity inquiry carried out for the purpose of setting aside or enforcing property-related transactions is a *legally* controlled process. It is delivered by a court, most likely in the absence of a decision-specific medical capacity assessment preceding the impugned transaction. Evidence that capacity was found by a lawyer or a notary preceding the transaction will be highly relevant, although not conclusive. Corroborating non-medical evidence will also be key and may come from a number of sources. The task in these cases is to recreate, as completely as possible through a relatively thick description, the circumstances of the original transaction. Evidence from family members and other persons familiar with the donor at the time regarding the donor's behaviour will be relevant, together with whatever medical evidence is available.

These cases are notable for the lengthy, detailed, and comprehensive narratives they provide, which are assembled from a broad reach of sources. In the case of *Re Elsie Jones*,³⁵ for example, which considered a mother's capacity to transfer property into joint ownership with her daughter, Maureen, the court noted that the donor had received legal advice from an "experienced ... solicitor", who would have been equally experienced in assessing client capacity. But the court went on to consider the

ty, and self-determination. See the discussion in *Fleming v Reid* (1991), 4 OR (3d) 74 at 88, (*sub nom Fleming v Reid (Litigation guardian)*) 82 DLR (4th) 298 (CA); *Malette v Shulman* (1990), 72 OR (2d) 417 at 423-24, 67 DLR (4th) 321 (CA); *St George's Health Care NHS Trust v S*, [1998] 3 WLR 936 at 950-51, [1998] 3 All ER 673 CA (Eng).

³⁴ See Frankfurt, *supra* note 10 at 11. Frankfurt uses the term "wanton" to describe humans who do not have the capacity to act rationally and therefore autonomously; the class of wantons "includes all nonhuman animals that have desires and all very young children. Perhaps it also includes some adult human beings as well."

³⁵ *Canada Trust Co v Ringrose*, 2009 BCSC 1723 at paras 81, 102-11 (available on CanLII) [*Re Elsie Jones*]. See also *Hemminger (Guardian ad litem of) v Sande*, 2001 BCSC 728 at paras 12-82, 39 ETR (2d) 196; *Modonese v Delac Estate*, 2011 BCSC 82 at paras 7-66, 65 ETR (3d) 254 [*Modonese*]; *Banton v Banton* (1998), 164 DLR (4th) 176 at 190-208 (available on CanLII) (Ont Gen Div); *Calvert (Litigation guardian of) v Calvert* (1997), 32 OR (3d) 281 at 284-93, 27 RFL (4th) 394 (Gen Div).

following factors in coming to a decision regarding Ms. Jones's capacity at the time of the transfer: the relative financial positions of the parties (the mother, her daughter, and her two sons); the changing nature of Ms. Jones's relationship with Maureen; Ms. Jones's diagnosis of vascular dementia, in 2003, by Dr. Sheldon; Ms. Jones's belief that her son was stealing from her; the involvement of the police and the mental health team following Ms. Jones's complaints about her son; an interview with Dr. Sheldon regarding Ms. Jones's attitude toward her son; Dr. Sheldon's notes regarding long-standing dysfunction in the family, as recounted by Maureen; Dr. Sheldon's examination of Ms. Jones on the day following the transfer (no mental capacity assessment was carried out preceding the transfer); extensive evidence from Maureen regarding her understanding of her mother's capacity throughout this period; and evidence provided by Ms. Jones's accountant regarding his encounters with Ms. Jones over a number of years. At the conclusion of this lengthy and detailed narrative, the court held that Ms. Jones did not have the required mental capacity at the time of the transfer.

Many cases involving property-related transactions where the mental capacity of the donor is impugned will also involve claims of undue influence³⁶ (or, less frequently, unconscionability or both undue influence and unconscionability). From the point of view of the plaintiff—the donor or disappointed heir—the outcome of a successful undue influence or unconscionability challenge and of a successful capacity challenge will be the same: the transaction will be set aside, with a resulting redistribution of assets. A claim of undue influence requires, doctrinally, a different and a separate analysis, and the factors central to undue influence—the relative weakness or vulnerability of the donor in the context of a relationship of dependence (which raises the presumption of undue influence) or the existence of manipulation or coercion (actual undue influence)—are, theoretically, irrelevant to the capacity question.³⁷ On a formal level, mental capacity and undue influence—or unconscionability—are considered, in a given case, as parallel analyses, concerned with, and considering differ-

³⁶ In *Re Elsie Jones* (*supra* note 35 at paras 112-20), the court also concluded that the relationship between Ms. Jones and Maureen raised the presumption of undue influence, which had not been rebutted. (No separate analysis was provided.) See also *Riley v Riley*, 2010 BCSC 161 at paras 65-74, 55 ETR (3d) 226; *Modonese*, *supra* note 35 at paras 96-129; *Kapacila v Otto*, 2007 SKCA 140 at para 11, 302 Sask R 226; *Cadieux v Collin-Evanoff* (1988), 14 QAC 18 at 23 (available on CanLII) (Qc CA); *Archer v St John et al*, 2008 ABQB 9 at paras 69-77, 439 AR 260; *O'Neil v Wallace O'Neil (Succession de)*, 2010 QCCS 2768 at paras 48-59 (available on CanLII); *Dunn (Trustee of) v Kiernan*, 2011 ABPC 203 at para 18 (available on CanLII).

³⁷ See Margaret Hall, "Equity and the Older Adult: The Doctrines of Undue Influence and Unconscionability" in Ann Soden, ed, *Advising the Older Client* (Markham, Ont: LexisNexis Butterworths, 2005) 329 at 329-31.

ent, factual aspects of the case: the relational or contextual aspects going to undue influence or unconscionability, and the objective or cognitive aspects going to capacity. As discussed and set out in the cases, however, these analyses are less distinct on either a textual or a rhetorical level, with the court's conclusions on each point coming instead at the end of a *holistic* account of the transaction and the context in which it took place.³⁸ Evidence of cognitive ability³⁹ is embedded in what is essentially a life story, as that story surrounds and gives meaning to the disputed transaction.

B. Health Treatment

Capacity assessment in the health care decision-making context⁴⁰ is, in contrast, almost completely controlled by health professionals in a clin-

³⁸ See e.g. *Re Elsie Jones*, *supra* note 35; *Lowery v Falconer*, 2008 BCSC 516, 39 ETR (3d) 188.

