

**RETHINKING THE ADULT GUARDIANSHIP RESPONSE: MENTAL CAPACITY
AND VULNERABILITY IN THE CONTEXT OF DEMENTIA IN OLD AGE**

by

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Abstract

The current discourse around supported decision making and the *Convention on the Rights of persons With Disabilities* has challenged medico-legal guardianship and the mental capacity construct at its conceptual core, re-conceptualising decision-making as a skill which can be developed and/or enabled through practice and support. Two major gaps in the supported decision making paradigm have precluded a true paradigm shift, however: a failure to consider the needs of persons unable to express will or preference of any kind in relation to day to day tasks, and a failure to consider exploitation through the high-jacking of mere choices (i.e. non-genuine decisions) by others. The phenomenological nature of dementia intersects with the distinctive relationship and social contexts of old age to make these gaps especially meaningful in the context of dementia in old age. While a guardianship model that includes substitute decision-making would fill these gaps, the theoretical and practical problems associated with the current medico-legal guardianship model must be addressed. Using the methodology of pragmatic inquiry, this study proposes re-thinking adult guardianship as a response to vulnerability (the impaired performance of thinking processes in connection with an individual's social, relationship and material contexts), and sets out a preliminary guardianship model constructed on that basis.

Lay Summary

Supported decision-making does not provide a complete replacement for guardianship, particularly in the context of dementia in old age. The current medico-legal guardianship model (structured and justified by the mental capacity construct described in this research **study**) is also problematic in this context. This research study proposes rethinking adult guardianship as one response to vulnerability, where increased vulnerability arising from a person's impaired performance of thinking processes is not absorbed or is exacerbated by that person's social, material and relationship contexts. Rethinking guardianship as a response to vulnerability is consistent with, and justified by, principles and policy considerations embedded in the doctrines of common law and equity. This study concludes by setting out a (preliminary) vulnerability-based guardianship model, including a framework for assessing vulnerability.

Preface

This dissertation is original, unpublished work by the author, Margaret I. Hall.

The empirical research carried out in connection with this research study (described and reported in Chapters 5-6) was covered by UBC Behavioural Research Ethics Board Certificate of Approval #H12-03209 (Project Title “The Mental Capacity Construct as a Basis for Guardianship Interventions Involving Older Adults: Pragmatic Inquiry and Policy Implications”).

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Dedication

For my mother, Marguerite Frost, and my father, William F. Hall

Chapter 1. Introduction

The first part of this introductory Chapter describes the subject of this research, and sets out the purpose and research questions guiding this research study. An over-view of the following Chapters in this research study is then provided. The Chapter concludes with an explanation of the way in which the concept of vulnerability is understood and used in this research study.

1.1 Subject of this research: rethinking adult guardianship in the context of dementia in old age

The law is never concerned with the thought processes of individuals *per se*. Legal response is limited to situations where an individual's performance of thinking processes (judging, comprehending, remembering) creates problems, for the person and/or for others, that are recognised as justifying legal intervention. Several areas of the civil (non-criminal) law are concerned, for different reasons, with the problematic performance of thinking processes; these include adult guardianship and mental health legislation, legislation enabling advanced planning instruments of different kinds, and doctrines of law and equity relating to agreements and bequests. In each case, the law's concern and intervention must be justified. That justification is rooted partly in public policy (where a problem is understood to engage the public interest), partly in legal principle, and partly in the dominant cultural paradigm of a particular time and place. A justification may become more or less valid, therefore, as policies, principles and paradigms change over time. The late 20th century ascendancy of autonomy as a legal principle has meant that all laws relating to the performance of thinking processes must be justified in terms that include the recognition/protection of individual autonomy. This has not always been the case.

From the feudal law of the manor to the modern medico-legal guardianship model, adult guardianship (as one legal response to the problematic performance of thinking processes) has taken several forms and been justified on a number of bases in Anglo-Canadian law. The essential mechanism of guardianship has remained constant, however: the authorisation of one person to act/make decisions on behalf of another. The justification for adult guardianship has changed more significantly over the course of this history. Guardianship was justified in the feudal system by the imperative of ensuring that the obligations owed by a subject to the Lord

were carried out. If the subject was incapable of carrying out those obligations for reasons relating to his performance of thinking processes, guardianship provided a mechanism through which those obligations could be met. The doctrine of *parens patriae*, arising in the middle ages, provided the justification for guardianship until the introduction of adult guardianship legislation in the late 19th/early 20th centuries. *Parens patriae* conceptualised the relationship between the Crown (later the state) and “lunatics” as one in which an obligation to protect was owed by the Crown/state to an individual who was incapable of protecting him or herself. Until the guardianship reforms of the late 20th century, adult guardianship legislation implicitly rested on a *parens*-like justification. The old category of “lunatics” (having absorbed the even older category of “idiot”) was replaced by new categories based on medical status (mentally infirmity or disorder, for example) but the justification remained the same: the state’s parent-like responsibility to protect persons who, by reason of their performance of thinking processes, could not protect themselves.

The protection-based justification for adult guardianship began to lose validity in the latter decades of the 20th century with the ascendancy of autonomy as a pre-eminent legal principle, increasing respect for diversity and human rights, and the incorporation of social disability theory within equality jurisprudence. These theoretical developments were accompanied by increasing public awareness of the ways in which protection-based authority over others could be (and often was) abused. In accordance with these broader social developments, the adult guardianship reform movement sought to re-construct guardianship as a mechanism for protecting and maximising individual autonomy. The medico-legal guardianship model that emerged from the reform movement conceptualised guardianship as a response to decision-specific mental capacity impairment¹ as opposed to a need for protection and management arising from a generalised inability to fend for one’s self. The guardian became a “decision-maker” (rather than a protector). As a substitute decision-maker, the guardian’s role was to implement those decisions the individual *would have made* if capable of doing so (as opposed to

¹ Mental capacity, referring to the cognitive ability to carry out the mental process of decision-making, is used in this study as synonymous with “decision-making ability.” The word “capacity” is used in this study as synonymous and interchangeable with “capability” and “competence.” This is consistent with both general or everyday usage and legal usage, and is adopted for that reason, although a distinction is sometimes 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 J Royal Society of Medicine 415 at 415.

making decisions the guardian felt were in the person's best interests), effectively extending autonomous decision-making after the independent exercise of that autonomy was no longer possible. Some jurisdictions also provided for an assisting and/or supporting decision-maker to enable the person's direct autonomous decision-making where possible.

The idea that mental capacity can be accurately, objectively, and precisely measured is integral to the coherence of the medico-legal guardianship model. Limiting guardianship to specific categories of decisions (more specific than the traditional management categories of property and person), and distinguishing between persons capable of making decisions with support and those incapable of doing so, requires the ability to identify and delineate between finer grades of cognitive decision-making processes. By removing subjective or value-based judgment from the assessment process, the scientific/objective measurement of mental capacity is also essential to the validity of adult guardianship as a means of protecting autonomy; theoretically, scientific assessment would prevent unconventional behaviour from being mislabeled as evidence of impaired capacity. The role of the court in the medico-legal model is limited to ensuring that evidence of decision-making is sufficiently objective and value-neutral, and determining whether suitable arrangements for managing the person's impaired capacity are in place (choosing between rival would-be guardians, for example).

The supported decision making paradigm, in contrast, has rejected substitute decision-making (and therefore adult guardianship itself) as fundamentally *unjustifiable*, either on the basis of a *parens* like protection principle or on the basis of autonomy (the medico-legal guardianship model described above). At the core of the supported decision-making paradigm is a re-conceptualisation of decision-making itself as a skill, developed through practice and support, rather than a bio-mechanical characteristic of brain function. The medico-legal guardianship question (is person X capable of making decision Y) is, on this basis, wrong in theory and discriminatory in effect. Person X is always capable of making decision Y, with appropriate support; the right question is, what support does X need to make her own decision? By explaining persons as always capable of decision-making the supported decision-making paradigm under-mines the justification for medico-legal guardianship and removes the need for any alternative justification (because support \neq legal intervention and autonomy interference, no

justification for that interference is required).² Incorporating the core tenets of social disability theory, the supported decision-making paradigm characterises differential legal treatment on the basis of impaired mental capacity as both discriminatory and autonomy-impairing, actively preventing the person from developing her own decision-making ability by empowering another to make decisions on her behalf (in the same way that one who is always cooked for will never learn to cook). On the terms of this analysis, reforms to guardianship (limiting the scope of guardianship authority to certain kinds of decisions e.g.) do not change the essentially discriminatory and autonomy-impairing nature of guardianship *per se*. The assessment of mental capacity for the purpose of appointing even an assisting or supporting decision-maker is characterised as discriminatory in and of itself.

This emerging new paradigm³ (which would replace the medico-legal guardianship model) must be distinguished from guardianship legislation providing for supported and/or assisted decision-making as an alternative to substitute decision-making on a guardianship continuum, with the choice of alternative depending on the assessment of that person's mental capacity (or "decision-making ability"). At the conceptual core of the supported decision-making paradigm is a rejection of the mental capacity assessment itself, however carried out, as the basis for appointing any kind of decision-maker. The "dis-ability" of "impaired decision-making" can be resolved, instead, through creation of and access to adequate supports, in the same way that disability arising from physical differences can be resolved through modifications to the built environment. This idea of mental in/capacity as socially constructed is of-a-piece with social disability theory, as incorporated within equality jurisprudence (as discussed in Chapter 2). The supported decision-making paradigm has also been deeply informed by its connection to the community living movement and, in particular, the identification of specific practical problems caused by medico-legal guardianship and substitute decision-making for persons with developmental and intellectual disabilities.⁴ These problems include the discriminatory *de facto*

² The United Nations Committee on the Rights of Persons With Disabilities (within the Office of the High Commissioner on Human Rights), General Comment No. 1 (interpreting Article 12 of the Convention on the Rights of Persons With Disabilities), discussed in detail in Chapter 2, *infra*, also casts doubt on the idea of mental capacity as a medically meaningful idea.

³ Thomas Kuhn, in his seminal work, *The Structure of Scientific Revolutions*, defined a paradigm as a comprehensive model of understanding within a field of practice. See Thomas Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 1962).

⁴ Writing in 2000, Robert Gordon noted the strong role played by organisations representing the interests of persons with mental (intellectual) disabilities (notably the national and provincial associations for community living) in the

identification of intellectual/developmental disability itself as equal to impaired decision-making capacity;⁵ the illusion of “substitute” decision making for persons never considered capable of decision making (making the guardian a replacement and not a substitute decision-maker);⁶ guardianship as an enforced, perpetual childhood precluding the development of autonomy, decision-making skills and psychological well-being; and the devastation caused by the death of parent-guardians for persons who have been deprived of the opportunity to develop those skills.⁷ The development of the supported decision-making paradigm as a response to these specific problems is discussed further in Chapter 2.

The supported decision-making paradigm remains what Thomas Kuhn described as an “emergent paradigm” in the period of “paradigm revolution” that precedes a true paradigm *shift*, i.e. the adoption of a new master conceptual rule through which problems are identified and plausible solutions to those problems are understood or framed.⁸ Paradigms gain dominant status, according to Kuhn, “because they are more successful than their competitors in solving a few problems that the group of practitioners has come to recognize as acute.”⁹ Eventually, recurring problems arise within a field that resist resolution through the rules of the dominant paradigm, despite repeated efforts to make the problems fit the frame (efforts which may result in short-term *apparent* resolutions). So long as these stubborn problems remain visible, persistent failure eventually leads to the emergence of alternative theoretical frameworks during a creative period that Kuhn called a model revolution. A paradigm shift takes place when one of these alternatives

development of supported decision-making and the relative exclusion of “the elderly” who had been the “driving force” behind the guardianship reforms of the 1970s and 1980s. These developments are discussed further in Chapter 2.. See Robert Gordon, “The Emergence of Assisted (Supported) Decision-Making in the Canadian Law of Adult Guardianship and Substitute Decision-Making” (2000) 23:1 Intl J L & Psychiatry 61 at 72.

⁵ Even where guardianship legislation calls for a “decision-specific” capacity assessment.

⁶ See Louise Harmon, “Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment” (1990) 100:1 Yale LJ 1.

⁷ Nina A Kohn, Jeremy A Blumenthal & Amy T Campbell, “Supported Decision-Making: A Viable Alternative to Guardianship” (2013) 117:4 Penn St L Rev 1111 at 1113, 1117-120. See also, Kristin Booth Glen, “Changing Paradigms: Mental Capacity, Legal Capacity Guardianship, and Beyond” (2012) 44:1 Colum HRLR 93; Harmon, *supra* note 8; Law Commission of Ontario, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, by Michael Bach & Lana Kerzner (Ontario: Law Commission of Ontario, October 2010) online: <<http://www.lco-cdo.org/disabilities/bach-kerzner.pdf>>.

⁸ See, PM Strong, *The Ceremonial Order of the Clinic: Parents, Doctors and Medical Bureaucracies* (London: Routledge & Kegan Paul, 1979); Robert Dingwall, John Eekelaar & Topsy Murray, *The Protection of Children: State Intervention in Family Life* (Oxford: Basil Blackwell, 1983); Diane Vaughn described this kind of framing as “a way of seeing that is simultaneously a way of not seeing.” See Diane Vaughn, *The Challenger Launch Decision: Risky Technology, Culture, and Deviance at NASA* (Chicago: University of Chicago Press, 1997) at 394.

⁹ Kuhn, *supra* note 5 at 23.

defeats the others to become the dominant paradigm in the field. If an existing dominant paradigm simply absorbs or is altered by a new model the result is what Kuhn calls “normal science” (ie. incremental development of an existing paradigm) and not a paradigm shift. Applying Kuhn’s terminology, legislation in several Canadian provinces providing for a guardianship continuum (with the kind of decision-maker appointed depending on the person’s level/degree of decision-making ability) is “normal science” of this kind rather than a true paradigm shift,¹⁰ a further iteration of guardianship reform requiring the production and implementation of increasingly precise assessment tools to measure and separate out decision-making capabilities: is X capable of making decision-type A with support? Not capable of making decision-type B (and in need of a substitute decision maker)? Canada’s ratification of the *Convention on the Rights of Persons with Disabilities* with a reservation allowing for substitute decision making is a tacit endorsement of the continuum approach i.e. the co-existence of supported and substitute decision making within a medico-legal model.

I suggest that a true paradigm shift in favour of the supported decision-making paradigm has been precluded by two major gaps: the failure to recognise/respond to the needs of persons who are unable to express choice of any kind (the person in a coma, to use the most extreme example), and the failure to recognise and respond to the high-jacking of mere/non-genuine¹¹ choices by others for the purpose of exploitation. The term “mere choice” is used here to describe choices that are distorted by problems in the individual’s performance of thought processes (choices can be distorted in this way by delusions, an inability to understand or comprehend, or where judgment is impaired). Both problems are particularly pertinent in the context of dementia in old age- the context in which guardianship is most commonly used, by a considerable margin. The nature of dementia as a progressive disorder, experienced in connection with increasing physical frailty and the progress of underlying diseases such as Alzheimer’s, entails a declining ability to make decisions and to perform other kinds of thinking processes (judging, comprehending, remembering) culminating in an inability to effect choice of any kind. As dementia progresses, a person’s ability to care for themselves or carry out the

¹⁰ See, Kohn, Blumenthal & Campbell, *supra* note 9.

¹¹ In the sense that genuine decisions have been understood and explained through doctrines of common law and equity, as discussed further in Chapter 4.

activities of daily life will generally decrease together with the person's ability to perceive the implications of those changes. The early stages of dementia, on the other hand, are often characterised by distortions in judgment at a time when the individual retains the ability to effect or carry out mere choices. At the same time, the distinctive social and relationship contexts of old age (described in Chapters 4 and 6) make it more likely that these mere choices will be manipulated and exploited by others.

Substitute decision-making responds to these problems by providing a mechanism through which decisions can be made and mere choices over-ridden, and the survival of medico-legal guardianship (despite sustained and significant critique) can be attributed to its ability to fill these gaps. Medico-legal guardianship is not validated by the gaps in the supported decision-making paradigm, however, and the problems identified by its critics remain. The supported decision-making critique has explained the ways in which medico-legal guardianship has been a source of problems for persons with developmental disabilities. As examined and discussed in this research study, medico-legal guardianship also gives rise to special problems the context of dementia in old age.