³⁹ Including, in the case of wills and will-like property dispositions, a consideration of any insane delusions—"the belief in things impossible; the belief in things possible, but so improbable, under the surrounding circumstances, that no man of sound mind would give them credit; to which we may add, the carrying to an insane extent impressions not in their nature irrational" (*Prinsep v Dyce Sombre* (1856), 10 Moo PC 232 at 247, 14 ER 480)—often expressed as some variation on "my children are plotting against me."

⁴⁰ British Columbia's *Health Care (Consent) and Care Facility (Admission) Act* (RSBC 1996, c 181 (Supp), s 7) requires the person to demonstrate that he or she understands the information provided by the health care provider and understands that the information pertains to him or her. Ontario's *Health Care Consent Act, 1996* (s 4(1), being Schedule A of *An Act to repeal the Advocacy Act, 1992, revise the Consent to Treatment Act, 1992, amend the Substitute Decisions Act, 1992 and amend other Acts in respect of related matters*, SO 1996, c 2) provides that "[a] person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision." Alberta's *Adult Guardianship and Trusteeship Act* (SA 2008, c A.4-2, s 1(d) [*Alberta Adult Guardianship Act*]) defines capacity as:

in respect of the making of a decision about a matter, the ability to understand the information that is relevant to the decision and to appreciate the reasonably foreseeable consequences of

- (i) a decision, and
- (ii) a failure to make a decision.

See Saskatchewan's *The Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, s 2(1)(b) [*Saskatchewan Health Care Directives Act*]:

"[C]apacity" means the ability:

- (i) to understand information relevant to a health care decision respecting a proposed treatment;
- (ii) to appreciate the reasonably foreseeable consequences of making or not making a health care decision respecting a proposed treatment; and
- (iii) to communicate a health care decision on a proposed treatment.

ical setting, as opposed to the kind of legally controlled processes of historical recreation described above. The consequence of a finding of incapacity, in the health care context, will be the identification or appointment of a substitute decision maker, or if the applicable legislation allows, the following of the person's past wishes as set out in an "advance directive".⁴¹ The finding of capacity may subsequently be challenged, but retrospective legal review will be very much the exception to the rule. Even where that finding is challenged, its basis—the medical assessment of capacity to consent to treatment—ensures a continuing level of medical evidentiary control that will be missing in the property cases. If treatment has (or has not) taken place, no retrospective evaluation can set aside that action and rearrange the outcome accordingly, unlike in the property cases discussed above. The remedy, if any, will be damages.⁴²

Medical actors are not mere passive enactors of the legal framework, and distinctly medical values and ideologies will inform how the legal framework is applied. Traditional protectionist or paternalist medical principles, with no direct analog in law, have historically worked to present the central issue in health care decision making as a tension between the paternalistic "best interests" proclivities of medical professionals and the legally protected autonomy rights of patients. From the late 1960s onward, however, patient autonomy has been recognized within the bioethics discourse and, on the formal level, within medical decision-making practice, as the pre-eminent value.⁴³ This recognition more closely aligns medical norms with legal norms, with capacity conceptualized as enforcing the true or genuine (and therefore autonomous) choices of individuals through the non-recognition of false (i.e., incapable) instruction.⁴⁴

⁴¹ *Personal Directives Act*, RSA 2000, c P-6, Part 2; *Saskatchewan Health Care Directives Act*, *supra* note 40, Part II; *The Health Care Directives Act*, SM 1992, c 33, CCSM c H27, ss 4-11; *Consent to Treatment and Health Care Directives Act*, SPEI 1996, c 10, Part III; *Advance Health Care Directives Act*, SN 1995, c A-4.1, Part I; *Personal Directives Act*, SNWT 2005, c 16, ss 4-10; *Adult Guardianship and Planning Statutes Amendment Act*, 2007, SBC 2007, c 34, s 29.

⁴² The financial outcomes at stake in retrospective property-related capacity evaluations, in contrast, create more incentive for disappointed third parties to engage the legal process.

⁴³ See David J Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (np: Basic Books, 1991) at 1-3. See also Wolpe, *supra* note 13.

⁴⁴ Despite this formal account, however, it has been suggested that the "enthusiastic application of the [mental] capacity requirement" is used, in practice, as a mechanism for "moderating" the consequences of an absolute right to refuse medical treatment: Mary Donnelly, *Healthcare Decision-Making: Autonomy, Capacity and the Limits of Liberalism* (Cambridge, UK: Cambridge University Press, 2010) at 71. In this counter-story, traditional protectionist medical values are given force *through* the mechanism of capacity assessment, which can be activated and used to exclude otherwise autonomous

C. Guardianship and Guardianship-Type Interventions⁴⁵

Guardianship is a legal process with legal consequences (appointing a substitute decision maker empowered to make legally recognized decisions on behalf of another. Unlike a medical diagnosis, treatment is not the (formal) outcome of a finding of incapacity in this context.⁴⁶ Generally speaking, guardians may be appointed through two processes: by court appointment or through a process of “statutory guardianship”, on the basis of a certificate of incapacity issued by a medical professional, as specified in the legislation.⁴⁷

decisions on the grounds that the decision maker is not capable of making the decision in question.

⁴⁵ The term “guardianship and guardianship-type interventions” here refers to a legally authorized inquiry into an individual’s mental capacity for the purpose of appointing a substitute or co-decision maker, who is authorized to make decisions and to carry out and organize day-to-day activities on behalf of that individual. (The model of co-decision making positions that appointee as *helping* the individual with these tasks.) “Guardianship and guardianship-type interventions” also include the legally authorized, involuntary admittance of an individual to a care facility or nursing home, which also entails a projected, continuing, and legally authorized control of individual, day-to-day activities.

⁴⁶ See e.g. *Patients Property Act*, RSBC 1996, c 349 [*BC Patients Property Act*]; *Infirm Persons Act*, RSNB 1973, c I-8; *Incompetent Persons Act*, RSNS 1989, c 218; *Mentally Disabled Persons’ Estates Act*, RSN 1990, c M-10; *Alberta Adult Guardianship Act*, *supra* note 40; *Substitute Decisions Act*, 1992, SO 1992, c 30 [*Ontario Substitute Decisions Act*]; *Adult Protection Act*, RSPEI 1988, c A-5 [*PEI Adult Protection Act*]; *Adult Protection and Decision Making Act*, being Schedule A to the *Decision Making, Support and Protection to Adults Act*, SY 2003, c 21 [*Yukon Adult Protection Act*]; *Guardianship and Trusteeship Act*, SNWT 1994, c 29 [*Northwest Territories Guardianship Act*]; *The Adult Guardianship and Co-decision-making Act*, SS 2000, c A-5.3 [*Saskatchewan Adult Guardianship Act*].

⁴⁷ In the latter case, guardianship may be limited. In British Columbia, statutory guardianship is limited to property guardianship by the Public Guardian and Trustee (the process is laconically set out in the *BC Patients Property Act* (*supra* note 46, s 1(a)). See also *Guidelines for Incapability Assessments*, *supra* note 29). Statutory guardianship has been controversial because it allows for this crucial capacity determination, with its dramatic social consequences—which can be said to demarcate the public from the private sphere in the individual context—to be made without court control, usurping the traditional role of the courts as the guarantors of personal rights. For this reason, reforms to adult guardianship law in British Columbia, for example, originally contained no provision for statutory guardianship. The *usefulness* of statutory guardianship has ultimately led to its retention, however, in the adult guardianship legislative reforms that have taken place in Canada over the last two decades. Statutory guardianship may be helpful where there is no “private” individual ready, willing, and able to initiate and take on a guardianship application; the process itself is considerably swifter and less costly (important factors given the public nature of the process). The limitation to the Public Guardian and Trustee is intended to balance the risk to individual rights that would otherwise be entailed by the absence of a court process.

Despite this overtly legal character, however, the guardianship process is highly medicalized. Even in the context of court-appointed guardianships, medical capacity assessment will be required and will almost always be controlling, in dramatic contrast to the wide discussion of evidence found in the (retrospective) property transaction cases. In property cases, relevant medical evidence may well be missing or cobbled together from non-capacity-specific medical encounters (visits to the family doctor, for example).⁴⁸ In contrast, guardianship applications will be preceded by a specific capacity assessment that is undertaken for that purpose, and that assessment will virtually always control the outcome of the case. Legal disagreement with the medical assessment is rare and, when it occurs, is almost always the result of particular factual situations where competing medical assessments are put before the court, laying bare the constructed (as opposed to natural or “out-there”) character of the capacity assessment and, indeed, the dementia diagnosis that frequently underlies it. The case of *British Columbia (Public Trustee) v. Batiuk*⁴⁹ provides a rare example. In that case, which involved a hotly contested application brought by the Public Guardian and Trustee that would have had the ultimate effect of removing pair of caregivers from the home of a wealthy widow, the following medical diagnoses and findings on capacity were before the court:

- That Mrs. Batiuk (Mrs. B) was “incapable of managing her affairs as a result of ‘mental infirmity due to chronic paranoid schizophrenia, cerebral atrophy and organic brain syndrome particularly evidenced by cognitive impairment including impaired orientation, attention, memory and language’”;
- That Mrs. B was “competent to make personal decisions but incapable of giving a power of attorney” (and that further assessment was required);
- That Mrs. B was probably “incapable of managing her affairs by reason of mental infirmity due to chronic schizophrenia and cerebrovascular disease,” and probably incapable of managing her person;
- That Mrs. B was “capable of managing her affairs ... [with] no indication of chronic paranoid schizophrenia,” that the caregivers’ discontinuance of antipsychotic medication with no adverse effects to Mrs. B cast “serious doubt on the diagnosis of schizophrenia,”

⁴⁸ See Glyn Davies & Lesley Taylor, “Private Committeeship in British Columbia: A Study of Due Process” (1989) 8:1 Can J Fam L 185 at 196-98. If challenged, the basis will almost always be a conflict between competing would-be guardians, as opposed to relating to the determination of capacity itself.

⁴⁹ (1996), 7 CPC (4th) 343, 15 ETR (2d) 60 (BC Sup Ct) [*Batiuk* cited to CPC].

and that Mrs. B showed improvement in cognitive function as an outcome of the discontinuance of this medication;

- No evidence of chronic schizophrenia, and that, despite evidence of organic brain damage from a stroke, Mrs. B was capable of giving a power of attorney;
- That Mrs. B “knows what she wants and is competent in communicating her wishes and needs to others and knows what she is doing,” and was quite competent to grant her caregivers power of attorney;
- That Mrs. B was as rational and competent as the average person, despite speech difficulties, and was “in no way obtunded either by medication or a pathological condition.”⁵⁰

The court concluded that Mrs. Batiuk was mentally capable.

Competing medical assessments, in this context, work to pull back the curtain of objective biological fact, revealing the human work of construction that is always—although usually hidden—carried out behind it. In the more usual course of events, however, that curtain stays closed. Once the medical assessment comes into being, whether on the basis of mere diagnosis (as set out in old-fashioned, status-based legislation, such as the *Patients Property Act*) or through a modern “best practice” functional assessment⁵¹ carried out by an interdisciplinary health team, that assessment assumes the mystifying authority of the bio-fact from the perspective, and for the purposes, of the law. (Although the machinations behind the curtain will always remain visible to the medical observer.) This medical control has been criticized by authors, who describe it as an abdication of due process for older adults,⁵² but in fact, it is the inevitable outcome of the determinative role assigned to cognitive capacity, in this context, as a “scientific” matter on which physicians are the designated experts.

If current and projected courses of behaviour are in question—financial decision making now and in the future, as opposed to a discrete, past transaction—the consequence of a finding of mental incapacity will be the appointment of a long-term substitute decision maker, or guardian. (Long-term need not mean forever, but connotes a period beyond an iden-

⁵⁰ *Ibid* at paras 42, 45-46, 48, 52-53, 56.

⁵¹ See e.g. *Capacity Assessment*, O Reg 460/05, s 3. Prescribed guidelines for assessing capacity can be accessed at Capacity Assessment Office, *Guidelines for Conducting Assessments of Capacity* (2005), online: Ontario Ministry of the Attorney General <<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp>>.

⁵² Davies & Taylor, *supra* note 48 at 198-200.

tified, discrete, and pending decision.)⁵³ Unlike pending, discrete health care decisions, and past, retrospectively assessed property-related decisions, the precise nature of all decisions that a guardian might possibly make on behalf of another person is unknowable at the time that this person's capacity is assessed. The *abstraction* of capacity in this context sets it apart from the (relatively embodied) inquiries in the other contexts considered here. Despite the efforts of modern guardianship legislation to more closely resemble the health care decision-making paradigm, limiting capacity evaluation and guardianship powers to more specific kinds of choices,⁵⁴ anticipating or allowing explicitly for temporal limits,⁵⁵ and providing for shared or co-decision making,⁵⁶ the very idea of guardianship is necessarily predicated on the recognized need, in some circumstances, for stable, ongoing, formalized, and therefore publicly reviewable, relationships of responsibility. In these circumstances, a requirement of a decision-specific capacity assessment preceding each decision would be ludicrously cumbersome and unworkable. Modern guardianship legislation therefore, as it must in order to effect its essential purpose, retains at its core the evaluation of a person's current and projected ability to make certain of decisions. These classes of decision are given a finer breakdown in modern legislation but cannot be limited to discrete decisions in a specific and known context.