In sum, a role remains for adult guardianship, but medico-legal guardianship can no longer be justified in its present form. The objective of this research is to determine whether the problems associated with medico-legal guardianship can be resolved through "normal science" (a next phase of guardianship reform), whether a more radical re-conceptualisation is warranted and, if so, to identify the basis for a new adult guardianship paradigm. This study has been carried out with a focus on the distinctive problems arising in the context of dementia in old age, as the context in which guardianship is most likely to be used in response to the supported decision-making gaps identified above. Guardianship is not an abstraction, but something that happens to people, and an evaluation of adult guardianship must be grounded in context rather than a diffuse abstract category of "persons with impaired decision-making ability". The questions guiding this research, and the methodology of pragmatic inquiry through which those questions have been examined, are intended to provide this kind of contextualised approach.

1.2 Guiding questions and purpose of this research study

The purpose of this research study is to construct a model of adult guardianship that addresses the problems associated with medico-legal guardianship while filling the gaps in the supported decision-making paradigm. The success/validity of that model depends on a coherent theoretical justification (rooted in policy, principle, and authoritative cultural paradigms) and on the feasibility of effective practical implementation. The methodology of pragmatic inquiry used in this research (as discussed in Chapter 3) provides for an examination/analysis of both of these elements. Consistent with this purpose and methodology, this research study has been guided by two over-arching research questions:

1. Whether and to what extent the current medico-legal guardianship model, as structured by the mental capacity construct, provides an adequate and effective response to problems arising from the chronic and progressive changes in thinking processes that are associated with dementia in old age (taking into account the often ambiguous relationship between “normal aging” and the signs and symptoms of dementia). The effectiveness of that response also requires theoretical coherence and justification in terms of legal principles. In particular:

- To what extent is the mental capacity construct coherent as an “organizing idea” (in the pragmatist sense) for guardianship in the context of dementia in old age?
- To what extent is the mental capacity construct capable of consistent enactment by medical and legal actors (involved in the processes of guardianship) in the context of dementia in old age?
- To the extent that it is not, what specific problems or difficulties are generated by this lack of coherence/workability?

2. Whether an alternative guardianship model based on and structured by an underlying/framing theory of vulnerability can provide a more complete and effective response to problems arising from the chronic and progressive changes in thinking processes associated with dementia in old age, and if so how that response be can justified on the basis of legal principles. In particular:

- Can vulnerability provide a more coherent and workable “organizing idea” (in terms of both theoretical coherence and potential for consistent implementation) for adult guardianship, especially in relation to dementia in old age? What would a coherent/workable theory of vulnerability in this context look like?.

1.3 Over-view and structure of this research study

This research study is divided into four parts. The first part (Chapter 2) provides an historical account of adult guardianship from its pre-common law origins in the law of the manor to medico-legal guardianship, adult guardianship reform, supported decision making and the *Convention on the Rights of Persons With Disabilities*. Throughout this period, the guardianship response has been and remains concerned with the perceived needs of persons whose performance of the processes of thinking- remembering, judging, comprehending, communicating, etc.- create difficulties in terms of coping with the world. The perception of those needs, together with the structures developed to meet them, have necessarily evolved in connection with their historical place and time in a way that “fits” and is compatible with that broader context. Understanding adult guardianship as an idea that is plastic and evolving in this sense provides a theoretical foundation for the examination of guardianship in the following chapters. This understanding and approach is also fundamental to the epistemology and methodology of pragmatic philosophy used in this research study (as discussed in Chapter 3). Chapter 2 concludes with an over-view of dementia as a historically located physiological phenomenon, including a summary of the ways in which dementia has been explained and understood from antiquity to the present.

The second part of this study (Chapter 3) describes the methodology used in this research study and the epistemology underlying that methodology. The methodology of pragmatic inquiry, as articulated and practised by the pragmatist philosopher John Dewey, seeks to resolve “doubt” about the validity of a “situation” (the term used by Dewey to describe a field of practice as that field is organized by a particular idea). The validity of a situation depends on the general acceptance of its organizing idea as true; a situation becomes de-stabilised, and increasingly untenable, where doubt arises about the truth of that idea. Doubt may arise where repeating problems within the field cannot be resolved, or where the broader context in which the field is

situated changes in ways that “jar” with the organizing idea. Pragmatic inquiry is a response to that doubt, requiring the systematic examination of an idea as it works to organise a particular field of practice and, on the basis of that examination, an assessment of its validity. The objective of pragmatic inquiry is to resolve doubt, either through revising the idea under inquiry or by proposing a more valid alternative that resolves the problem/s giving rise to doubt in a way that is consistent with other social truths.

Pragmatic inquiry is rooted in the epistemology of the philosophical pragmatism of James and Dewey (as opposed to the legal pragmatism associated with Oliver Wendell Holmes and the “brass tacks” legal realists). Philosophical pragmatism rejects what Dewey called a “spectator theory of knowledge” in which the individual, standing outside of the world, comes to know that world and its essential reality through a process of passive surveillance.¹² For the pragmatist philosophers “[t]ruth happens to an idea, it becomes true, it is made true by events”¹³ and ideas become true (or cease to be true) to the extent that they “remov[e] some specific trouble and perplexity.”¹⁴ To become true in this way an idea must work or fit together with other truths to form a coherent conceptual framework, “so as ever to show a minimum of jolt, a maximum of continuity.”¹⁵ Pragmatist epistemology and the methodology of pragmatic inquiry provide a very useful way of thinking about how medico-legal guardianship has been structured by the mental capacity construct, the doubt that has arisen about the validity of medico-legal guardianship, and the necessity of re-thinking the theoretical basis of the adult guardianship (as a

¹² John Dewey, *The Quest for Certainty* (New York: Capricorn, 1960) at 193-194, cited in Cornel West, *The American Evasion of Philosophy: A Genealogy of Pragmatism* (Madison: University of Wisconsin Press, 1989) (“[t]heories which assume that the knowing subject, that mind or consciousness, have an inherent capacity to disclose reality, a capacity operating apart from any overt interactions of the organism with surrounding conditions, are invitations to general philosophical doubt.” at 90).

¹³ William James, *Pragmatism* (Cambridge: Harvard University Press, 1975) at 35, cited in C. West, *Ibid.*, at 65. Dewey coined the term “warranted assertibility” as a preferable, more accurate alternative to “truth” and “knowledge”; Larry Hickam has described this “cumbersome but descriptive phrase” as “pointing in two directions”: “Warranted” points backwards in time toward something that has been accomplished. What is warranted is the result of reflection that has been effective in the sense that some specific doubt or difficulty has been resolved. “Assertibility” points forward in time towards something yet to be done. What is assertible is something general, and therefore something potentially applicable to future cases that are relevantly similar to the one by means of which it was produced. Unlike the alleged knowledge... studies by most epistemologists... warranted assertibility is claimed to be neither certain nor permanent. The best it can offer is a measure of stability in an otherwise precarious world.” Larry A Hickman, *Pragmatism as Post-Modernism: Lessons from Dewey* (New York: Fordham University Press, 2007) at 207.

¹⁴ John Dewey, *Reconstruction in Philosophy* (Boston: Beacon Press, 1948) at 156.

¹⁵ *Ibid.*

field of practice) in order to resolve that doubt. The use of traditional philosophical pragmatic inquiry as a legal research methodology is a distinct and, I think, important contribution made by this research study.

As described in detail in Chapter 3, the methodology of pragmatic inquiry consists of three research phases. The first phase is a theoretical examination and analysis of the organizing idea in the doubtful situation under examination, followed by the proposal of an alternative organizing idea that would remove the doubt identified. The second phase of pragmatic inquiry involves a practical testing of those ideas (the current organizing idea and the alternative proposed) in the field under inquiry. The objective or outcome of pragmatic inquiry is the reorganisation of the field of practice in a way that would resolve the doubt giving rise to the inquiry. The first and second phases of pragmatic inquiry are set out in the third part of this research study (Chapters 4, 5 and 6). Judgment between these two ideas (in terms of organizing the field of practice) is the third phase (set out in Chapter 7).

Chapter 4 provides a theoretical examination and analysis of the mental capacity construct in a number of legal contexts, including adult guardianship, and identifies the special problems arising from medico-legal guardianship (as organized by the mental capacity construct) in the context of dementia in old age. Chapter 4 concludes by setting out a preliminary theory of vulnerability as an alternative organizing idea in the field of adult guardianship. The vulnerability theory described in Chapter 4 defines vulnerability as arising through the intersection of the self, involving the problematic performance of thinking processes, with the individual's relationship and social context. This idea of vulnerability is rooted in long-standing principles of equity and the common law. The vulnerability theory proposed in Chapter 4 also resonates with alternative theories of mental capacity developed outside of legal discourse and/or through inter-disciplinary collaboration which, despite their formal identification in terms of mental capacity (as required by the current legislative framework), are more coherently understood as descriptions/explanations of vulnerability.

The second phase of pragmatic inquiry (described in Chapters 5 and 6) involved empirical research carried out for the purpose of examining the mental capacity construct (as the current organizing idea in adult guardianship) and the theory of vulnerability described in Chapter 4 in

the field of practice i.e. as both ideas are understood and used by legal and medical actors involved in the implementation of adult guardianship. Chapter 5 describes the structure of the empirical research phase, which involved the collection of data through semi-structured interviews carried out with two sets of participants (members of interdisciplinary health teams and retired judges) and the research method of applied thematic analysis that was used to identify themes in the data. Chapter 6 sets out the themes identified in both data sets, including an integrated over-arching theme for each set.

The third phase of pragmatic inquiry set out in Chapter 7 (Judgment) synthesizes and analyses the findings from phases 1 and 2 and, on the basis of that analysis, answers the research questions posed in this Chapter. A preliminary vulnerability based guardianship model is set out in the latter part of Chapter 7 (responding to the research question, “what would a coherent/workable theory of vulnerability in this context look like?”) I conclude that, on the terms of pragmatic inquiry and the epistemology of philosophical pragmatism, vulnerability has the potential to provide a more successful organizing idea in the field of adult guardianship, filling the gaps in the supported decision-making paradigm while addressing the problems created by the mental capacity construct in the context of dementia in old age.

1.4 Conclusions: re-thinking adult guardianship as a response to vulnerability

The theory of vulnerability and vulnerability-based guardianship model developed through this research proceeds from an understanding of vulnerability as universal; there are many vulnerabilities, and we are all vulnerable in some respects. Adult guardianship provides one response to a particular kind of heightened vulnerability arising where problems in the performance of thinking processes intersects with a person’s relationship, social, and material contexts in a way that creates unreasonable risk.¹⁶ Vulnerability can be reduced through a recalibration of the self/context relationship, either by strengthening the self (through medical treatment or supported decision-making, for example) or by enabling/effecting changes to context (disrupting an exploitative relationship, for example, or providing housing/home supports). Tools enabling context change, including guardianship, are most likely to be useful

¹⁶ Describing a degree of vulnerability that is not acceptable as a matter of public policy, resonating with the public interest recognised by the common law of necessity and the doctrines of equitable fraud, as discussed in Chapter 4.

where recalibration of the relationship between context and self cannot be effected through treatment or other mechanisms for strengthening the self. The decision to appoint a guardian should therefore be made in connection with a consideration and weighing of those other tools (both legal and non-legal) and not in isolation. The authority guardianship confers to over-ride mere choices makes it particularly useful as a means of disrupting exploitative/abusive relationship context in a situation where self-strengthening tools (medical or social) are not applicable.

A purposeful approach to the assessment of vulnerability will therefore include evaluation of a person's performance of thinking processes (including cognitive testing/assessment and functional assessment) together with an evaluation of relevant contextual factors, and the interaction between context and self. The approach to assessment set out in Chapter 7 builds on the discussion of alternative mental capacity assessment models described at the conclusion of Chapter 4 (which I describe as *de facto* evaluations of vulnerability despite their framing in terms of capacity or decision-making ability) and the themes arising from the phase 2 empirical research carried out with judges and older adult mental health team members (described in Chapter 6).

The continuing, persuasive power of the mental capacity construct (as the basis of medico-legal guardianship), despite the conceptual difficulties described in Chapter 4, is largely due to its usefulness as a way of explaining guardianship in terms that are compatible with the pre-eminent legal principle of autonomy. Any new "organizing idea" or paradigm must also be rooted in, and justified by, legal principle. The new vulnerability-based guardianship paradigm and model constructed through this study is rooted in and justified by the fundamental legal principle of fairness, the public interest in humane development of the law underlying the common law doctrine of necessity, and the public interest in preventing exploitation enshrined in and exercised through the doctrines of equitable fraud.

Understanding guardianship as one of a number of legal responses whose purpose is the reduction of vulnerability (as opposed to the protection of vulnerable persons i.e. the *parens* paradigm) is also compatible with the idea of autonomy as relational, a characteristic that can be developed as well as diminished through relationship with others (as opposed to an innate characteristic of persons which is only diminished by the interference of others) and that waxes

and wanes, changing in character, over the life-course.¹⁷ The autonomy ideal associated with classic liberalism (and providing the theoretical basis for medico-legal guardianship) - the “self-sufficient, independent... self-reliant, [and] self-realizing individual who directs his efforts toward maximizing his personal gains”¹⁸ - is progressively losing validity as a theory of human nature that is not restricted to adult (non-old), non-disabled, unencumbered white males. The current challenges to medico-legal guardianship are, at root, a rejection of this idea of autonomy, which would exclude all persons who are not and cannot be self-reliant. Autonomy for persons standing outside of the liberal autonomy ideal must be conceptualised on different terms, as a way of being that that is dependent on and constructed through relationships, supports, and interventions of different kinds- including, where warranted under the circumstances, adult guardianship.

¹⁷ See, Nedelsky, Jennifer. *Law's Relations: A Relational Theory of Self, Autonomy and the Law* (Oxford, UK: Oxford University Press, 2011).

¹⁸ Lorraine Code, *What Can She Know? Feminist Theory and the Construction of Knowledge* (Ithaca: Cornell University Press, 1991) at 77. “His is 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.” *Ibid.*, at 77-78.

Chapter 2. Adult Guardianship and Dementia in Current and Historical Context: From the Law of the Manor to the *Convention on the Rights of Persons With Disabilities*

2.1 Introduction

The first part of this Chapter provides an over-view of current adult guardianship legislation in Canada. The second part of this Chapter provides an historical over-view of adult guardianship in Anglo-Canadian law, from the feudal manor to the *Convention on the Rights of Persons With Disabilities*. The third part of this Chapter provides an over-view of dementia, as both a physiological and socially constructed phenomenon, from antiquity to the present.

2.2 Adult guardianship: current Canadian law

A “guardian” is defined in the Oxford English Dictionary as “One who guards, protects, or preserves; a keeper, defender; one to whom the care and preservation of any thing is committed.”¹ A guardian “in Law” is further defined as “a person who has, or by law is entitled to, the custody of the person or property (or both) of an infant or other person legally incapable of managing his or her own affairs.”² This simple articulation sets out the basic mechanism of the modern law of adult guardianship, and its parameters: legal guardianship follows a finding of legal “incapability,” and a guardian can only be appointed for a person so found. The purpose and role of the guardian is to “manage” those matters that the person is incapable of managing him or herself. Modern adult guardianship legislation (incorporating the reform model discussed in this Chapter, *infra*) has replaced the language of management with the language of decision-making, re-casting the guardian as a decision-maker (substitute, assisting, or supporting, depending on an individual’s decision-making ability and the options available in a particular jurisdiction).

¹ *The Oxford English Dictionary*, 2015, *sub verbo* “guardian”.

² *Ibid.*

2.2.1 Adult guardianship legislation

Adult guardianship is currently provided for by legislation in all Canadian provinces.³ Despite differences between provincial statutes, Canadian guardianship legislation shares the following fundamental characteristics:

- A finding of present and projected⁴ legal incapability made by a public decision-maker (a court in the case of court appointed guardianship or a Health Authority designate in the case of statutory guardianship);⁵
- A requirement that medical evidence of incapability be provided, and accepted, by the public decision-maker;
- Appointment of a guardian by that public decision maker *after* incapability has been established (in the case of court appointed guardianship, the public decision-maker may accept or reject the guardian proposed, or choose between would-be guardians);
- Ongoing oversight with regard to the guardianship relationship by the court and the Public Guardian and Trustee (or analogous public body/officer).

Within this general framework, distinctions between provincial legislation are both substantive and organizational. Adult guardianship legislation may be provided for in a stand-alone statute or bundled together with legislation pertaining to “advance planning” instruments (such as powers

³ *Adult Guardianship and Trustee Act*, SA 2008, c A-4.2; *Adult Guardianship Act*, RSBC 1996, c 6; *Patients Property Act*, RSBC 1996 c 349; *The Adult Guardianship and Co-decision-making Act*, SS 2000, c A-5.3; *Vulnerable Persons Living With a Mental Disability Act*, CCSM c V90; *Substitute Decisions Act, 1992*, SO 1992, c 30; *Supported Decision Making and Adult Guardianship Act*, SPEI 1997, c 49; *Incompetent Persons Act*, RSNS 1989, c 218; being Schedule A of the *Decision Making, Support and Protection to Adults Act*, SY 2003, c 21; *Guardianship and Trusteeship Act*, SNWT (Nu) 1994, c 29; *Infirm Persons Act*, RSNB 1973, c I-8; *Mentally Disabled Persons' Estates Act*, RSNL 1990, c M-10.

⁴ “Projected” does not mean irreversible; all guardianship legislation provides for a person to be found no longer in need of a guardian. See *Patients Property Act*, *supra* note 3 (“[o]rder declaring patient no longer incapable”, s 4). The Yukon’s *Adult Protection and Decision Making Act*, *supra* note 3, at Schedule A of the *Decision Making, Support and Protection to Adults Act*, *supra* note 3, also provides for temporary guardianship with respect to financial decision-making.

⁵ Statutory guardianship refers to the legislative mechanism through which the Public Guardian and Trustee is appointed as guardian of finance (only) for a person who has been found to be incapable by a health authority designate. This procedure is described in more detail in this chapter and in Chapter 5.

of attorney or health directives) in a single piece of legislation.⁶ The language of “guardianship” may or may not be used; in British Columbia, for example, the *Patients’ Property Act* refers to court appointed guardians as “committees” and the person subject to guardianship as a “patient.”

Adult guardianship legislation in all Canadian jurisdictions provides for court appointed guardianship. Statutory guardianship (which provides for the Public Guardian and Trustee to be appointed as guardian of finances through an extra-judicial process) is provided for in Canada only in British Columbia and Ontario.⁷ The statutory guardianship process in each province is broadly similar, providing for appointment of the Public Guardian and Trustee as guardian of finances and property⁸ where a certificate of incapability or incapacity has been issued by a health authority designate. Ontario’s *Mental Health Act* provides that a certificate of incapacity may be issued only with respect to a patient of a psychiatric facility. Part 2.1 of the British Columbia *Adult Guardianship Act* provides that any person having reason to believe that an adult may be incapable of managing his or her financial affairs may notify the Public Guardian and Trustee (PGT); the PGT then arranges for a two-part (functional and medical) mental capacity assessment; and the Health Authority designate is empowered to issue a certificate of incapability following that assessment. A health care provider who has reason to believe that an adult may be incapable of managing his or her financial affairs may directly request an assessment (without first making a report to the PGT). The costs associated with administering the person’s finances and/or property are borne by the individual (the Public Guardian and Trustee reimburses itself from the account of the person for whom it acts as guardian).

At present, guardianship legislation in Canada includes both post-reform and traditional (pre-reform) legislative models. Despite distinctions between these models (discussed in more detail in the following section) the essential guardianship mechanism remains the same: the appointment of one person to make decisions and act on behalf on another with respect to her or his (broad or narrow) incapability or (where provided for in reform legislation) to assist the

⁶ See e.g. Ontario’s *Substitute Decisions Act*, *supra* note 3. See also Alberta’s *Adult Guardianship and Trusteeship Act*, *supra* note 3.

⁷ In Ontario, statutory guardianship (like court appointed guardianship) is dealt with in the *Substitute Decisions Act*, *supra* note 3; in British Columbia, statutory guardianship is dealt with in Part 2.1 of the *Adult Guardianship Act*, *supra* note 3.

⁸ The PGT may decline the appointment/request further assessment.

individual in making those decisions. The discussion below refers to/includes both traditional and post-reform guardianship legislation.

Adult guardianship legislation in all provinces provides for “substitute” decision-making, ie, for a guardian (whether appointed by a court or through statutory guardianship) to make certain kinds of decisions on behalf of a person found to be incapable in one or more decision-making domains. Post reform legislation incorporates the principle that the substitute decision maker must effect, in so far as possible, the decision that the individual herself *would have made* if capable of doing so.⁹ If that decision cannot be known or ascertained, the decision must be made in the best interests of the individual (a kind of default *would have made* decision, if we presume that individuals are most likely to make decisions in their own best interests).

Adult guardianship legislation in Alberta,¹⁰ Saskatchewan,¹¹ Manitoba¹² and the Yukon¹³ provides for assisted-decision-making (in which decisions are made by the individual together with an appointed co-decision maker) in addition to substitute decision-making; both Prince Edward Island¹⁴ and British Columbia¹⁵ have passed but not brought into force legislation providing for assisted decision-making.¹⁶ The Yukon’s *Adult Protection and Decision Making Act* does not allow courts to make assisted decision making orders, but does allow adults to enter into supported decision-making agreements (if the adult understands the nature and effect of such an agreement). Similarly, Alberta’s *Adult Guardianship and Trustee Act* (Division 2) provides for an adult to make a “supported decision-making authorisation” and gives him or her certain powers for this purpose. Division 3 provides for the court appointment of a co-decision-maker only regarding personal “matters” or decisions. Legislation in Saskatchewan (the *Adult*

⁹ See, *Adult Guardianship and Trustee Act*, *supra* note 3, s 2(d): “in determining whether a decision is in an adult’s best interests, consideration must be given to any wishes known to be expressed by the adult while the adult had capacity, and, any values and beliefs known to have been held by the adult while the adult had capacity”.

¹⁰ *Adult Guardianship and Trustee Act*, *ibid*.

¹¹ *The Adult Guardianship and Co-decision-making Act*, *supra* note 3.

¹² *Vulnerable Persons Living With a Mental Disability Act*, *supra* note 3.

¹³ *Adult Protection and Decision Making Act*, *supra* note 3.

¹⁴ *Supported Decision Making and Adult Guardianship Act*, *supra* note 3.

¹⁵ *Adult Guardianship Act*, *supra* note 3.

¹⁶ Part 2 of British Columbia’s *Adult Guardianship Act*, *supra* note 3, was intended to replace the *Patients Property Act*, *supra* note 3 (see discussion *infra*); Prince Edward Island’s *Supported Decision Making and Adult Guardianship Act*, *supra* note 3, has also yet to be proclaimed.

Guardianship and Co-decision-making Act) provides for the court to issue an assisted decision-making order in both property and personal matters. Ontario's *Substitute Decisions Act* does not provide for supported or assisted decision-making at this time.

2.2.2 Scope of guardianship authority

The scope of decision-making authority conferred on a guardian as substitute decision-maker may be very broad, or limited to certain categories of decisions (those categories are defined in the applicable legislation). The scope of decision-making authority is determined by the mental capacity finding preceding the guardian's appointment (the assessment of a person as capable of making "personal" decisions but not decisions about financial matters, for example).¹⁷ The availability of more limited forms of guardianship in terms of scope of authority, therefore, depend on the availability of finer or more precise assessments of decision-making capacity.

Both traditional and reform legislation provides for appointment of a plenary guardian who "stands in the shoes" of the person (with a few exceptions such as marriage and will-making).¹⁸ Traditional and reform legislation also provides for appointment of a guardian with respect to relatively capacious categories of decisions: decisions regarding finance and property, on the one hand, and "personal" decisions (including health care) on the other. Reform legislation also provides for guardians to be appointed with respect to more limited kinds of decisions. Ontario's *Substitute Decisions Act*, for example, provides that a guardian may be appointed where a person is incapable with respect to any or all of the following decisions relating to personal care: health care, nutrition, shelter, clothing, hygiene or safety.¹⁹ Alberta's *Adult Guardianship and Trustee Act* provides that a guardian shall be granted authority to act and make decisions only with

¹⁷ The kind and "degree" of capacity required turns on the complexity of the matter in question. See *Banks v Goodfellow* (1870), LR 5 QB 549 (Eng). This is why marriage has traditionally required a relatively low level of capacity, and the essence of marriage has been characterised in the simplest of terms. See *Banton v Banton* (1998), 164 DLR (4th) 176 (ONSC).

¹⁸ The *Patients Property Act*, *supra* note 3, s 15 provides that the committee [the language used to describe a guardian in the Act] "has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind" with regards to the domain/s (property, person or both) in which the person has been found incapable.

¹⁹ *Supra* note 3. A person is considered to be incapable of making a decision about these matters if she or he "is not able to understand information relevant to making a decision" concerning that matter, s 45; Section 55 provides that the court may appoint a guardian for a person who is incapable of personal care (as defined) above and in need of a person authorised to make decisions on her or his behalf.

respect to those personal matters considered necessary, including: the adult’s health care; where, with whom and under what conditions the adult is to live, either permanently or temporarily; with whom the adult may associate; the adult’s participation in social activities; the adult’s participation in any educational, vocational or other training; the adult’s employment; the carrying on of any legal proceeding that does not relate primarily to the financial matters of the adult; and any other personal matters as the Court considers necessary.²⁰

Within the scope of her authority, a guardian can both over-ride mere choices that are not true decisions (the mere choice to make a significant gift to a new friend, for example) and make or assist with choices/decisions where the individual cannot express or effect any choice for herself or needs help in doing so.²¹ These guardianship tasks are very different in nature, although the legislation does not distinguish between them but refers to both more generically in terms of decision-making. The tension with autonomy is more acute in relation to over-riding mere choice; supported and assisted decision-making is also more coherent in the second context (helping the person to formulate and express a decision) than the first (helping the person to reverse a mere choice). Over-riding mere choice is justified in traditional *parens* based guardianship on the basis of protection. The theoretical framework of medico-legal guardianship reform conceptualises substitute decision-making as a mechanism for implementing the “real” decision the individual would have made if capable of doing so thereby preserving the individual’s true, if no longer independently extant, autonomy. This explanation is of course less credible with regard to the person who has no past, capable self; the question of what the person in that situation would have done if capable is abstract only, leaving “best interests” as the default basis on which mere choice is over-ridable (one problem to which the supported decision-making paradigm, discussed *infra*, is a response).

²⁰ *Supra* note 3, s 33.

²¹ Substitute decision-making enables the substitute decision-maker to make a decision on behalf of another but does not preclude her from consulting to the fullest extent possible with the individual in making that decision; many adult guardianship statutes require the substitute decision maker to do so (including both the “reform” *Substitute Decisions Act*, *supra* note 3, and the “traditional” *Patients Property Act*, *supra* note 3).

2.3 From the law of the manor to supported decision-making and the *Convention on the Rights of Persons With Disabilities*: the history of guardianship in Anglo-Canadian law

2.3.1 Introduction

As described in the preceding section, adult guardianship legislation in Canada, whether pre or post-reform, conforms to the medico-legal guardianship model structured by the mental capacity construct described in Chapter 4. This model is of a piece with the culturally authoritative bio-medical paradigm and the explanation of human behaviour it provides. The medico-legal guardianship model is neither natural nor inevitable, however. Most recently, medico-legal guardianship has been challenged by the emergent supported decision-making paradigm (as discussed *infra*). As described below, guardianship has historically been responsive to both practical and ideational changes in the wider social context.

2.3.2 Lost in the mists of time: the emergence of adult guardianship in Anglo-Canadian law

“Adult guardianship” is a modern term, a product of the 20th century. The historical laws and legal mechanisms referred to in this section are functionally akin to (and so can be considered early forms of) guardianship; in this functional sense, some form of guardianship has been part of English law from the “mists of time”²² to the present day.

English laws relating to persons described as “lunatics” and “idiots” predate the common law. According to Prof. Doug Surtees (in his excellent account of the origins of adult guardianship), Henry II assumed control over the property of persons of “unsound mind” at some point towards the end of his reign in the 12th century.²³ Prior to this assertion of Kingly jurisdiction, the authority to take possession of the land of a tenant unable to perform his feudal duties belonged to the feudal Lords of the Manor.²⁴ The King’s assumption of the Lords’ authority has been explained as part of the general extension of centralised Crown jurisdiction during this period,²⁵

²² *E (Mrs) v Eve*, [1986] 2 SCR 388 at para 32 [*In Re Eve*].

²³ Doug Surtees, “How Goes the Battle? An Exploration of Guardianship Reform” (2012) 50:1 *Alta L Rev* 115. The Supreme Court of Canada, in *In Re Eve*, *ibid* at para 32, described the origins of the jurisdiction as “lost in the mists of antiquity” although the “most probable theory” was that Edward I had assumed the authority from the feudal lords in the 13th century.

²⁴ *In Re Eve*, *supra* note 22.

²⁵ Surtees, *supra* note 23.

and as a response to the “manifold abuses of this power” by the feudal Lords, “at last providing, by common consent, that it should be given to the King as the general conservator of his people, in order to preserve the idiot from wasting his estate, and reducing himself and his heirs to poverty and distress.”²⁶ Sir James Munby²⁷ and others (including the Supreme Court of Canada in *Re Eve*) have located the origins of the *parens patriae* jurisdiction with respect to mentally incapable adults in this transfer of authority to the King from the feudal Lords. According to the account given by the Supreme Court of Canada in *Re Eve*, the King’s jurisdiction over “mental incompetents” (inherited from the feudal Lords, then transferred to the Chancellor, and eventually to the superior courts) was eventually merged or “assimilated” with the court’s “wardship” jurisdiction regarding children. This “assimilated” *parens patriae* jurisdiction “continues to this day” so long as it has not been specifically supplanted by legislation.²⁸

The ancient jurisdiction originally distinguished between the Crown’s interest in the stewardship of property belonging to “idiots” or “fools” (individuals never having possessed the mental ability required to manage their property)²⁹ and “lunatics” or *non compos mentis* (those losing this ability as adults).³⁰ The distinction between the two, and the respective jurisdiction of the Crown with regard to each, was recorded in (if not created by) the *Statute De Prerogativa Regis*

²⁶ George Bowyer, *The English Constitution: A Popular Commentary on the Constitutional Law of England* (London: Levey, Robson and Franklin, 1841) at 277-278.

²⁷ Munby, J., “Protecting the Rights of the Vulnerable and Incapacitous Adults: The Role of the Courts- An Example of Judicial Lawmaking” (2014) *Child and Family Law Quarterly* 64 at 77. According to quotes in Sir Henry Theobald, *The Law Relating to Lunacy* (London: Stevens and Sons Ltd., 1924), cited in *In Re Eve, supra* note 22, *De Prerogativa Regis* (described by Theobald as an instrument regarded as a statute that dates from the thirteenth or early fourteenth century) recognized the jurisdiction but did not create it. Theobald speculates that “the most probable theory [of its origin] is that either by general assent or by some statute, now lost, the care of persons of unsound mind was by Edw. I taken from the feudal lords, who would naturally take possession of the land of a tenant unable to perform his feudal duties” at para 32.

²⁸ See *Beson v Director of Child Welfare (Nfld)*, [1982] 2 SCR 7166. See also *In Re Eve, supra* note 22 at para. 42 (“even where there is legislation in the area, the courts will continue to use the *parens patriae* jurisdiction to deal with un contemplated situations where it appears necessary to do so for the protection of those who fall within its ambit”).

²⁹ FNB 233; Co Litt 42; Fleta 1.6, c 42; Joseph Harrison, *The Practice of the High Court of Chancery*, vol 1 (Philadelphia: William P. Farrand, 1807) (“An idiot, or natural fool, is one that hath no understanding from his nativity, and therefore is by law presumed unlikely to attain any. A man is not an idiot if he hath any glimmering of reason, so that he can tell his parents, his age, or other common matters. But a man who is born deaf, dumb and blind is looked upon by the law as in the same state with an idiot; he being supposed incapable of any understanding, as wanting all those senses which furnish the human mind with ideas.” at 490).