As embodied, moreover, those decisions at the centre of the guardianship inquiry are qualitatively different from the discrete and punctate decisions at issue in the property or health care contexts⁵⁷—whether to

⁵³ See Margaret Isabel Hall, "Capacity, Vulnerability, Risk and Consent: Personhood in the Law" in Deborah O'Connor & Barbara Purves, eds, *Decision-Making, Personhood and Dementia: Exploring the Interface* (London, UK: Jessica Kingsley, 2009) 119 at 123-24 [Hall, "Capacity, Vulnerability, Risk and Consent"].

⁵⁴ See e.g. *Alberta Adult Guardianship Act*, *supra* note 40, ss 33(1)-(2); *Ontario Substitute Decisions Act*, *supra* note 46, ss 59-60; *PEI Adult Protection Act*, *supra* note 46, ss 8, 16; *Yukon Adult Protection Act*, *supra* note 46, s 38; *Northwest Territories Guardianship Act*, *supra* note 46, s 11; *Saskatchewan Adult Guardianship Act*, *supra* note 46, s 15.

⁵⁵ See e.g. *Alberta Adult Guardianship Act*, *supra* note 40, s 33(8); *Ontario Substitute Decisions Act*, *supra* note 46, s 63; *PEI Adult Protection Act*, *supra* note 46, s 26; *Yukon Adult Protection Act*, *supra* note 46, s 37(2)(a); *Northwest Territories Guardianship Act*, *supra* note 46, s 9; *Saskatchewan Adult Guardianship Act*, *supra* note 46, s 14(4).

⁵⁶ See e.g. *Saskatchewan Adult Guardianship Act*, *supra* note 46, s 14(1)(a); *Yukon Adult Protection Act*, *supra* note 46, Part 1; *Alberta Adult Guardianship Act*, *supra* note 40, s 13(1). The *Ontario Substitute Decisions Act* (*supra* note 46, s 66) and the *Northwest Territories Guardianship Act* (*supra* note 46, s 12) require the guardian to consult with the individual and to enable his or her participation in decision making to the fullest possible extent, although they do not explicitly provide for co-decision making.

⁵⁷ See Rebecca Kukla's analysis and criticism of the "punctate decision" as the (formally recognized) key event in health care decision making and the "building block" of autonomy: "Conscientious Autonomy: Displacing Decisions in Health Care" (2005) 35:2 *The Hastings Center Report* 34.

make a will or whether to have an operation—referring, rather, to one’s ongoing performance of life’s essential tasks.⁵⁸ The distinction is important. The decision-making model plays a crucial role within the capacity-autonomy equation or paradigm: if the individual is capable of making the kind of decision in question, then the content of that decision is (again, formally) not relevant. The locus of the capacity analysis in the *decision process* avoids the substantive evaluation of choices and behaviours. At the same time, the construct of mental capacity, and therefore the mechanism of the decision at its conceptual core, is most ideologically charged in this context. This is due to the paradigmatically inherent, depersonalizing effects of a finding of projected incapacity (where persons are defined as beings capable of rational thought, as opposed to the class of being referred to by Frankfurt as “wantons”—a non-person category that includes, for Frankfurt as for Feinberg, “the senile”).⁵⁹

IV. After Capacity: Theorizing Vulnerability

The capacity construct works well enough in the property-decision and health treatment context, as a mechanism for determining the “right” outcomes in situations of conflict or doubt. The capacity construct in the context of guardianship and guardianship-type interventions is, by contrast, much more problematic—even, I suggest, dysfunctional. It is a source of difficulty and confusion for the professionals charged with finding capacity, together with a consequential depersonalization of those found to be incapable.

These difficulties have driven both the reforms in modern guardianship legislation and the proliferation of capacity assessment tools over the last fifteen to twenty years. Legislation in modern guardianship jurisdictions may explicitly require, and provide guidelines for, functional capacity assessment.⁶⁰ Even in jurisdictions, such as British Columbia, where the traditional legislative approach persists (defining capacity in terms of “disability” or “infirmity”), the functional approach to assessment may be adopted as best practice.⁶¹ Despite these developments, however, the mental capacity construct remains intact: whether capacity is defined as a cognitive-status diagnosis or as decisional ability, the formal focus of the functional assessment inquiry remains fixed on the individual’s internal mental and rational ability, now evaluated in relation to the specific function, or functions, in question. The crucial question is posed in the Ontario

⁵⁸ See also Robert Chia, “The Concept of Decision: A Deconstructive Analysis” (1994) 31:6 *Journal of Management Studies* 781.

⁵⁹ See Frankfurt, *supra* note 10 at 11.

⁶⁰ See *Capacity Assessment*, *supra* note 51, s 3; Capacity Assessment Office, *supra* note 51.

⁶¹ See *Court and Statutory Guardianship*, *supra* note 29 at 14-16.

guidelines as, “Does this person’s level of decisional ability match the demands of the specific situation with which they are faced?”⁶² Context and performance, in this account, are relevant as *evidence* of that essential cognitive-decisional ability. The cognitive ability to make a decision—and the choice of the person who has the cognitive-decisional *ability* to “decide,” but who is, on an embodied level, being exploited or living in squalor, for example—cannot be interfered with or displaced. This non-interference respects the capable person’s right to make objectively “bad” or foolish decisions. In this way, functional capacity, and the functional capacity assessment, can be seen as a finer-grained iteration of the autonomy or mental capacity threshold, presented in the objective-authoritative “hard”-science language of standardized measures and scores (with the rapidly expanding repertoire of standardized functional and cognitive assessment tools supplementing the once-sufficient diagnosis and prognosis), and supported by the “soft” evidence provided by interviews and collateral information.

From another perspective, however, the medical shift towards functional assessment, by explicitly seeing and asking about performance (i.e., behaviour) and context, albeit in the guise of a more complete and “scientific” measure of capacity, may be seen as implicitly acknowledging the essential function of guardianship as a social response to vulnerability. The question “Does this person’s level of decisional ability match the demands of the specific situation with which they are faced?” can be understood as asking, in effect, How is this person coping on a day-to-day level without assistance? If functional capacity and the functional capacity assessment effect a regularization of the capacity inquiry as a *de facto* (but insistently not *de jure*) assessment of vulnerability, how much does the continuing language of capacity really matter? Or can it be considered, as in the property context, as a useful, no-cost, theoretical mechanism for reconciling social policy objectives with core, but essentially abstract, values of liberal individualism?