³⁰ Harrison, *supra* note 29 at 491: “A lunatic, or *non compos mentis*, is one who hath had understanding, but by reason of disease, grief, or other accident, hath lost the use of his reason. A lunatic is indeed properly one who hath lucid intervals, sometimes employing his senses, and sometimes not, and that frequently depending on the change of the moon. But under the general name of *non compos mentis*... are comprised not only lunatics, but persons under frenzies, or who lose their intellects by disease; those that grow deaf, dumb and blind, not being *born* so; or such, in short, as are judged by the court or chancery incapable of conducting their own affairs.”

in the late thirteenth century.³¹ *Non compos mentis* individuals were treated by the law as if they could regain mental capacity in the future (whether or not they currently enjoyed “lucid” moments) and, accordingly, the Crown was required to manage the property of such a person on that person’s behalf, taking no profits. Having “once lived his life on an equal footing with others... there was always that glimmer of hope that he would do so again”,³² and should a lunatic regain lucidity (either permanently or episodically) his property and profits would be returned. The property of fools, on the other hand, who would never regain capabilities they had never enjoyed, was managed on behalf of the Crown; the profits from their estates became the King's property, subject only to the King's duties to provide the incapable individual with the necessities of life, not commit waste or destruction, and to pass the estate to any heirs upon death.

The Crown’s authority with regards to ether “idiots” or “lunatics” could be granted to private individuals (as proto-guardian figures) but the implications attendant on doing so were very different in each case. Before 1540 (and the establishment of the Court of Wards and Liveries) a private person had to purchase custody of an “idiot” by paying a fine together with “rent” (both payable to the Crown) with respect to her or his property. A person purchasing guardianship status in this way was obliged to protect the individual, to provide him or her (but not the individual’s family) with the necessities of life, and to protect and maintain the individual’s estate. In return, the guardian was able to retain any profits over and above the rent owed to the Crown, and expenditures required to provide for the individual. In the case of persons found to be “lunatics” or *non compos mentis*, in contrast, a private person could obtain a grant of custody and access without paying a fine. The guardian of a person adjudged to be *non compus mentis* was required to maintain the individual *and* his family at his or her social rank, and to preserve and protect the person’s estate. Unlike the guardian of a person adjudged to be an idiot, the guardian of a lunatic was not entitled to keep any surplus revenues (as all property was to be managed for the benefit of the lunatic). Identification of an individual as belonging to either category was carried out by a jury of twelve men, on the Chancellor’s issuance of a writ.

³¹ Surtees, *supra* note 23.

³² Louise Harmon, “Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment” (1990) 100:1 Yale LJ 1 at 16.

The very different practical consequences of a “finding” of idiocy as opposed to lunacy seems to have led to an early blurring of the distinction between these two categories, despite the sharp distinction drawn between them in the *Statute De Prerogativa Regis*. Historian Richard Neugebauer has shown that, although a writ for finding a person to be *non compos mentis* was established at least by the 13th century,³³ the *writ de idiota inquirendo* (the writ issued for the purpose of establishing idiocy) was by far the more common proceeding. Neugebauer suggests that this apparent contradiction between law “on the books” and law “in practice” could be explained by the relative profitability (from the Crown’s perspective) of a “finding” of idiocy.

Significant changes to this scheme took place with the establishment of the Court of Wards and Liveries in 1540. Fines for purchasing the custody of persons referred to as idiots were abolished; rents, in relation to their property, also disappeared around this time,³⁴ and the property of idiots or fools came to be managed according to the same standards as the property of lunatics.³⁵ The wheel, in other words, had turned; idiots were increasingly dealt with in the same way as lunatics,³⁶ creating a more generic category of lunacy in which the old distinctions were increasingly blurred. Guardians for both classes of persons were now required to maintain individuals and their families according to their social status (as opposed to mere necessities), in addition to protecting and preserving the person’s estate. Guardians of idiots (those who had been given a “grant of idiocy” by the Crown) were no longer entitled to keep surplus property revenues but were required to account for revenues and expenditures to the Court.³⁷ Professor Surtees, in his account, directs the reader to Blackstone’s comment regarding this shift, that “the

³³ Richard Neugebauer, “Mental Handicap in Medieval and Early Modern England” in David Wright & Anne Digby, eds, *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (Abingdon: Routledge, 1996) 22 at 32; See also Sir Anthony Fitzherbert, *Nouvelle Natural Brevium* (London: Richard Tottell, 1553).

³⁴ Neugebauer, *ibid* at 33.

³⁵ Surtees, *supra* note 23 (referring to Blackstone’s comment that “the clemency of the crown and pity of juries gradually assimilated the condition of idiots to that of lunatics” at 117); See also Sarah Burningham, “Developments in Canadian Adult Guardianship and Co-Decision-Making Law” (2009) 18:1 Dal J Leg Stud 119.

³⁶ Neugebauer, *supra* note 33 at 35. Prior to 1540 80% of all grants were “idiocy grants”; between 1540-1560 this number dropped to 60%, and during the reign of Elizabeth I to 50%; by 1640 it was no more than 30%.

³⁷ Neugebauer, *supra* note 33 at 40.

clemency of the crown and pity of juries gradually assimilated the condition of idiots to that of lunatics”³⁸.

After the abolishment of the Court of Wards and Liveries in 1660, the Crown assumed responsibility for the personal care and well-being of both lunatics and fools in addition to property stewardship (a jurisdiction eventually assumed by the Chancery)³⁹ although personal responsibilities were most often in fact carried out by families. *The Practice of the High Court of Chancery Vol. 1* (published in 1808)⁴⁰ described the method of proving a person to be a lunatic as “very similar to that of proving him an idiot”;⁴¹ issuance by the chancellor of a writ “in the nature of” the *writ de idiota inquirendo* to inquire into the individual’s mind, determination by jury of *non compos mentis*, and commitment of the care of the person (together with an allowance for his or her maintenance) to a “friend” known as a committee.⁴² To avoid what were referred to as “sinister practices” the “next heir is seldom permitted to be the committee of his person; because it is in his interest that the party shall die. But... there lies not the same objection against his next of kin, provided he be not his heir; for it is in his interest to preserve the lunatic’s life, in order to increase the personal estate by savings, which he or his family may hereafter be entitled to enjoy.”⁴³

2.3.3 Private guardianship and the emergence of substitute decision-making

The idea of substitute decision making, introduced into guardianship in the 19th century in the case of *Ex parte Whitbread*,⁴⁴ was a radical conceptual innovation. The idea of the guardian as “substitute decision maker” (rather than manager) introduced the abstract, and (perhaps co-incidentally) the *ideological*, into what had been understood as a practical response to a practical problem.

³⁸ Surtees, *supra* note 23 at 117; See also Burningham, *supra* note 35.

³⁹ Surtees, *supra* note 23 at 117; See also Burningham, *supra* note 35.

⁴⁰ Harrison, *supra* note 29 at 491, in which it is stated that it “seldom happens that a jury find a man an idiot... but only *non compos mentis*”.

⁴¹ The Court of Wards and Liveries was abolished in 1646 (during the Commonwealth) and following the restoration the Crown’s *parens patriae* power with relation to persons of “unsound mind” (including the proto-guardianship mechanism discussed here) was assigned to the Lord Chancellor.

⁴² Harrison, *supra* note 29 at 491.

⁴³ *Ibid* at 492.

⁴⁴ [1816] 35 Eng Rep 878 (Ch) [*Ex Parte Whitebread*].

Louise Harmon has identified substitute decision making as a legal fiction adopted mid-way through the 19th century for the purpose of effecting something that could not otherwise be done: enabling the distribution of income or property from a lunatic's estate to his or her family members *during* that person's life. Such a distribution would not have been permissible under the original mandate to preserve the lunatic's estate in his or her interests.⁴⁵ Harmon describes how the doctrine of "substituted judgment" was adopted through the effective exercise of equitable jurisdiction over the affairs of lunatics (as gradually asserted through the exercise of the Chancellor's powers of administration) in the mid-19th century, beginning with the "seminal" decision of Lord Eldon in *Ex parte Whitbread*.⁴⁶ Lord Eldon's "crafting" of the legal fiction of substitute decision making in this case allowed him to resolve the conflict between his evident desire to allow the petition brought before him,⁴⁷ the core liberal legal principle of private property (setting the boundary between state power and individual freedom), and the court's mandate (descended from the King's obligation) to preserve the lunatic's estate in his or her interests.⁴⁸ Without recourse to the fiction of substitute judgment, these principles would have prevented Lord Eldon from accessing the private property of one person for the benefit of another. In articulating the fiction, Lord Eldon "reiterate[ed] the principle of tenderness to the lunatic" ("the Court, in making the allowance, has nothing to consider but the situation of the Lunatic himself, always looking to the probability of his recovery, and never regarding the interest of the next of kin"); the very exercise of that "tenderness," in a case of this kind, required the court to adopt an internal and subjective point of view to "discover what the lunatic himself probably would have done" and carry out those "probable desires."⁴⁹ In this case, those "desires" were found to support granting an allowance to the petitioner. The closeness of family relation

⁴⁵ Harmon, *supra* note 32.

⁴⁶ *Ex Parte Whitbread*, *supra* note 44, cited in Harmon, *ibid* at 19.

⁴⁷ Harmon, *supra* note 32 at 22. "By all appearances, Mr. Hinde [the "lunatic" in the case] was being well cared for, and the allowance was to go to a prospective legatee. And perhaps the niece was a sympathetic petitioner. She may have been destitute, too ill to work, or the mother of hungry children. We do not know the circumstances of her need. All we really know, and this only by inference, is that Lord Eldon was inclined to grant her petition."

⁴⁸ *Ibid* ("the Court... has nothing to consider but the situation of the Lunatic himself, always looking to the probability of his recovery, and never regarding the interest of next of kin" at 22), citing Lord Eldon's judgment in *Ex Parte Whitbread*, *supra* note 44. The jurisdiction of the Courts, descended from the King's delegation of his personal responsibility to the Lord Chancellor, developed into something like an equitable jurisdiction "by virtue of [the Chancellor's] general power, as holding the great seal, and keeper of the Kings conscience." See *ibid* at 19, referring to Joseph Story, *Commentaries on Equity Jurisprudence: As Administered in England and America*, 12th ed (Boston: Little, Brown & Company, 1877) at 608. See also Surtees, *supra* note 23.

⁴⁹ Harmon, *supra* note 32 at 22.

(the petitioner was a niece), together with “evidence of the lunatic’s former intentional states” were crucial in determining his “probable desires” in this case.⁵⁰

The focus of Harmon’s critical analysis is the process through which Lord Eldon’s fiction jumped categories, moving from the context in which it was developed (distribution of the property of a wealthy lunatic to a relative in need) to a very different (and conceptually inappropriate) context: health-related choices for persons who had always been considered to have extremely limited mental abilities (the historical category of idiots). In this latter context, “evidence of former intentional states” would be non-existent; it was highly strained to construct the choice to remove a person’s kidney to implant in another, for example, or cease life-saving treatment, as in that person’s best interests because it was the decision that he or she would really have made if capable of doing so.⁵¹ This importation of substitute decision-making may be understood in the broader context of the disappearance of developmental/intellectual disability⁵² within a broader more abstract category of “lunacy” (erasing meaningful differences). The significance of that distinction in terms of embodied experience (life as lived) has re-emerged in the supported decision-making critique of substitute decision-making.

2.4 Emergence of the modern law: from the *Imperial Lunacy Act* to the *Patients Property Act*

Prior to the 19th century, the early forms of guardianship described above were primarily focused on stewardship, or management of the individual’s property. The prevention of impoverishment incidentally protected the individual’s person by ensuring that resources were available to provide for his or her needs. Responsibility for the protection of both property and person, and the authority necessary to effect that responsibility, belonged to the Crown. Private guardianship- the grant of authority/responsibility for an incapable person- was a delegation, to a private individual, of that public function. This essentially public nature is retained in the modern structures of guardianship, in which a finding of incapability by a court or public body (in the case of statutory guardianship) is followed by the appointment of a private individual or public officer to carry out the guardianship task, subject to ongoing public over-sight.

⁵⁰ *Ibid* at 25.

⁵¹ *Ibid* 31-71.

⁵² The old category of fools.

The origins of modern adult guardianship legislation can be traced to the *Imperial Lunacy Act* of 1890,⁵³ following the *Lunacy Act* of 1845.⁵⁴ The primary focus of both statutes was the administration of asylums and private hospitals for “lunatics” (an inclusive category in which the old categories of idiots and lunatics were merged), including procedures relating to admission and treatment. The *Imperial Lunacy Act* provided that “lunacy” could be established through medical affidavits, as an alternative to a full judicial inquiry,⁵⁵ defining a lunatic as “any person idiot, lunatic or of unsound mind and incapable of managing him-self and his affairs, and whether found lunatic by inquisition or not” (formally merging the categories of lunatic and idiot).⁵⁶ The provisions relating to guardianship set out procedures for appointing an agent to manage the property of a lunatic, and gave courts the power to appoint a relation or friend to “take charge” of the lunatic and to make orders for the commitment of his or her estate⁵⁷. The *Imperial Lunacy Act* also provided for a “Master-in-Lunacy,” setting out his powers and obligations, including the “general care, protection and management of the estate of all lunatics” and supervision and enforcement of “the performance of all duties and obligations of committees [guardians] of lunatics.”⁵⁸

Legislation effectively hiving off those portions of the *Imperial Lunacy Act* relating to guardianship (with the larger part of the Act becoming the basis for modern mental health legislation) created a new legal category in the early part of the 20th century: adult guardianship. The language of “lunacy” was replaced with “incapability” and “mental infirmity” in the early 20th century, a shift that Israel Doron has associated with the “development of medicine, biology, a more “scientific” legal culture, and, especially, the emergence of modern psychiatry.”⁵⁹ The addition of *age*, as an enumerated, specific source of “mental infirmity.” was another 20 century development. Adult guardianship legislation remained primarily concerned with the

⁵³ 53 Vict, c 5.

⁵⁴ 8&9 Vict, c 100.

⁵⁵ Robert M Gordon & Simon Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) at 1-17, 1-18. See also, Canadian Centre for Elder Law Studies, (2006) *A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario*, CCLES Report No. 4 (Vancouver: Canadian Center for Elder Law Studies, October 2006).

⁵⁶ *Imperial Lunacy Act*, *supra* note 53, s 3.

⁵⁷ Burningham, *supra* note 35.

⁵⁸ *Imperial Lunacy Act*, *supra* note 53, Part V (“Administration and Management of the Estate of Lunatic Patients and Lunatics”). The “Master-in-Lunacy” is the ancestor of the modern office of the Public Guardian and Trustee.

⁵⁹ “Thus, lunacy was replaced by incompetence.” See Israel Doron, “From Lunacy to Incapacity and Beyond: Guardianship of the Elderly and the Ontario Experience in Defining ‘Legal Incompetence’” (1999) 19:4 Health L Can 95 at 101.

management of an incapable person's property and estate, on the assumption that the majority of mentally infirm persons would be institutionalised (thereby providing for the personal needs of such persons). Guardianship of "the person" was provided for, but given little descriptive content. Once appointed, a guardian assumed the power to stand in the person's shoes with regards to his or her property, person, or both (a "plenary" guardianship order). Statutory guardianship" also developed during this period.

Adult guardianship law in Canada generally did not depart in any significant way from the traditional *Imperial Lunacy Act* model until the "wave" of adult guardianship reforms beginning in the late 1970s, and legislation in several Canadian jurisdictions retains many aspects of the traditional model.⁶⁰ British Columbia's *Patients Property Act*, for example, provides for a "committee" (guardian) to be appointed by a court for a "patient" (a person who is "by reason of mental infirmity arising from disease, age or otherwise is incapable of managing his or her affairs" or "his or her self").⁶¹ The committee of a person incapable of managing his or her "affairs" is empowered to exercise "all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and sound and disposing mind";⁶² where the person is incapable of managing him or her "self" the committee "has the custody of the person of the patient." Establishing the patient's mental infirmity requires affidavits from two medical practitioners setting out their opinion that the individual is incapable of managing his or her affairs and/or person because of mental infirmity arising from disease, age or otherwise or disorder or disability of the mind arising from the use of drugs. The legislation provides no further guidance regarding the meaning of incapability, the manner of its assessment, or the exercise of guardianship authority. Until 2014 (s discussed *infra*), the *Patients Property Act* also provided for statutory guardianship (requiring only issuance by a health authority designate of a certificate of incapability).

⁶⁰ *Patients Property Act*, *supra* note 3. Canadian jurisdictions retaining traditional guardianship legislation also include New Brunswick (*Infirm Persons Act*, *supra* note 3), Nova Scotia (*Incompetent Persons Act*, *supra* note 4), and Newfoundland (*Mentally Disabled Persons' Estates Act*, *supra* note 3).

⁶¹ Prior to reform of the statutory guardianship process (now dealt with in Part 2.1 of the *Adult Guardianship Act*, *supra* note 3) the *Patients Property Act*, *supra* note 3, also provided for statutory guardianship.

⁶² Although the guardian would be ultimately accountable to the court, and required to keep accounts of expenditures.

The guardianship reform movement discussed in the following section emerged in part as a critique of traditional guardianship legislation like the *Patients Property Act*.⁶³ Guardianship reform led to legislative change in several Canadian provinces; the first of the “new” guardianship statutes was Alberta’s *Dependent Adults Act*, passed in 1978. In British Columbia, a reform statute passed in 1993 (Part 2 of the *Adult Guardianship Act*)⁶⁴ was intended to replace the *Patients Property Act*; that statute remains un-proclaimed⁶⁵ although guidelines issued by the Public Guardian and Trustee provide for application of the *Patients Property Act* in a way that is consistent with the modern model. These developments are discussed in more detail in the following section.

2.5 Mental capacity, decision-making, and the reform movement in adult guardianship

The adult guardianship reform movement arising in the mid-1970s was a response to the perceived paternalism of the traditional model described above. From that time to the present, some form of legislative reform involving guardianship or other aspects of substitute decision making has taken place in all Canadian jurisdictions. Variation exists between provincial jurisdictions (as discussed in Part 2.2.1 of this Chapter) but the general characteristics of adult guardianship reform can be summarised as follows:

- An emphasis on procedural fairness, rights protection and self-determination;
- Modernization of advance planning documents (e.g. powers of attorney; representation agreements);
- New and refined assessment procedures;
- Statutory articulation of duties for guardians;
- Statutory schemes for responding to allegations of abuse, neglect and self-neglect of vulnerable and/or incapable adults;
- Statutory schemes relating to health care consent (including codification of common law rules);

⁶³ Statutory guardianship, as a form of guardianship without court involvement, also came under criticism during this period, although its practical usefulness ensured its survival.

⁶⁴ *Supra* note 3.

⁶⁵ Part 3 of the *Adult Guardianship Act*, *supra* note 3 (proclaimed) sets out an adult protection scheme (implemented by the Community Living and Health Authorities in the province as designated authorities).

- Modernization of the legal structure for a Public Guardian and Trustee or analogous office/body.⁶⁶

The language of mental infirmity was criticised for creating a system in which guardians were appointed on the basis of status: the person who was found to be mentally infirm (because of a developmental disability or diagnosis of dementia, for example) would, on that basis, be considered incapable of “managing” her-self and/or her property and have a guardian appointed to do so on her behalf.⁶⁷ Guardianship reform replaced the diagnosis of mental infirmity (as the basis for a finding of legal incapacity) with a more circumscribed assessment of “decision-making ability” or mental capacity, focusing on the person’s cognitive ability to carry out specific decision-making functions. It was anticipated that this narrower focus would limit the scope of guardian authority in many (perhaps most) cases. Plenary guardianship (with the guardian standing in the shoes of the adult) would become less common as more limited forms of substitute decision-making became available.⁶⁸ Within this more precise scope of substitute decision-making authority, a guardian would make the decisions the individual would have made if capable of doing so: a substitute, rather than a replacement, decision-maker. Outside of this limited scope of decision-making authority the individual would retain her or his ability to exercise full independent autonomy without interference.⁶⁹

These reforms to adult guardianship, beginning in the 1970s, sought to re-think and re-structure guardianship as a “mechanism for promoting autonomy.”⁷⁰ The adult guardianship reform

⁶⁶ Chalke, Jay (2005) *Canadian Trends: Guardianship in British Columbia and Other Provinces (A Report Prepared for the Law Reform Commission Annual Conference, Dublin, Ireland, December 2, 2005)* at 10.

⁶⁷ For example, that an individual diagnosed/identified with an infirmity would be, for that reason, subject to guardianship. See Sarita Verma & Michel Silberfeld, “Approaches to Capacity and Competency: The Canadian View” (1997) 20:1 *Intl J L & Psychiatry* 35.

⁶⁸ “Limited” personal guardianship is provided for in Manitoba, Ontario, Saskatchewan, Prince Edward Island, the Yukon and the Northwest Territories. Limited personal guardianship of this kind is also provided for in British Columbia’s (still un-proclaimed) *Adult Guardianship Act*, *supra* note 3, Part 2 (Part 2.1 of the *Adult Guardianship Act* applying to statutory guardianship, discussed below, came into force in December of 2014). The “old” (but still in force) guardianship legislation in British Columbia (the *Patients Property Act*, *supra* note 3) does not provide for limited personal guardianship.

⁶⁹ A partial or limited guardian is granted specific and limited powers and authorities by the court and those powers not granted to the guardian remain with the adult. *Adult Guardianship and Trusteeship Act*, *supra* note 3; *Vulnerable Persons Living with a Mental Disability Act*, SM. 1993, c. 29; *Substitute Decisions Act*, *supra* note 3; *Adult Protection Act*, RSPEI 1988, c A-5; *Adult Protection and Decision Making Act*, *supra* note 3; *Guardianship and Trusteeship Act*, *supra* note 3; *Adult Guardianship and Co-decision-making Act*, *supra* note 3.

⁷⁰ Burningham, *supra* note 35, at 120.

movement was coterminous and consistent with the ascendancy of autonomy as both a medical and a legal value⁷¹ (enshrined in the *Canadian Charter of Rights and Freedoms*),⁷² the extension of civil rights to hitherto excluded groups, and the de-stigmatization of difference.⁷³ Sarah Burningham has identified “the principle of normalization as particularly important in the development of partial guardianship as plenary guardianship was recognized as being at odds with the goal of integrating people into the community.”⁷⁴ Writing in Canada, Robert Gordon, Simon Verdun-Jones and Donald MacDougall described adult guardianship reform in the 1980s as “propelled” by “four main factors: the projected impact of the population aging process; a decline in the use of public institutions for the care of those suffering from mental disabilities; a rising concern in relation to abuse and neglect of the elderly; and, the advent of the *Canadian Charter of Rights and Freedoms*”⁷⁵, “stimulated” by “an emerging body of criticism aimed at the existing legal framework.”⁷⁶ Erica Wood has traced the impetus for adult guardianship reform in the United States to civil rights based challenges to institutional commitment procedures, which inspired the early guardianship reform “pioneers” “to take a hard look at the antiquated state guardianship laws that had developed over the last century.”⁷⁷ A series of high-profile newspaper articles in the United States in the 1980s (*Guardians of the Elderly: An Ailing System*)⁷⁸ concluded that the “nation’s guardianship system, a crucial last line of protection for

⁷¹ Paul Root Wolpe, “The Triumph of Autonomy in American Bioethics: A Sociological View” in Raymond DeVries & Janardan Subedi, eds, *Bioethics and Society: Sociological Investigations of the Enterprise of Bioethics* (Englewood Cliff: Prentice Hall, 1998) 38; David J Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991). “By the 1994 edition of *Principles* [of Bioethics], Beauchamp and Childress had acknowledged that ‘autonomy rights have become so influential that it is today difficult to find affirmations of traditional models of medical beneficence.’... Within a remarkably short time, autonomy had ‘won the day’ and respect for patient autonomy became the central focus in all medical interventions. This occurred especially quickly in the United States, where autonomy and freedom from external control had long been regarded as fundamental ‘American values’. The shift in ethical focus spread to other countries and, by the end of the twentieth century autonomy, had become the dominant value for healthcare ethics in most Western jurisdictions.” Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge: Cambridge University Press, 2010) at 15 at 15)

⁷² See Robert Gordon et al, “Reforms in the Field of Adult Guardianship Law: A Comment on Recent Developments” (1987) 6:1 Can J Fam L 149 at 149.

⁷³ In many respects the rise of the modern “non-interventionist” model of adult guardianship is of a piece with the coterminous “non-interventionist” reform movement in child protection. Cf. Margaret Isabel Hall, “A Ministry for Children: Abandoning the Interventionist Debate in British Columbia” (1998) 12:2 Intl JL Pol’y & Fam 121.

⁷⁴ Burningham, *supra* note 35 at 142.

⁷⁵ Gordon et al, *supra* note 72.

⁷⁶ *Ibid* at 151.

⁷⁷ Erica F Wood, “History of Guardianship” in Mary Joy Quinn, ed, *Guardianships of Adults: Achieving Justice, Autonomy and Safety* (New York: Springer Publishing, 2005) 17 at 20.

⁷⁸ Fred Bayles & Scott McCartney, *Guardians of the Elderly: An Ailing System*, The Associated Press, September 20-24, 1987.

the ailing elderly, is failing many of those it is designed to protect” citing a number of horror stories in which sweeping powers over the property of the elderly were granted (and then exploited) without due process and on the basis of casual “allegations” of dementia. The 1988 “Wingspread” National Guardianship Symposium held in Wisconsin in 1988, acknowledged as a seminal point in the guardianship reform movement, was organized in reaction to the *Guardians of the Elderly* “revelations.”⁷⁹

Responding to these concerns (both practical and principled), the new reform model reframed the purpose of guardianship as the protection of the (“constantly at risk”) autonomy of disabled and older persons, by providing “legal protection against the unwanted paternalism of over-zealous health care and human-service professionals, who often sought to intrude as co-conspirators with self-interested family members”.⁸⁰ In this way, guardianship would become a mechanism for protecting rather than removing autonomy (the critique levelled at the traditional model).⁸¹ The scope of guardianship authority would flow from the domain-specific scope of the individual’s impaired decision-making ability, defined as the cognitive ability to understand the nature of a particular decision (including information relevant to that decision) and its reasonably foreseeable consequences. This definition (adopted by Weisstub’s *Enquiry on Mental Capacity* carried out in 1990⁸² and subsequently adopted by provinces carrying out guardianship reform)⁸³ parallels the decision-specific approach to mental capacity areas of the law other than guardianship (as discussed in Chapter 4). The objective scientific assessment of cognitive decision-making capacity, by purporting to remove value-based judgment from the assessment of

⁷⁹ For an account of the history of the American guardianship reform movement see Marshall B Knapp “Reforming Guardianship Reform: Reflections on Disagreements, Deficits, and Responsibilities” (2002) 31:3 *Stetson L Rev* 1047; Jennifer L Wright “Guardianship for Your own Good: Improving the Well-being of Respondents and Wards in the USA” (2010) 33:5-6 *Intl J L & Psychiatry* 350 at 352-353; Wood, *supra* note 77 at 17.

⁸⁰ Knapp, *ibid.* at 1051; Burningham, *supra* note 35 (“[g]uardianship was originally developed as a social and legal tool meant to protect vulnerable persons. It is now evolving as a mechanism to promote autonomy” at 119)

⁸¹ Terry Carney, *Guardianship, Citizenship, & Theorizing Substitute-decisionmaking Law* (Legal Studies Research Paper Series, University of Sydney Law School, 2012) [Sydney Law School Research Paper No 12/25] (the development of private “advance planning mechanisms” during this same period was similarly positioned as “protect[ing] the rights of self-determination of aged people to manage their lives in accordance with their own wishes and values.” at 5) [Carney, *Guardianship, Citizenship, & Theorizing Substitute-decisionmaking Law*]. See also, Christy Holmes, “Surrogate Decisionmaking in the 90s: Learning to Respect Our Elders” (1996-1997) 28 *U. Tol. L. Rev.* 605

⁸² D. N. Weisstub (Chair). *Enquiry on Mental Competency: Final Report*. (Toronto: Queen’s Printer, 1990).

⁸³ Verma & Silberfeld, *supra* note 67.

decision-making capacity, was key to this re-imagining; requiring, in turn, the development of more precise and value neutral assessment tools (a process described by Kapp and Mossman as the “search for the perfect capacimeter”).⁸⁴

Assisted/supported decision-making also emerged during this period as an alternative to substitute decision making on a guardianship continuum or spectrum.⁸⁵ Assisted/ supported decision-making was intended to provide an alternative to substitute decision making of any form (whether limited or plenary) where the individual was capable of making her or his own decisions with the assistance of another person, a determination made through the decision-specific assessment of mental capacity. These alternative forms of guardianship would be even less intrusive and more supportive of autonomy than limited or circumscribed substitute decision-making, preserving the legal personhood of the individual and avoiding the stigmatising label of incompetence or incapability. A guardianship continuum including this range of alternatives would more realistically reflect the variety of decision-making abilities among individuals, as opposed to the “one size fits all” over-breadth of plenary guardianship. Canadian guardianship legislation incorporating this continuum approach (including both assisted/supported decision-making and substitute decision-making) is discussed in this Chapter under the heading “2.2.1 Adult guardianship legislation”.

Alberta was the first Canadian province to pass guardianship legislation incorporating key tenets of the reform model discussed above.⁸⁶ The new legislation introduced a “functional” determination of capability (identifying a person’s ability to carry out the cognitive “functions” of decision-making), as opposed to the identification of more generalised mental incompetence, as the basis for appointment of a guardian.⁸⁷ The legislation also incorporated the principle of

⁸⁴ Marshall B Knapp & Douglas Mossman, “Measuring Decisional Capacity: Cautions on the Construction of a ‘Capacimeter’” (1996) 2:1 Psychol Pub Pol’y & L 73. (“[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” at 79).

⁸⁵ Robert Gordon, “The Emergence of Assisted (Supported) Decision-Making in the Canadian Law of Adult Guardianship and Substitute Decision-Making” (2000) 23:1 Intl J L & Psychiatry 61 at 62. See also, Tim Stainton, “Supported Decision-Making in Canada: Principles, Policy and Practice” (2015) 3(1) Research and Practice in Intellectual and Developmental Disabilities 1.

⁸⁶ *Dependent Adults Act*, S.A. 1976, c. 63, s. 6(1).

⁸⁷ Gordon et al, *supra* note 72, at 152.

“limited, tailor-made guardianship”⁸⁸ corresponding to area-specific decision-making abilities, although plenary guardianship remained available in circumstances where the court was “satisfied that a partial guardianship order would be insufficient to meet the needs of the person.”⁸⁹ The Act also required that the individual be served with a copy of the guardianship application, a significant procedural reform, and created the office of the Public Guardian and Trustee (providing a guardian-of last-resort for the individual with no friends or family members able and/or willing to take on the role).

In British Columbia, a comprehensive reform initiative in adult guardianship and related areas was undertaken in the 1990s, with partial success. A number of individuals, community groups and service groups⁹⁰ joined together in 1989 to form a coalition (The Project to Review Adult Guardianship) to engage in research, develop proposals, and advocate for reform.⁹¹ A parallel inter-ministry government working group was also established during this period; in 1990, community and government came together to form a Joint Working Committee on Adult Guardianship. In the spring of 1992, the Joint Committee released a discussion paper (*How Can We Help*) based on extensive public discussion and the work of various working groups focusing on specific issues (including a small joint working committee). Further consultation was held around the province and in the fall of 1992 a second version of *How Can We Help* was published. The Report contained recommendations for legislation, which were submitted to and accepted by government.

On the basis of those recommendations, a suite of four statutes⁹² (referred to collectively as adult guardianship legislation) was passed in 1993. The four statutes came into force in 2000 although not all parts of the legislation were proclaimed. Part Two of the *Adult Guardianship*

⁸⁸ *Ibid.*

⁸⁹ s. 6(3).