To the extent that capacity and vulnerability exist in theoretical opposition to one another—not as mere words, but as each is informed by the discourse that has developed around and between them—the continuing language of capacity matters a great deal. Vulnerability is necessarily positioned within the capacity-autonomy paradigm as a kind of “incapacity lite”⁶³ that would justify interference without the (apparent) scientific-

⁶² Capacity Assessment Office, *supra* note 51, II.1. Questions related to context may be characterized in terms of needs and supports (e.g.: What does the person *need* in order to function adequately, avoiding a guardianship order? Are the required *supports* available in the community?).

⁶³ See Margaret Isabel Hall, “Material Exploitation and the Autonomy Ideal: The Role of Equity Theory in Adult Protection Legislation”, online: (2008) 5 Elder Law Review 9,

objective legitimacy of the capacity finding. The traditional association of vulnerability with weakness, “victimhood, deprivation, dependency, or pathology”⁶⁴ may be understood as, at least in part, a function of this relationship to the dominant paradigm and the capacity-autonomy threshold: you *can* make your own decisions, therefore the decisions you make are your own; where they are sufficiently bad to attract outside intervention, you have willfully taken yourself outside the pale of reasonable self-governance. You have become a failed state, the faulty subject *non pareil*. Rejection of this characterization has led to a rejection of vulnerability itself, as both patronizing and harmful, derived from stereotypes and the kind of substantive value judgments that negate individual autonomy. This counter-narrative, also, is a function of the capacity-autonomy paradigm; the persistence of the capacity construct in the guardianship context has frustrated a coherent, theoretical development of vulnerability. Instead, vulnerability exists in the shadow of, and is defined by, its relationship to capacity: the *other* where capacity is the norm; a protectionist-based, as opposed to autonomy-based, ground for intervention; subjective where capacity is objective; sentimental and sloppy where capacity is clear-eyed and scientific.⁶⁵

Despite the theoretical and ideological hegemony of capacity, it is embodied vulnerability, as opposed to abstract capacity, that most often serves as the de facto locus of evaluation and response for the courts, lawyers, and the health professionals who play the dominant role in the capacity-finding process.⁶⁶ Within the conceptual framework of the capacity-autonomy equation, however, that evaluation is, and must be, covert—occurring outside of the official margins, unexamined, undefined, and therefore undefended. The evaluation of individual vulnerability in the capacity assessment process, where it is acknowledged to have taken

Part V <<http://www.austlii.edu.au/au/journals/ElderLawRw/>> [Hall, “Material Exploitation”].

⁶⁴ Martha Albertson Fineman, “The Vulnerable Subject: Anchoring Equality in the Human Condition” (2008) 20:1 Yale JL & Feminism at 8 [Fineman, “The Vulnerable Subject”]. In “Equity Theory”, I suggest that this discourse, and the stigma it engenders, may have the effect of increasing the social vulnerability of individual members of groups identified as “vulnerable” within it, such as older adults (MI Hall, “Equity Theory: Responding to the Material Exploitation of the Vulnerable but Capable” in Israel Doron, ed, *Theories on Law and Aging: The Jurisprudence of Elder Law* (Berlin: Springer, 2009) 107 at 108 [Hall, “Equity Theory”]).

⁶⁵ Perhaps corresponding to social constructs of femininity on the one hand, masculinity on the other.

⁶⁶ For an interesting discussion of the tension between the legal requirement to “find” (abstractly defined) capacity and the embodied realities of social work practice with older adults, see Louise Holland, *Abandonment or Autonomy: How Do Social Workers Know the Difference?* (MSW Thesis, University of Northern British Columbia, 2010) [unpublished].

place, will be identified as a deviant and faulty, paternalistic and protectionist practice. The charged, covert, and unspeakable centrality of vulnerability in this context has given rise to the apparent conflict or debate between protection and autonomy that has dominated and distorted the discourse around guardianship for decades. The language of “debate” is, of course, a rhetorical mechanism: in this discourse, “protection” is the rhetorical straw man in opposition to which “autonomy” is, heroically, defined.

A. *Situating Vulnerability: Relational Autonomy*

The idea of autonomy as an internalized mental quality associated with self-possession and free will that sits at the core of the capacity-autonomy paradigm and ideology, is embodied, in mainstream liberal culture, in the crude figure of the autonomous man.⁶⁷ That figure has long played a dominant role in legal doctrine and legal discourse generally, and in the law pertaining to mental capacity in particular. (He is also now enshrined as the dominant principle in bioethics, overshadowing the traditional medical value of beneficence.) Elsewhere, however, the theoretical coherence and credibility of the autonomous man, and of the world view he embodies, has been seriously eroded. Jennifer Nedelsky and other, primarily feminist, writers have reimagined autonomy as fundamentally *relational*, contextual, and *developed* (as opposed to innate, to be held on-to, lost, or taken), exercised through (and not in resistance to) relationships with other human beings, both as a process of autonomous thought or decision making, and as a set of substantive characteristics.⁶⁸ For

⁶⁷ The “hyperbolized” figure is described by Lorraine Code as:

[S]elf-sufficient, independent, and self-reliant, a self-realizing individual who directs his efforts toward maximizing his personal gains. His independence is under constant threat from other (equally self-serving) individuals: hence he devises rules to protect himself from intrusion. Talk of rights, rational self-interest, expediency, and efficiency permeates his moral, social, and political discourse (*What Can She Know? Feminist Theory and the Construction of Knowledge* (Ithaca, NY: Cornell University Press, 1991) at 77-78).