⁹⁰ Including the BC Association for Community Living and the Alzheimer’s Society of BC.

⁹¹ This account is drawn from A.J. McClean *Review of Representation Agreements and Powers of Attorney Undertaken for the Attorney General of the Province of British Columbia* (Victoria, BC: Ministry of Attorney General (BC), Policy, Planning and Legislation Branch, 2002) at 4. No bibliographic information pertaining to the *How Can We Help* document is provided in the Report, and the author was unable to find the document itself. See also, Canadian Centre for Elder Law Studies *A Comparative Analysis of Adult Guardianship Laws in British Columbia, New Zealand and Ontario*, *supra* note 55 at 3-11.

⁹² *Adult Guardianship Act*, S.B.C. 1993, c. 35, see now R.S.B.C. 1996, c.6; *Health Care (Consent) and Care Facility (Admission) Act*, S.B.C. 1993, c. 48, see now R.S.B.C. 1996, c.181; *Public Guardian and Trustee Act*, S.B.C. 1993, c. 64, see now R.S.B.C. 1996, c.383.

Act, intended to replace the *Patients Property Act* with respect to both statutory and court-appointed guardianship, has never been brought into force.⁹³ That legislation contained the following elements:

- the elimination of statutory property committees so that guardianships could only be created through court appointment
- three levels of decision-makers depending on the nature and degree of the adult's need for a substitute
- court appointment only where informal solutions do not address the needs of the adult
- monitors to oversee the conduct of individual guardians
- court reviews of guardianships including committees appointed prior to the *Adult Guardianship Act* coming into force.

The Office of the Public Guardian and Trustee has identified the following specific concerns with the 1993 law as reasons for the government's decision not to bring it into force:⁹⁴

- the cost of eliminating statutory committees particularly in relation to individuals of modest financial means
- the cost of having three levels of court appointed substitute decision-maker, particularly in relation to adults with degenerative conditions who might require multiple court appearances
- the cost and complexities of the evidence needed to determine the level of authority needed
- the workability of the monitor provisions
- the cost and intrusiveness of the ongoing court reviews including mandatory capability reassessments and detailed document service requirements

⁹³ 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* (Vancouver, BC: Special Report of the Public Guardian and Trustee of British Columbia, 2005) at 9.

⁹⁴ *Ibid.*

- the cost of reviewing existing *Patients Property Act* committeeships in order to bring them under the new law.

Part 2.1 of the *Adult Guardianship Act* applying to statutory guardianship (in Part 2.2.1 of this Chapter and in Chapter 5) was brought into force in 2014; court appointed guardianship in British Columbia remains governed by the *Patients Property Act*,⁹⁵ although guidelines issued by the Public Guardian and Trustee provide for application of the PPA in a way that is consistent with the modern approach (focusing on decision-making ability rather than infirmity, and limiting guardianship authority where possible).

In those jurisdictions where legislative reform has been more successful, however, changes in the law do not appear to have resulted in significant changes to practice, and “[t]he persistence of old ways of doing guardianship, despite changes in substance and procedure in the governing laws” has been described as “a subject for both wonder and concern.”⁹⁶ Guardianship orders sought and granted remain, in the great majority of cases, orders for plenary guardianship, despite the existence of less intrusive alternatives. Jennifer L. Wright, referring to the American experience, has identified a “disconnect between the perceptions of most of the regular participants in this guardianship system” (including lawyers and judges), who place value on keeping the guardianship process “simple, friendly, inexpensive, and available to all who need its protections”, and the “insights of those who have invested effort in studying the working of the guardianship system.”⁹⁷ Wright concludes that this disconnect is “one probable source of the difficulty in making actual guardianship practice conform to legislative reforms.”⁹⁸ Leslie Salzman, also writing in the United States, has identified the “judicial habit or culture of entering broad orders, the additional time and effort required to conduct a meaningful assessment of the individual’s “capacities” together with the practicality of broad guardianship orders” as reasons for this persistence (“the entry of a broad order both avoids confusion about the scope of the

⁹⁵ See the discussion in this chapter under the heading “2.2.1 Adult guardianship legislation”.

⁹⁶ Wright, *supra* note 79 at 350, referring to the similar wave of “modernizing” legislation in the United States. Wright provides a useful (if brief) historical account of adult guardianship legislative reform in the United States at 352-353.

⁹⁷ Wright, *ibid.*, at 352.

⁹⁸ *Ibid.*

guardian's authority and the need for future proceedings to expand a more limited order.”)⁹⁹

Doug Surtees' examination of 446 guardianship applications in Saskatchewan between 2001, (when assisted-decision making legislation became effective) and 2008 concluded that “the vast majority of orders granted under the 2001 legislation remain virtually plenary orders,” despite the fact that section 14(2) of Saskatchewan's *Adult Guardianship and Co-decision-making Act* prohibits a court from making such an order “unless alternative ways to assist the adult in making decisions with respect to matters relating to his or her person, including less intrusive forms of support or assistance in decision-making, have been tried or carefully considered.”¹⁰⁰ Surtees concludes that there are only “two plausible explanations for the finding that the overwhelming majority of Saskatchewan guardianship orders, granted under the current legislation, appear to be crafted as virtually plenary orders”:

The first explanation is that in the overwhelming majority of cases, guardians continue to request, and courts continue to grant, orders that are unnecessarily plenary. If this is so, it is contrary to the legislation and the principles which are to guide its interpretation and administration. The specific principle being violated is the "least restrictive order that is sufficient to meet the adult's need" principle, although there is overlap with other principles as well. Indeed, if this explanation is correct, one must conclude that the legislation is not being correctly administered and that the sections of the legislation limiting the court's power to make orders are not being complied with. Perhaps one cause of this situation is a lack of knowledge on the part of the bench and the bar. Perhaps the built-in financial incentive applicants have in acquiring broader orders, likewise, plays a causal role. After all, applicants who are required to obtain successive orders will face increased transaction costs.

The other possible explanation is that the orders that are granted, despite their tendency to be virtually plenary orders are, in fact, the orders that are needed. It might be the

⁹⁹ Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act* (Legal Studies Research Paper Series, Cardozo Law School, 2009) [Cardoza Legal Studies Research Paper No 282] at 294; Lawrence A Frolik, “Guardianship Reform: Where the Best is the Enemy of the Good” (1998), 9:2 *Stan L & Pol’y Rev* 347; Lawrence A Frolik “Promoting Judicial Acceptance and Use of Limited Guardianship” (2002) 31:3 *Stetson L R* 735.

¹⁰⁰ Surtees, *supra* note 23 at 122.

case that these almost all-inclusive orders *are* the least restrictive orders that are sufficient to meet the adults' needs. If this explanation is correct, we have a separate problem. Outside of traumatic accident or acute medical events, loss of capacity typically does not occur all at once. We also know, however, that a great number of people with diminished capacity experience a diminishing of that capacity over time. Therefore, if the virtually plenary orders are appropriate, it must be the case that applicants are unnecessarily waiting too long.¹⁰¹

A third possibility may be the usefulness of plenary substitute decision-making (as opposed to shared or supported decision-making or substitute decision-making that is limited in scope) in relation to both the physiological nature of dementia as a progressive disease (with the rate of progress generally unpredictable and the identification of limited decision-specific abilities in the “shifting sands” of dementia problematic) and the significance of guardianship as a means of over-riding mere choice in the earlier stages of dementia.

2.6 The supported decision making paradigm and Article 12 of the *Convention on the Rights of Persons with Disabilities*

The guardianship reform movement, while refining the guardianship model of the late 19th and early 20th centuries, did not substantively change its essential premise: that guardianship is a response to physiological mental impairment, whether defined as “mental infirmity” or impaired mental capacity (the cognitive ability to carry out processes of decision-making). The supported decision-making paradigm described below represents a more fundamental break from this model.

The emergence and development of the supported decision-making paradigm is associated with Article 12 of the *Convention on the Rights of Persons with Disabilities*¹⁰² and, in particular, the

¹⁰¹ *Ibid* at 126.

¹⁰² See Nina A Kohn, Jeremy A Blumenthal & Amy T Campbell, “Supported Decision-Making: A Viable Alternative to Guardianship” (2013) 117:4 Penn St L Rev 1111; the *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 2515 UNTS 3, art 12 (entered into force 3 May 2008), itself is silent on “decision-making” of any kind. The General Comment (*infra* note 103) has interpreted Article 12 as effectively abolishing substitute decision-making of any kind (including guardianship) and creating an obligation in the part of the state to adopt and provide support for supported decision-making.

interpretation of Article 12 by General Comment #1 (issued by the UN Committee on the Rights of Persons with Disabilities, the body charged with interpreting the Convention).¹⁰³

Article 12 (“Equal recognition before the law”)¹⁰⁴ provides as follows:

1. States parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law
2. States parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life
3. States parties shall take appropriate measures to provide access to persons with disabilities to the support they may require in exercising their legal capacity
4. States parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free from conflict of interest and undue influence, are proportional and tailored to the persons circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests
5. Subject to the provisions of this Article, States parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans,

¹⁰³ CRPD, *General Comment No. 1 (2014)*, 11th Sess, adopted 11 April 2014, UN Doc C/GC/1, at para 26, online: <[https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf? OpenElement](https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement)> [CRPD, *General Comment No. 1*]. The *General Comment* is provides an “authoritative, if not binding interpretation”; See Wayne Martin et al, “Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?” (2015) Report Submitted to the UK Ministry of Justice, online: <<http://repository.essex.ac.uk/13624/1/EAP-Position-Paper-FINAL-copy.pdf>>.

¹⁰⁴ GA Res 61/106, 61st Sess, Supp No 49, UN Doc A/RES/61/106 (2006).

mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property

The General Comment has interpreted Article 12 as requiring the abolition of mental capacity as the basis of legal incapacity, stating that parties to the Convention must “review the law allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person’s autonomy, will and preferences.” The Comment distinguishes between ideas of “legal” and “mental capacity” as follows:

Legal capacity refers to the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency). It is the key to accessing meaningful participation in society. Mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including environmental and social factors... Under article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity.¹⁰⁵

“Mental capacity” is defined further in the Comment as “highly controversial”, “not, as is commonly presented, an objective, scientific and naturally occurring phenomenon” but “contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.”¹⁰⁶ The General Comment defines Article 12 as “a basic general principle of human rights protection and... indispensable for the exercise of other human rights... [and] the general principles of the Convention”: respect for the inherent dignity, individual autonomy - including the freedom to make one’s own choices-, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women;

¹⁰⁵ CRPD, *General Comment No. 1*, *supra* note 103 at para 13.

¹⁰⁶ *Ibid* at para 14.

and respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.¹⁰⁷

At the conceptual core of the supported decision-making paradigm is the understanding that all persons are capable of making decisions expressing their will and preference, thereby retaining legal capacity and maximal autonomy, so long as they receive the appropriate support.¹⁰⁸ In this way, the supported decision-making paradigm is conceptually of-a-piece with the social disability model¹⁰⁹ locating “disability” in the failure of the social world to accommodate impairments and/or to exacerbate the impact of impairment by creating barriers of different kinds (including legal barriers). From a social disability perspective, the disability of blindness (for example) is a consequence of a social world that has been constructed for the benefit of sighted persons without taking into account the situation and needs of persons without sight. Disability is “something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society.”¹¹⁰ Re-arrangement of the social world to accommodate the impairment of non-sightedness, for example, would resolve the *disability* of blindness (without curing the impairment of non-sightedness); without disability, the impairment of non-sightedness would become mere difference, neither good nor bad. The social creation of disability is therefore conceptualized as a form of discrimination and persons experiencing disability are “an oppressed group in society”¹¹¹ analogous to other oppressed groups. Within this conceptual framework or paradigm, law has a crucial role to play as a mechanism for

¹⁰⁷ *Ibid* at para 4.

¹⁰⁸ Piers Gooding, “Navigating the Flashing Amber Lights of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns” (2015) 15:1 Hum Rts L Rev 45 (“[s]upported decision-making refers to a decision made by a person, on his or her own behalf, with support from others in order to exercise legal capacity” at 51).

¹⁰⁹ Union of the Physically Impaired Against Segregation, *Fundamental Principles of Disability* (London: Union of Physically Impaired Against Segregation, 1976) (defining disability as “the disadvantage or restriction of activity caused by a contemporary social organization which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities”); Michael Oliver, *Social Work with Disabled People* (Basingstoke: Macmillan, 1983); Michael Oliver “The Social Model of Disability: Thirty Years On” (2013) 28:7 Disability & Society 1024.

¹¹⁰ Michael Oliver, *Understanding Disability: From Theory to Practice* (Basingstoke: Macmillan, 1996) at 22.

¹¹¹ *Ibid*.

resolving disability (as opposed to impairment) through the reform of social structures, thereby ameliorating discrimination.¹¹²

The social-disability model was developed by and for young and middle aged persons with physical disabilities, and the model has been criticized for failing to take account of cognitive differences (i.e. differences in the performance of thinking processes).¹¹³ Nevertheless, the theoretical framework of the social disability model is integral to the supported decision making paradigm: that decision-making disability is caused by the failure to provide the necessary social support and by the active removal of the opportunity to develop decision-making skills where a substitute decision-maker is appointed.

The UN Office of the High Commissioner of Human Rights has defined supported decision making as “the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal or legal matters.”¹¹⁴ The UN Committee of the Rights of Persons with Disabilities has provided the following, more fulsome definition:

Supported decision-making can take many forms. Those assisting a person may communicate the individual’s intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity... The individual is the decision maker; the support person(s) explain(s) the issues, when necessary, and interpret(s) the signs

¹¹² *Eaton v Brant-County Board of Education*, [1997] 1 SCR 241; *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624; McColl et al, “People With Disabilities Under the *Charter*: Disability Rights at the Supreme Court of Canada Under the *Charter of Rights and Freedoms*” (2016) 5:1 Can J Disability Studies 183. The *Americans With Disabilities Act*, 42 USC 12101 et seq (1990), is also premised on this idea.

¹¹³ See Tom Shakespeare & Nicholas Watson, “The Social Model of Disability: an Outdated Ideology?” in Barbara M Altman & Sharon N Barnartt, eds, *Exploring Theories and Expanding Methodologies: Where We Are and Where We Need to Go*, vol. 2 (Bingley: Emerald Group Publishing, 2001) 9.

¹¹⁴ UN General Assembly, OHCHR, Tenth session Agenda item 2, ‘ANNUAL REPORT OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS AND REPORTS OF THE OFFICE OF THE HIGH COMMISSIONER AND THE SECRETARY-GENERAL: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities’ Distr. GENERAL A/HRC/10/48 26 January 2009.

and preferences of the individual. Even when an individual with a disability requires total support, the support person(s) should enable the individual to exercise his/her legal capacity to the greatest extent possible, according to the wishes of the individual.¹¹⁵

Michael Bach and Lana Kerzner have defined supported decision-making in terms of facilitating an individual's *capability* (referring to a person's ability to function or "get things done"). drawing on the conceptual framework developed by Amartya Sen. Within this framework, "being capable" or "having capabilities" is a "combination of what we refer to as individual decision-making 'abilities' and of decision-making 'supports' and accommodations."¹¹⁶ "Different decision-making abilities" can therefore "be turned into decision-making capabilities with appropriate decision-making supports and accommodations sufficient to exercise legal capacity."¹¹⁷ Individual decision *making*" refers to "getting individual decisions made consistent with one's will and/or intention" with supports and accommodations as required.¹¹⁸ Certain situations, Bach and Kerzner suggest, may require a "temporary 'facilitated' decision-making legal status... while personal relationships can be built that would enable the person's will and/or intention to become known by others as the basis for decision making."¹¹⁹

Robert Gordon has observed that the concept of decision-making as an inter-dependent activity more accurately reflects the way all people make decisions in their "everyday" lives, and that "truly *independent* decision-making is a myth."¹²⁰ In this sense, supported decision-making has

¹¹⁵ UN Committee on the Rights of Persons with Disabilities "Chapter Six: From provisions to practice: implementing the Convention, Legal Capacity and Supported Decision-Making" in UN Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities (Geneva, 2007).

<https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html>

¹¹⁶ Michael Bach & Lana Kerzner *A New Paradigm for Protecting Autonomy and The Right to Legal Capacity* (2010) Law Commission of Ontario at 21.

¹¹⁷ *Ibid.*, at 22. Bach and Kertzner set out 6 categories of support: life-planning; independent advocacy; communicational and interpretative; representational; relationship-building; and administrative. *Ibid.*, at 72.

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid.*, at 24.

¹²⁰ Gordon, *supra* note 85 at 65. "In complex, post-industrial and postmodern societies there is a high level of dependency upon the skills, acumen, ability, and knowledge of others when a variety of decisions are to be made.... Assistance is sought because the adult faces a decision (or decisions) that require both an understanding and an appreciation of the consequences of a choice or option that presents itself, or because he or she needs a skilled agent to carry out certain tasks (e.g., the completion of an income tax return). Most adults, when asked to reflect upon normal decision-making practices in their daily lives, usually realize the extent to which they engage in *inter* dependent decision-making. Importantly, this interdependence is not seen as indicative of mental incapability."

been described as reflecting and consistent with a conceptualisation of autonomy as *relational* (i.e. exercised through our relationships with others) rather than the idea of autonomy as equivalent to independence and self-reliance.¹²¹ We all need support in relation to some kinds of decisions, but some of us need more support with a greater number of decisions. Gordon notes concerns that formal appointment of a supporting decision-maker may have a detrimental effect on organic informal relationships of support, “potentially “disrupt[ing] existing and effective networks of support that surround the affected adult.”¹²² Additional “problems and criticisms” identified by Gordon include the inherent difficulty of the task (supporting and advising appropriately without interfering), the slide into making decisions *for* the other person on the one hand or neglecting to act on the other, and the potential for abuse and exploitation.¹²³ Special concerns arise where individuals are not embedded in supportive relationship networks from whose ranks a suitable assistant/supporting decision-maker could be drawn (“who is to provide the assistance in the absence of family and friends?”)¹²⁴

Can it be assumed that family, friends or “community” will rally around sufficiently to make meaningful and (admirable) aspirations for reliance on community-based ideas of “supported” decision-making, or should civil society (ie through mobilising volunteer support) or the state (such as through funding and co-ordinating “community visitor/guardian” schemes) supply the shortfall for the friendless or isolated? If tailor-made personal arrangements are no longer viable due to the advanced age or social isolation of the person, should this trigger access to more impersonal and bureaucratic default guardianship from state agencies such as Public Trustees (or offices of the Public Advocate), under public guardianship arrangements not uniformly provided for in many jurisdictions outside Australia? Or is this state of affairs the moral equivalent of having been unlucky in life, with lack of support being one’s “lot in life” and thus not something to be remedied? None of these questions have easy answers.”¹²⁵

¹²¹ See, Piers Gooding “Supported Decision-making: A Rights-based Disability Concept and Its Implications for Mental Health Law” (2012) 20(3) *Journal of Psychiatry, Psychology and Law* 431.

¹²² *Ibid* at 73.

¹²³ *Ibid* at 74-75,

¹²⁴ *Ibid* at 74.

¹²⁵ *Ibid*. See also, Carney, *Guardianship, Citizenship, & Theorizing Substitute-decisionmaking Law*, *supra* note 81 at 11.

Both Gordon and Terry Carney (writing in Australia) note the work of advocacy organizations within the community living movement (working with and on behalf of persons with intellectual/developmental disabilities) to develop support networks for adults without family and friends “willing and able to provide support and assistance.”¹²⁶ These organisations have driven and dominated the development of supported decision making generally (unlike the guardianship reform movement described above) to the exclusion of other groups “particularly the elderly.”¹²⁷ Reflecting this focus, Manitoba’s *Vulnerable Persons Living With a Mental Disability Act*, the first Canadian legislation providing for assisted/supported decision making, is limited in application to persons with intellectual/developmental disabilities (specifically excluding persons developing mental disabilities later in life), repealing and replacing the old “mental retardate” provisions of the Manitoba *Mental Health Act*.¹²⁸ The idea of *developing* decision-making skills with support is certainly more applicable in relation to persons with developmental disabilities than the continuing *loss* of decision-making skills, together with other thinking skills (judgment, comprehension, remembering, etc.), in the context of dementia in old age. The “family and friends” support networks Gordon describes will also, generally, take a very different form in the latter context, i.e. adult children and (themselves aging) spouses as opposed to parents and siblings. There is no equivalent to the services provided through Community Living organisations (supported group homes, for example) for persons with dementia in old age. In accordance with this context, the literature on supported decision-making has primarily focused on the needs of persons with developmental disabilities (and the particular problems caused by substitute decision-making in that context).

Critiques of the supported decision-making paradigm (supported decision making as a complete replacement for guardianship) should not be confused with criticism of supported decision-making itself. Those critiques are directed to the proposed disappearance of both adult

¹²⁶ Gordon, *supra* note 85 at 74; Carney, *Guardianship, Citizenship, & Theorizing Substitute decision-making Law*, *ibid.*

¹²⁷ Gordon, *supra* note 85 at 72. Gordon also refers to McKenzie, Tod, & Yellen’s work on “[c]ommunity-based intervention strategies for cases of abuse and neglect of seniors” as recognising the potential of assisted decision-making for the elderly” (in this context). Pearl McKenzie, Linda Tod & Penny Yellen, “Community-based Intervention Strategies for Cases of Abuse and Neglect of Seniors” in Michael J MacLean, ed, *Abuse and Neglect of Older Canadians: Strategies for Change* (Toronto: Thompson Educational Publishing, 1995) 17.

¹²⁸ Gordon, *supra* note 85 at 67.

guardianship and mental capacity assessment, described by Kayess and French as “bordering on a complete denial of the instrumental limitations associated with cognitive impairments.”¹²⁹

Peter Bartlett has suggested that the effectiveness of Article 12 is limited by its failure to provide an alternative method of evaluation that would determine when and what kinds of supports are necessary.¹³⁰ Nor does the Convention provide a mechanism for responding to a situation where an individual rejects support that she or he objectively needs.¹³¹ Freeman and others have argued that removal of mental capacity as a legally meaningful concept would effectively “violate” other rights “expressed and asserted” in the CRPD including the right to enjoyment of the highest attainable standard of health, the right to liberty, and the right to justice.¹³² Noting the presumption of capacity in law and medicine, the authors conclude “that where it is proven in a given case thorough psychiatric assessment that the person does not have decision-making capacity in a particular domain (for example with respect to hospital admission, treatment, or financial transactions), at a particular time, the initial legal presumption must also be reassessed.”¹³³

Leslie Salzman has described Article 12 as a “paradigm shift” through its creation of a “true presumption of legal capacity”, calling for a “more nuanced approach towards determining decision-making status and greater reflection on how to assist an individual within the decision-making process.”¹³⁴ Kristin Booth Glen describes this new “paradigm” as “insist[ing] on the full legal capacity of every person with intellectual disabilities... do[ing] away with substituted decision-making in favour of society’s obligation to provide appropriate supports to permit everyone to make his or her own decision” (as opposed to the “old idea of incapacity as an illness or defect that renders the person suffering it to an object of charity and protection, subject to plenary guardianship based on best interests which constrains her personal life and the control

¹²⁹ Rosemary Kayess & Phillip French, “Out of Darkness and into Light? Introducing the *Convention on the Rights of Persons with Disabilities*” (2008) 8:1 Human Rights L Rev 1 at 1.

¹³⁰ Peter Bartlett “The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law” (2012) 75:5 Mod L Rev 752 at 762.

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ Melvyn Colin Freeman et al, “Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities” (2015) 2:9 Lancet Psychiatry 844 at 845. See also George Szmukler, “UN CRPD: Equal Recognition Before the Law” (2015) 2:11 Lancet Psychiatry 29.

¹³⁴ Salzman, *supra* note 99 at 285.

of her property.)”¹³⁵ A true shift (in the Kuhnian sense) has not occurred, however; adult guardianship, and the supported decision-making paradigm, remain stalled at the cross-roads. On one hand, the gaps in the supported decision-making paradigm will continue to preclude a paradigm shift in its favour, as evidenced by Canada’s ratification of the CRPD in 2010 with a reservation regarding Article 12 that would allow for the continuation of substitute decision making (including adult guardianship).¹³⁶ On the other, the current adult guardianship model is problematic for the reasons identified in this Chapter (relating to the experience of persons with intellectual and developmental disabilities); special problems also arise in the context of dementia in old age, as examined in Chapter 4.

2.7 Dementia

At this most objective end of mental illness (that is, in the field of “organic” dementias) it turns out there is no hard scientific boundary between disease and normality. Lines can be drawn, but their exact location is a matter of evaluative judgment based on correlations between neuro-pathology and symptoms and signs. But which symptoms and signs? How much forgetfulness is pathological? What counts as normal aging?¹³⁷

The World Health Organization defines dementia as a “syndrome, usually of a chronic or progressive nature, in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing.”¹³⁸ These changes in thinking

¹³⁵ Kristin Booth Glen, “Changing Paradigms: Mental Capacity, Legal Capacity Guardianship, and Beyond” (2012) 44:1 Colum HRLR 93 at 98. See also Nandini Devi, Jerome Bickenbach & Gerold Stucki, “Moving Towards Substituted or Supported Decision-making? Article 12 of the Convention on the Rights of Persons with Disabilities” (2011) 5 European J Disability Research 249; Terry Carney, “Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?” (Legal Studies Research Paper Series 4, University of Sydney Law School, 2015) [Sydney Law School Research Paper No 15/03] 37.

¹³⁶ See, Stephen Hoffman, Lathika Sritharan & Ali Tejpar, “The UN Convention on the Rights of Persons With Disabilities and Its Impact on Mental Health Law and Policy in Canada” in Jennifer Chandler & Colleen Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016) 53 at 64; Sheila Wildeman “Protecting Rights and Building Capacities: Challenges to Global Mental Health Policy in Light of the Convention on the Rights of Persons With Disabilities” (2013) 41:1 JL Med & Ethics 48.

¹³⁷ Julian Hughes, Stephen Louw & Steven R. Sabat, eds., *Dementia: Mind, Meaning and the Person* (Oxford: Oxford University Press, 2005).

¹³⁸ World Health Organization “Dementia” (Fact Sheet) April 2016), online: <http://www.who.int/mediacentre/factsheets/fs362/en/> See also, Alzheimer Society of Canada *Rising Tide: The*

processes are “commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.”¹³⁹ The “ability to process thought” can be ascertained only through a person’s performance of thinking processes and the dementia diagnosis, accordingly, turns of the evaluation of that performance. The “signs and symptoms of dementia” may be caused by several underlying physiological phenomena including Alzheimer’s disease, vascular dementia, frontotemporal lobe dementia, Lewy Body disease, Creutzfeldt-Jakob disease, stroke and prolonged alcohol abuse. The diagnosis of dementia does not depend on a conclusive identification of its source, however; indeed, the cause of a person’s dementia is more likely to remain theoretical during her or his life. Diagnosis of probable cause is nevertheless an important element of the dementia diagnosis, distinguishing treatable symptoms resembling dementia (delirium caused by infection, for example) from the “chronic and progressive” syndrome of dementia.

Dementia is not exclusive to the old, nor is dementia an inevitable and universally experienced characteristic of old age. The great majority of persons diagnosed with dementia are old however (between 90 and 98%), and the likelihood of developing dementia increases exponentially with age (falling off around the age of 90).¹⁴⁰ This demography of dementia- the connection between old age and changes in thinking and judgment (particularly memory)- is “probably as old as mankind itself” and was observed by the ancient Egyptians, Greeks and Romans.¹⁴¹ Despite this association, evidence indicates that the ancients did not understand dementia to be an inevitable feature of the long life.¹⁴² References to old age in the literature of the ancient Greeks and Romans describe a heterogeneous and multi-faceted experience, including both positive and

Impact of Dementia on Canadian Society (2010)

http://alzheimer.ca/sites/default/files/files/national/advocacy/asc_rising_tide_full_report_e.pdf

¹³⁹ *Ibid.*

¹⁴⁰ According to a report released in 2012 by the World Health Organisation and Alzheimer’s Disease International between 90 per cent and 98% per cent of all cases of dementia are diagnosed after the age of 65 ((*Dementia: A Public Health Priority* http://www.who.int/mental_health/publications/dementia_report_2012/en/). A report published by the Alzheimer’s Society UK in 2014 (*Dementia UK Update* https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/dementia_uk_update.pdf) estimates that early onset (before age 65) dementia accounts for 5.2% of all persons diagnosed with dementia in the UK, and that within that group dementia increases “sharply” between the ages of 60 and 64. The *Rising Tide* Report (*ibid*) estimates that between 93 and 95% of persons developing Alzheimer’s disease are ‘late-onset’ are age 65 or over.

¹⁴¹ Francois Boller & Margaret M. Forbes “History of Dementia and Dementia in History: An Overview” (1998) 158(2) *Journal of the Neurological Sciences* 125.

¹⁴² See Boller & Forbes, *ibid.*, at 3 referring to Cicero in *De Senectute*

negative aspects, wisdom and peace alongside physical and possibly mental decline; as Seneca the Younger wrote, “[t]here is not one type of old age for all people.”¹⁴³ The possibility of dementia in old age was nevertheless (then as now) a subject of dread, as evidenced in the following passage from the *Bacchides* (written by the Roman playwright Plautus in 820 BC):

Whom the gods hold dear die young, with strength and sense and mind intact. If any god loved him he should have died more than ten years ago or more than twenty. He walks a bane upon the earth: no mind, no sense, as useful as a rotten mushroom.¹⁴⁴

The great legal reformer Solon (560-630 BC), recognised old age (along with physical pain, violence, drugs, and the “persuasion of a woman”) as a source of impaired judgement and his legal code (replacing the “Draconian” Code of Draco) provided that a man could no longer bequeath his property to whoever he wished if his judgment was affected by old age.¹⁴⁵ Laws in both ancient Greece and Rome also enabled a son to bring a lawsuit against a father “in order to stop him from squandering away his fortune.”¹⁴⁶

According to Boller and Forbes, dementia in old age “does not seem to have inspired much interest or concern” in the middle ages¹⁴⁷ As in ancient times, dementia appears to have been understood as an unfortunate but uncontrollable and inevitable fate for some (if not all) in old age (Boller and Forbes quote the philosopher Roger Bacon as expressing the view that “senility is a consequence of the original sin.”)¹⁴⁸ Shakespeare’s tragedy *King Lear* provides a famous dramatic account of dementia in old age: a “tale told by an idiot, sound and fury signifying nothing.”

The idea of “senile dementia” (dementia in old age) as a disease of the mind emerged in the 19th century, in particular through the “landmark” work of Jean Etienne Esquirol. Esquirol, writing

¹⁴³ Attributed to *Consolation ad Marciam*, 1 AD; Tim Parkin “The Ancient Greek and Roman Worlds” in Pat Thane, ed. *The History of Old Age* (London: Thames & Hudson, 2005) 31 at 31.

¹⁴⁴ *Ibid.* at 74.

¹⁴⁵ *Ibid.*

¹⁴⁶ Karen Cokayne *Experiencing Old Age in Ancient Rome* (London: Routledge Classical Monographs, 2003) at 73. Cokayne writes that similar legal procedures existed in Ancient Rome although, in practice the “handing over of affairs” is thought to have occurred amicably without the need for legal action.

¹⁴⁷ Boller & Forbes *supra* note 141 at 5.

¹⁴⁸ *Ibid.* Use of the term “dementia” is identified by Boller and Forbes as emerging in France in 1380.

in 1838 (in a treatise titled *Mental illness as considered in medical, hygienic, and medico-legal reports*), described “senile dementia” as “a cerebral disease caused by an impairment of sensibility, intelligence and will”:

A demented man has lost the goods he used to enjoy; he is a wealthy person turned poor. An idiot [referring to persons that would today be referred to as mentally or intellectually disabled], by contrast, has always been unfortunate and poor.¹⁴⁹

In addition to “senile dementia”(dementia caused by old age), Esquirol enumerated several other possible sources of “impairment” including excessive drinking and eating, head injury, poverty, unhappy love, unfulfilled ambitions, excessive masturbation, fears, domestic problems, political upheaval, mercury abuse, syphilis, apoplexy, paralysis, mania, hemorrhoids, menstrual disorders, and difficulties following birth.¹⁵⁰ Around this same time, the pioneering French psychiatrist (and father of forensic psychiatry) Etienne-Jean Georget identified the causes of dementia as “weakening, ageing or associated disease,” and categorised dementia and “idiota” as the “only two irreversible conditions in psychiatry.”¹⁵¹

The idea of dementia as a disease or disorder developed further with the discovery of Alzheimer’s disease in the early 20th century. Alzheimer’s patients were remarkable precisely because they were *not* old, yet experiencing problems of behaviour and performance that closely resembled senile dementia; this phenomenon became known as Alzheimer’s disease.