⁶⁸ Jennifer Nedelsky, “Reconceiving Autonomy: Sources, Thoughts and Possibilities” (1989) 1:1 Yale JL & Feminism 7 at 10 [Nedelsky, “Reconceiving Autonomy”]; Catriona Mackenzie & Natalie Stoljar, “Introduction: Autonomy Reconfigured” in Mackenzie & Stoljar, *supra* note 11, 3 at 4. Christman has defined relational autonomy as “the label that has been given to the conception of what it means to be a free, self-governing agent who is also socially constituted and who possibly defines her basic value commitments in terms of interpersonal relations and mutual dependencies” (John Christman, *The Politics of Persons: Individual Autonomy and Socio-historical Selves* (Cambridge, UK: Cambridge University Press, 2009) at 164-65). Embedding autonomy in a relationship context recognizes the reality of many women’s lives, for whom relationships and their maintenance are often essential to self-identity and decision making, and at least potentially, brings those lives within the ambit of “autonomy” and the autonomous. Inclu-

Nedelsky, autonomy is practiced as a way of being in the world rather than a series of self-willed choices. We act as we are *constituted* to act and as our “meaning”, of which our social and relationship context is at least partially constitutive, inclines us to act.⁶⁹

Relationships per se are not sufficient for the development of autonomy in the relational account. The *right kind* of relationship context, of which the loving mother-child relationship may be the paradigm, but the hostile mother-child relationship is surely the antithesis, is required. In this way, and for this reason, theories of relational autonomy⁷⁰ necessarily involve questions of values and, therefore, value *judgment*. Some of us will be lucky enough to have developed within a relationship context conducive to the development of relational autonomy. Those of us who were not so lucky must subsequently find or create that context. Our material and personal situation will be crucial, probably determinative, to our success in this endeavour: Do we have access to sufficient money, time, and environmental supports? Are we fearful, exploited, or abused? Do we have personal characteristics that make it more difficult to navigate the social world? Many, accordingly, will be left out of the autonomy ambit, at least until such time as they are able to develop, or regain, “true” autonomy.

This apparent eliteness of relational autonomy, as a highly desirable quality possessed by the few, is less problematic if relational autonomy is understood to exist in relation to *vulnerability* rather than in opposition to capacity and, therefore, non-autonomy and non-personhood. Vulnerability—like relational autonomy, as it is described by Nedelsky and others—arises through the interaction of personal characteristics (also shaped by context) and through those contextually derived factors that together make up the individual’s total life situation, including education, relationships, experiences, and material circumstances and resulting opportunities, as well as connection to other people and other “worlds” through paid

sion among those who are recognized as autonomous is significant given the high social value of autonomy and, indeed, the historical and theoretical equation of autonomy with personhood itself.

⁶⁹ “[T]here are no human beings in the absence of relations with others. We take our being in part from those relations” (Nedelsky, “Reconceiving Autonomy”, *supra* note 68 at 9). Recognition of relationships as constitutive avoids the conflation of a woman’s identity with relationship-oriented roles that are *assigned* and defined by others (e.g., wife, mother, grandmother, daughter). These roles obscure women’s individual identities in a way that effectively constructs a “hyperbolic”, stereotypical companion for the atomistic autonomous man, equally unrealistic and crude yet also equally culturally entrenched, and therefore, at least potentially constitutive in its own right.

⁷⁰ Like accounts of autonomy as a substantive condition—as opposed to a value-neutral, free, and rational process—generally: see Stoljar, *supra* note 11; Benson, *supra* note 11; Kristinsson, *supra* note 11; Marina AL Oshana, “Personal Autonomy and Society” (1998) 29:1 *Jour Soc Phil* 81.

work or otherwise.⁷¹ In this way, vulnerability is not so much the absence of (relational) autonomy but its constant shadow, which may be expected to wax and wane over an individual's life course.⁷² And like relational autonomy, vulnerability is practiced as a *way of being in the world* that is neither chosen nor willed; as persons, whether vulnerable or not, we act as our meaning inclines us to act, and we take that meaning, in part, from our relationship context.⁷³

B. Vulnerability and Public Response: The Problem of Definition

The mental capacity construct provides, from the legal perspective, a hard, objective standard. No similar construction of vulnerability as an “out-there” bio-fact is possible. Vulnerability is necessarily relational, and legislation in jurisdictions recognizing, and providing a response to, vulnerability has struggled with the question of definition. Where the vulnerable are defined in terms of status characteristics—the elderly, the physically and mentally disabled—obvious problems of inappropriate overinclusiveness (together with less obvious, and more controversial, problems of underinclusiveness) arise,⁷⁴ “reawaken[ing]”, indeed, the “ghost of a ‘status approach’” that was intended to have been banished by functional capacity assessment.⁷⁵ This is vulnerability as “incapacity-lite”. The development of a common law “vulnerability” in the English courts suggests a more distinctive legal construct and one that is more akin to

⁷¹ In this way, the idea of vulnerability parallels undue influence and unconscionability—the doctrines of equitable fraud—which may be understood as explanations or theories of different aspects of the underlying concept: see Hall, “Equity Theory”, *supra* note 64 at 108-109.

⁷² An idea consistent with Martha Fineman’s “vulnerability thesis”, in which vulnerability describes a “universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility” (“The Vulnerable Subject”, *supra* note 64 at 8).

⁷³ *C.f.* Deborah O’Connor, Margaret Isabel Hall & Martha Donnelly, “Assessing Capacity Within a Context of Abuse or Neglect” (2009) 21:2 *Journal of Elder Abuse & Neglect* 156 at 164-65. Some proponents of a contextual approach to capacity assessment have emphasized its potential to extend the meaning and ambit of capacity, thereby making a finding of incapacity, with its attendant loss of autonomy, less likely: O’Connor, “Relational Framework”, *supra* note 21 at 23. The outcome of contextual or relational capacity, within the capacity-autonomy paradigm, must be non-intervention, in more (possibly most) cases. Is that the ideal? I suggest that it is not and that the expansion of capacity in this way will abandon more women like Dorothy (see *infra* note 90) to their “autonomy”.

⁷⁴ See e.g. Minn Stat § 626.5572(21) (2001). See also Manitoba’s *The Vulnerable Persons Living With a Mental Disability Act*, SM 1993, c 29, CCSM c V90, s 1(1) “vulnerable person”.

⁷⁵ Michael C Dunn, Isabel CH Clare & Anthony J Holland, “To Empower or to Protect? Constructing the ‘Vulnerable Adult’ in English Law and Public Policy” (2008) 28:2 *LS* 234 at 244.

the equitable doctrines of undue influence and unconscionability. In *Re SA*, Justice Munby described the developing⁷⁶ standard as follows:

In the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity. *This, I emphasise, is not and is not intended to be a definition. It is descriptive, not definitive; indicative rather than prescriptive.*⁷⁷

Discussing *Re SA* and the development of the court's inherent jurisdictions with respect to the vulnerable, Dunn et al. note—with caution—the implications of the court's analysis in that case: that “the court's inherent jurisdiction is not confined to ‘vulnerable adults’ defined through inherent vulnerability”:

[T]he incorporation of situational vulnerability into the construction of the ‘vulnerable adult’ draws upon an understanding of vulnerability as universal. Vulnerability becomes a concept tied to the personal, social, economic and cultural circumstances within which individuals find themselves at different points of their lives, and an endemic feature of humanity. Accordingly, justifying substitute decision-making on the basis of situational vulnerability could lead to interventions that are potentially infinite in scope and application. Might it not be possible, for example, that a man, involved in an abusive relationship and about to embark on cohabitation with his violent partner, could be defined as being situationally vulnerable in order to justify court interventions that place restrictions on his living arrangements, as a means of ensuring that he is able to make personal autonomous decisions in the future, without the imposition of constraint or the threat of violence? Equally, might it not be possible that a family with considerable financial debt could be defined as situationally vulnerable in order to justify court interventions which ensure that they restructure their debts in a manner that could ultimately relieve this putative vulnerability, thus ensuring that they can continue to make personal economic decisions that are free from the undue influence of bank charges or the threat of bankruptcy?⁷⁸

This is the fear of the slippery slope of open-ended intervention. But is the complexity of social reality and the nature of the self in the context of human relationships really beyond the reach of coherent legal analysis and response? Consider Lord Scarman's description of the doctrine of undue

⁷⁶ Developing as an exercise of the court's “inherent jurisdiction”.

⁷⁷ [2005] EWHC 2942 (Fam) ¶ 82 (available on QL) [emphasis added]. See also *Re G*, [2004] EWHC 2222 (Fam) (available on QL); *Re SK*, [2004] EWHC 3202 (Fam), [2005] 3 All ER 421; *A Local Authority v DL*, [2011] EWHC 1022 (Fam) (available on QL).

⁷⁸ Dunn, Clare & Holland, *supra* note 75 at 241.

influence, also concerned with the self in a social and relationship context, in the case of *National Westminster Bank PLC v. Morgan*:

There is no precisely defined law setting limits to the equitable jurisdiction of a court to relieve against undue influence. ... It is the unimpeachability at law of a disadvantageous transaction which is the starting-point from which the court advances to consider whether the transaction is the product merely of one's own folly or of the undue influence exercised by another. ... [T]his is a question which depends upon the particular facts of the case.⁷⁹

There is no substitute in this branch of the law for a "meticulous examination of the facts."⁸⁰

I suggest that it is possible to imagine a similarly fine-brushed, individualized, and context-sensitive approach outside of the property context to which undue influence has traditionally been confined. The traditional doctrines of equity—undue influence and unconscionability—provide a useful conceptual framework for seeing, and responding to, vulnerability in embodied context.⁸¹

I am arguing that the key question is not whether society *should* respond to vulnerability. The guardianship response to mental incapacity—including public guardianship-type interventions for the cognitively impaired under mental health legislation—is a response to vulnerability, couched in, and confused by, the language of capacity. I am not arguing for a necessary extension of legal or social intervention to a new class of persons, "the vulnerable", but for an honest reappraisal of the basis on which—and therefore, the *ways* in which—interventions currently happen. The vulnerability characterization, unhinged from the capacity-autonomy paradigm, allows us to see, understand, and therefore question the situational limitation of this public response to vulnerability as a *policy* decision. Recognizing vulnerability does not, by that reason alone, mean responding to all vulnerability, in all circumstances (the slippery slope feared by Dunn et al.). Responding to vulnerability depends on the availability of an effective response, together with a policy decision regarding whether vulnerability unchecked, in certain classes of cases, is permissible. Guardianship legislation, from this perspective, provides a

⁷⁹ [1985] AC 686 at 709, [1985] 2 WLR 588 HL (Eng).

⁸⁰ *Ibid.*

⁸¹ A key insight underlying the conceptual framework of undue influence in particular is the construction of vulnerability not as a constant and organically derived state of being, but as arising from the interplay between the relationship context and one's personal characteristics in a particular situation: see Hall, "Capacity, Vulnerability, Risk and Consent", *supra* note 53 at 127; Hall, "Equity Theory", *supra* note 64 at 114; Hall, "Material Exploitation", *supra* note 63; O'Connor, Hall & Donnelly, *supra* note 68 at 165-67; Margaret Hall, "Equitable Fraud: Material Exploitation in Domestic Settings", online: (2006) 4 Elder Law Review 7 <<http://www.austlii.edu.au/au/journals/ElderLawRw/>>.

response to the vulnerability of *older adults with cognitive-mental health deficits*,⁸² allowing for a particular and limited response—substitute decision making—that efficiently responds to the social needs involved (as discussed above), if not, with any exactitude, to the needs of the vulnerable subject him- or herself. The guardianship response is not, formally, limited to older adults but is most often, by a considerable margin, used in response to the vulnerability of older adults.

Conclusion

As Lord Rodger of Earlsferry reminded us in *D v. East Berkshire Community Health NHS Trust*, “[T]he world is full of harm for which the law furnishes no remedy.”⁸³ Objectively speaking, there are many people who struggle; who cannot pay their bills or are exploited; who, for a variety of reasons, do not care for themselves or their surroundings in accordance with basic norms of hygiene. And many of these people could, perhaps, be characterized as vulnerable. Is intervention justified on behalf of them all? We know that it does not happen—that no explanatory mechanism has emerged to enable it to happen. Why not? What is special about the group of people currently characterized as incapable that, as matter of (non-explicit) social policy, motivates intervention (which is then squared with the autonomy ideal through the theoretical mechanism of incapacity)?

The most obvious characteristic of the incapable—as opposed to the mentally ill, as a constructed class—is that they tend to be old.⁸⁴ Unlike the young mentally ill, there is an implicit social understanding that the presence of old, impoverished, and visibly delusional people begging on the street and sleeping in doorways is not tolerable in the way that the presence of visibly mentally ill “street people” has become an everyday feature of urban life. The *public* vulnerability of the old is intolerable in a way that the public vulnerability of the young, excepting children, is not. There may be compelling reasons for this policy choice and for the public

⁸² Browne, Blake, Donnelly, and Herbert have suggested a model of encumbrance, distinct from capacity, as a basis for intervention in the lives of the old, in which interference is justified only if the person is putting him- or herself at significant risk, if the person is “encumbered” (incompetent or subject to some other judgment-distorting condition), and if interference will be effective and not, in itself, a source of harm, as well as if the interference does not generate other or greater harm, is as mild as possible, is non-discriminatory, and is not, except as a last resort, seen as unjustified by the person subject to the interference: see Browne et al, *supra* note 30 at 289-90.

⁸³ [2005] UKHL 23 at para 100, [2005] 2 AC 373.

⁸⁴ For the purposes of this discussion, I will leave aside the developmentally disabled, whose situation is qualitatively distinct from the incapable elderly and from the mentally ill in important ways that are relevant here.

response on which it is based, given the increased frailty of older adults; what is important is that the choice, and the reasons for it, be acknowledged.⁸⁵ The mechanism of guardianship allows highly motivated family members and friends to respond to, and deal with, that vulnerability—whether that response is desired by the subject or not. (If assistance is desired, formal guardianship proceedings may not be necessary or pursued, except in cases of suspected exploitation and contested guardianship.)⁸⁶ Where no person is available to become a guardian, the available public response will be more limited: financial (and possibly personal) management by the Public Guardian and Trustee, or admittance to a nursing home.

This analysis is *not* intended to suggest that cognitive impairment (i.e., the dementias) is not real; cognitive impairment is a significant contributing factor to the kind of vulnerability that triggers public response. But mental illness in the non-elderly is equally real, as is addiction and the effects that an abusive relationship context have on self and relational autonomy.⁸⁷ Neither dementia nor mental illness—unlike cancer, for example—can be proven during life through a blood test or a cell on a slide.⁸⁸ Dementia, like mental illness, is established through observation of a person's speech, actions, and behaviours, and the medical evaluation of those external signs of the brain within. Despite this etiology, however, the dementia diagnosis is presented in popular culture as scientifically “hard” in a way that the mental illness diagnosis is not. The human subject of the dementia diagnosis, therefore, is perceived as morally blameless in a way that those diagnosed with mental illness are not, also giving rise to, and justifying, a particular social response (explained, at least in part, through the construct of decisional capacity).

Theorizing and then identifying vulnerability allows us to focus explicitly, and therefore carefully, on the identification of situations or contexts in which vulnerability justifies a social response. That is a question of policy. A second question requires serious and careful thought about what kind of response will actually be useful and workable to redress the *par-*

⁸⁵ Another way of looking at this same factor is to understand the relative fragility of older adults as going to the more purely sympathetic characterization of the incapable elderly, relative to the younger mentally ill, and on this basis, justifying a particular kind of social response, as with the similarly sympathetic and physically non-threatening category of children.

⁸⁶ See Kapp, *supra* note 23 at 414-15.#

⁸⁷ See the case of “Dorothy”, discussed *infra* note 90.

⁸⁸ Although new tests of cerebral spinal fluid are being developed for Alzheimer's, together with imaging tests for vascular dementia.

ticular and embodied problem identified.⁸⁹ The law cannot and should not respond where the available response is inappropriate and ineffective; this involves very different considerations, which are precluded by the mental capacity construct. The question of resistance, and the problem of oppressive socialization and other compelling contextual factors, will be crucial here—not because of their relationship to an abstract autonomy but because of their practical implications for response in the particular context of embodied lives. Intervention is easy if I gratefully accept the help offered by a benevolent relative or emissary of the state; it is hard if I refuse (e.g., I don't want to leave or to change my context, be it a squalid hovel or an abusive relationship). If I understand autonomy as innate, “my decision” must be enforced unless I have lost capacity (and having lost my autonomy, my decision is not my own anyway, and the problem is resolved). If I understand autonomy as relational and developed through context, the idea of my autonomous decision in these circumstances loses authority. I may be *unable* to “choose” another way of living and being until my context (and therefore my self) is changed.⁹⁰ This is a hard truth, and it raises moral, conceptual, and practical challenges. The capacity construct has worked to the extent that it has masked that truth, enabling intervention without consent in a limited class of situations, while maintaining the crucial social fiction of liberal autonomy.

⁸⁹ The capacity paradigm necessarily characterizes both the problem and the response in terms of decision making: the problem being a lack of decision-making ability; the solution being a substitute decision maker. But, unlike in the health care context, the greatest need may not be for a replacement decision maker but rather for material assistance, which may or may not be provided by a substitute decision maker. A vulnerability analysis focuses the inquiry on this question of need, and its provision. The appointment of a substitute decision maker may be one aspect of a response to vulnerability, but it is unlikely to be the only one.

⁹⁰ L. R. Bergeron describes the case of “Dorothy”, whose situation was reported to adult protective services by an emergency medical team, following her collapse after years of emotional, sexual, and financial abuse and exploitation by her second husband. Dorothy had previously been admitted, on several occasions, to the hospital for depression. The mental health social workers had suspected that “something was wrong” but had not reported the case to social services because Dorothy would not “admit” to any abuse. Nor would Dorothy agree to a mental health intervention. Two years after the intervention by adult protective services, Dorothy was asked by the author whether she felt that her “right to self-determination superseded the intervention she received.” This was her “direct and clear” response: “How dare you professionals speak of self-determination when I was obviously suffering?” Dorothy explained that she was “incapable” of speaking out about the abuse because of shame and guilt, feeling that she had brought it on herself her choice of marriage partner. She explained that her isolation and damaged self-worth, consequent on the abuse, had “greatly impacted her perspective and that what she needed was immediate distancing from her situation, at least initially, before she could effectively make her own decisions” (L René Bergeron, “Self-Determination and Elder Abuse: Do We Know Enough?” (2008) 46:3-4 *Journal of Gerontological Social Work* 81 at 89).

Recognizing and responding to vulnerability also requires us to think carefully, and without the obfuscation provided by the apparent scientific objectivity of the capacity threshold, about *judgment*. Perhaps we can understand the significance of the capacity threshold in particular, and the institutions of “social services” generally, in terms of a definitively modern flight from judgment. In leading us back to judgment, theorizing vulnerability (*after* capacity and the theoretical hegemony of the capacity threshold) leads us back into the embodied world. Judgment (as opposed to mere choosing) is neither arbitrary, nor subjective, nor idiosyncratic, but is deeply enmeshed with the world,⁹¹ anticipating a community of judgment makers who must be convinced of the rightness of my chosen course of action. Theorizing vulnerability opens that discussion, hitherto precluded by the closed—because it is “objectively” definitive—mental capacity threshold.

⁹¹ “[R]eflection on the theme of judgment teaches us the limits of theory, for judgment (whether in ethical or political life) attends to particulars that are beyond the purview of theory as such” (Ronald Beiner & Jennifer Nedelsky, “Introduction” in Ronald Beiner & Jennifer Nedelsky, eds, *Judgment, Imagination, and Politics: Themes from Kant and Arendt* (Lanham, Md: Rowman & Littlefield, 2001) vii at viii). Jennifer Nedelsky, “Embodied Diversity and the Challenges to Law” (1997) 42:1 McGill LJ 91 at 106-109.