Alzheimer’s disease was first used to describe persons diagnosed with dementia in old age (i.e. those previously described as experiencing senile dementia) in a “landmark editorial” by Dr Robert Katzman in 1976.¹⁵² By the latter part of the 20th century Alzheimer’s disease had become “almost synonymous with dementia, virtually replacing the previous, less obviously

¹⁴⁹ *Ibid.*, at 4. Boller & Forbes describe Esquirol’s work as a “great leap forward” in the study of dementia.”

¹⁵⁰ *Ibid.*, at 126.

¹⁵¹ Leonardo Caixeta et al “The development of the dementia concept in the 19th century” (2014) 72 (7) *Arq Neuropsiquiatr* 564 at 566 citing Georget EJ. *De la Folie. Considérations sur Cette Maladie*. Paris, Crevot, 1820.

¹⁵² Robert Katzman “The Prevalence and Malignancy of Alzheimer’s Disease: A Major Killer” (1976) 33(4) *Neurology* 217. See discussion, Murna Downs “Dementia in a Socio-Cultural Context: An Idea whose Time Has Come” (2000) 20(3) *Aging and Society* 369 at 370; Boller & Forbes *supra* note 141; Robert Katzman, Robert B. Terry & Katherine Bick *Alzheimer’s disease: senile dementia* (New York: Raven Press, 1978); Patrick Fox “From Senility to Alzheimer’s Disease: The Rise of the Alzheimer’s Disease Movement” (1989) 67(1) *The Milbank Quarterly* 58. See also, DR George, PJ Whitehouse, J Ballenger “The evolving classification of dementia: placing the DSM-V in a meaningful historical and cultural context and pondering the future of “Alzheimer’s” (2011) 35(3) *Culture Medicine & Psychiatry* 417; Thomas Kitwood *Dementia reconsidered: the person comes first* (Buckingham: Open University Press, 1997) at 22.

medical term, senile dementia.”¹⁵³ Thomas Kitwood has described this process as the “Alzheimerization” of dementia¹⁵⁴ through “a series of pragmatic decisions both financial and political”:

Through the corralling of research monies and successful lobbying the Alzheimer’s movement (an alliance of scientists, government representatives, members of the public and the media) two processes were established. First, Alzheimer’s became virtually synonymous with dementia, virtually replacing the previous, less obviously medical term senile dementia. Cognitive decline was therefore no longer to be seen as a normal part of aging but as a pathological process. Second, it helped to extend the boundaries of Alzheimer’s by removing age as a primary criterion of disease. Originally, a distinction was made between senile and pre-senile dementia, depending on the age of the patient.¹⁵⁵

Dementia has also been defined in recent years to include criteria relating to functioning in day-to-day life; Prof. Elisa Ash defines dementia as a “decline in cognitive function, such as loss of memory, judgment, language, complex motor skills and other intellectual functions leading to a decline in independent daily functions.”¹⁵⁶ Noting this trend, Julian C. Hughes has suggested that the “standard medical model nowadays” in clinical practice is “probably biopsychosocial”; “it is difficult to think of clinicians (as opposed to pure neuro-scientists) who would be inclined to think of the person with dementia solely in the technical terms of neuro-psychology (and even pure neuroscientists, I suspect, do not think in such terms when they think of persons with dementia).”¹⁵⁷ For the majority of political and legal actors,¹⁵⁸ and for the general public, however, the rhetorical discourse of dementia as dread disease (constructed around a simplified version of the medical model) remains the meaning of dementia. This particular idea of dementia as a disease of the self- a “living death” in which the self disappears, and the person

¹⁵³ Clive Baldwin & Andrea Capstick, eds., *Tom Kitwood on Dementia: A Reader and Critical Commentary* (Maidenhead, England: Open University Press, 2007) at 7.

¹⁵⁴ *Ibid.*

¹⁵⁵ *Ibid.*

¹⁵⁶ Elissa Ash “What is Dementia?” in Charles Foster, Israel Doron, and Jonathan Herring eds. *The Law and Ethics of Dementia* (Oxford: Hart Publishing, 2014) 3 at 3.

¹⁵⁷ Julian C. Hughes. *Thinking Through Dementia* (Oxford, UK: Oxford University Press, 2011) at 121

¹⁵⁸ See, for example, *Act respecting a national strategy for Alzheimer’s disease and other dementias*” SC 2017 c. 19.

becomes a kind of zombie- creates a high level of social stigma around the disorder, and the person labeled with it.¹⁵⁹

2.8 Conclusions

In this Chapter, I have explored the development of adult guardianship in Anglo-Canadian law, from the feudal manor to the *Convention on the Rights of Persons with Disabilities*. As the discussion in this Chapter has shown, “guardianship” has no fixed or inevitable meaning. The guardianship response has evolved from the pre-common law “mists of time” to the present in a way that is of-a-piece with the wider, social, legal and political context in which that response has been situated. We have seen how the scientific/objective measurement of mental capacity, conceptualised as a protector of autonomy in the adult guardianship reform movement, has been re-conceptualised as discriminatory and destructive of autonomy in the supported decision making paradigm. At the same time, critics of the supported decision-making paradigm contend that it fails to meet the needs, and protect the rights, of the persons it would defend. Those points of failure or gaps have a particular application to the context of dementia in old age, which has been generally ignored in the supported decision making discourse (although guardianship is used most frequently in that content). Together, these developments have created what Kuhn would call a paradigm revolution (the precursor to a paradigm shift).

¹⁵⁹ See, Elizabeth Peel “The living death of Alzheimer’s” v “Take a walk and keep dementia at bay”: representations of dementia in print media and carer discourse” (2014)36(6) *Sociology of Health and Illness* 885.

Chapter 3. Research Methodology: Pragmatic Inquiry and the Epistemology of Philosophical Pragmatism

3.1 Introduction

A research methodology is a theory about the nature and purpose of the research exercise that provides the conceptual framework for a particular research study. The research *method* chosen should generate the kind of information or knowledge that will best achieve this purpose. The choice of methodology is rooted in the epistemology, or theory of knowledge (“the nature of knowledge and its justification”),¹ that the researcher brings to the study. The researcher’s epistemology or understanding of what knowledge *is*, and how it is generated, underlies the choice of methodology.

The methodology used in this research is pragmatic inquiry. That methodology is rooted in the epistemological framework of philosophical pragmatism, as developed, in particular, by the American pragmatist philosopher John Dewey. The first part of this chapter describes the epistemology of classic American philosophical pragmatism and the methodology of pragmatic inquiry. The second part of this chapter provides an over-view of traditional legal pragmatism and the pragmatic turn in bioethics, situating the approach used in this study as a distinct legal research methodology.

3.2 Epistemology and methodology: pragmatism and pragmatic inquiry

This section sets out the theory of knowledge and methodology of pragmatic inquiry developed by the classic American philosophical pragmatists (Charles Saunders Pierce, William James James, and John Dewey). The philosophical pragmatism described below is distinct from the “legal pragmatism” associated with Oliver Wendell Holmes and the “freestanding” or “brass-tacks” pragmatic turn within law and bio-ethics. These latter pragmatisms are disconnected from the core concerns of the philosophical pragmatists: the nature of knowledge and truth; the function of ideas accepted as truths in the social organisation of “environments” or fields of activity; the ways in which truths evolve/are constructed, or lose their truth status; and the role of pragmatic inquiry in that process, as a structured methodology through which truths can be tested

¹ Thomas A Schwandt, *Dictionary of Qualitative Inquiry*, 2d ed (Thousand Oaks: Sage, 2001) 71.

(in response to “doubt”) and new organizing ideas developed (ideas which may subsequently *become* truths if and when they are adopted on a widespread social level as “habitual ways of thinking”). The self-described legal pragmatist Richard Posner described legal pragmatism as “clearing the underbrush” by dispelling the fictions of legal formalism (the idea that legal actors are controlled by abstract rules and principles) “and leav[ing] it to others to plant the forest” (a job that Posner would give to law and economics theorists).² Dewey’s philosophical methodology of pragmatic inquiry, in contrast, is both descriptive and constructive, clearing the underbrush” *and* “planting the forest.”

I contend that pragmatic inquiry, as a methodology rooted in the epistemology of philosophical pragmatism, is uniquely helpful in terms of understanding legal structures and legal problems and as a means of developing recommendations for law reform that is grounded in both principle and practice. The objectives of pragmatic inquiry align with the objectives of law reform: to locate and examine doubt, and to resolve that doubt by changing the legal framework as an “organizing idea” of the field of practice. The use of pragmatic inquiry as a legal research methodology is, therefore, one contribution of this research study.

3.2.1 Philosophical pragmatism: the classic American pragmatists

The neo-pragmatist Richard Rorty famously described the classic American pragmatists William James and John Dewey as “waiting at the end of the road” which Foucault and other post-modernists were “currently travelling”.³ Like the post-modernists, the pragmatists rejected the essentialist account of truth, i.e. the idea that truths were “out there” waiting to be discovered and, once discovered, were immutable: what Rorty called the idea of truth as a “mirror of nature.”⁴ The post-modern understanding of truths as constructed through social practices (social constructionism)⁵ was presaged by the pragmatist philosophers, although they described that process in different terms and using different analogies or metaphors. The pragmatists differed from the post-modernists, however, in terms of both methodology (the methodology of pragmatic inquiry described *infra*) and objective. Where the objective of post-modernist or

² Richard Posner, “What Has Pragmatism to Offer Law?” (1990) 63:6 S Cal L Rev 1653 at 1663, 1670.

³ Richard Rorty, *Consequences of Pragmatism* (Minneapolis: University of Minnesota Press, 1982) at xviii.

⁴ Richard Rorty, *Philosophy and the Mirror of Nature* (Princeton: Princeton University Press, 1979).

⁵ Vivien Burr, *An Introduction to Social Constructionism* (London: Routledge, 1995) at 3-8.

social constructionist theorists is the *de*-construction of (apparently natural) truths, the objective of pragmatic inquiry is the *re*-construction of truths for the purpose of “remov[ing]... some specific trouble and perplexity.”⁶

Post-modernist deconstruction has been criticized on the basis of relativism and even nihilism; if no truths are true-er than others everything is allowed and order is arbitrary. The pragmatist philosophers, in contrast, believed that some ideas were (for a period of time) true-er than others; an idea was true or valid (truer in that moment than alternatives past and future) so long as it “succeeds in its office”, in Dewey’s words, by satisfactorily resolving “troubles and perplexities” in a way that is consistent with other truths. Where the truth of an idea becomes degraded or untenable- where the persons using or affected by that idea no longer believe in it as true- a new truth will emerge to take its place. The objective of pragmatic inquiry is to guide the construction of that new truth.

3.2.2 Philosophical pragmatism: anti-essentialism and the nature of truth

[I]deas are not “out there” waiting to be discovered, but are tools- like forks and knives and microchips- that people devise to cope with the world in which they find themselves. They [the “founding fathers” of pragmatism] believed that ideas are produced not by individuals, but by groups of individuals- that ideas are social. They believed that ideas do not develop according to some inner logic of their own, but are entirely dependent, like germs, on their human carriers and the environment. And they believed that since ideas are provisional responses to particular and unreproducible circumstances, their survival depends not on their immutability but on their adaptability.⁷

The American philosophers Charles Saunders Pierce, William James, Oliver Wendell Holmes, and John Dewey are considered to be the “founding fathers” of classic American pragmatism.⁸ Despite areas of difference between them, these pragmatist philosophers were united in their rejection of what Dewey called a “spectator theory of knowledge” in which the individual,

⁶ John Dewey, *Reconstruction in Philosophy* (Boston: Beacon Press, 1948) at 156 [Dewey, *Reconstruction in Philosophy*].

⁷ Louis Menand, *The Metaphysical Club: A Story of Ideas in America* (New York: Farrar, Straus, & Giroux, 2001) at 196.

⁸ See Menand, *ibid.*

standing outside of the world, comes to know that world and its essential reality through a process of passive surveillance.⁹ Richard Rorty described this essentialist account of truth as an extension of the scientific method to all human knowledge and “the conviction that natural science- facts about how spatio-temporal things worked- was all the Truth there was.”¹⁰ There is no essential reality-based truth in the pragmatist account.

John Dewey described ideas as more or less “reliable, sound, valid, good, *true*” to the extent that they “succeed in their office” by “removing some specific trouble [emphasis added] and perplexity”:¹¹

If ideas, 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, eliminate defects, if they increase confusion, uncertainty and evil when they are acted upon, then are they truly false. Confirmation, corroboration, verification lie in works, consequences. By their fruits ye shall know them.¹²

An idea may therefore be “true” in one context, as that idea is used for a particular purpose (“an active reorganization of the given environment” for the “removal of some specific trouble and perplexity”), yet “untrue” in another. An idea may also cease to be true, or become true. “Truth” William James wrote, “happens to an idea, it becomes true, it is made true by events. Its verity is in fact an event, a process: the process namely of its verifying itself, its-verification.”¹³

⁹ John Dewey, *The Quest for Certainty* (New York: Capricorn, 1960) at 193-194, cited in Cornel West, *The American Evasion of Philosophy: A Genealogy of Pragmatism* (Madison: University of Wisconsin Press, 1989) (“[t]heories which assume that the knowing subject, that mind or consciousness, have an inherent capacity to disclose reality, a capacity operating apart from any overt interactions of the organism with surrounding conditions, are invitations to general philosophical doubt.” at 90).

¹⁰ Thomas Grey, “Holmes and Legal Pragmatism” (1989) 41:4 *Stan L Rev* 786 at 789 [Grey, “Legal Pragmatism”], citing Richard Rorty, “Introduction: Pragmatism and Philosophy” in Richard Rorty, ed, *Consequences of Pragmatism* (Minneapolis: University of Minnesota Press, 1982) xiii at xv.

¹¹ Dewey, *Reconstruction in Philosophy*, *supra* note 6 at 156.

¹² *Ibid.*

¹³ William James, *Pragmatism* (Cambridge: Harvard University Press, 1975) at 35 [James, *Pragmatism*], cited in West, *supra* note 9 at 65. Dewey coined the term “warranted assertibility” as a preferable, more accurate alternative to “truth” and “knowledge.” See also Larry A Hickman, *Pragmatism as Post-Modernism: Lessons from Dewey* (New York: Fordham University Press, 2007). Hickman has described this “cumbersome but descriptive phrase” as “pointing in two directions”: “Warranted” points backwards in time toward something that has been accomplished. What is warranted is the result of reflection that has been effective in the sense that some specific doubt or difficulty has been resolved. “Assertibility” points forward in time towards something yet to be done. What is assertible is

Dewey described the universe as one “whose evolution is not finished, of a universe which is still, in James’ term, ‘in the making,’ ‘in the becoming,’ of a universe up to a point still plastic.”¹⁴ In this way, the classic American pragmatism of the late 19th and early 20th centuries has been associated with the social and intellectual impact of Darwin’s theory of evolution; “truths” evolve in the way that an animal evolves in connection with the changing, total environment in which it is immersed, and the success or validity of evolutionary change is judged with reference to the enhancement of functional success as opposed to the relationship of change to any abstract category of the “real” or the “true.” Abstractions, while useful as a means of organizing (and thereby utilising) experience, should never be ascribed “a higher grade of reality.”¹⁵

The evolutionary nature of truth does not imply a state of continual uncertainty or questioning, however. To the contrary, the pragmatists insisted that most comfortable state for the human mind is one of repose or habits of thought. To be recognisable as true an idea must work or fit with existing truths, “so as ever to show a minimum of jolt, a maximum of continuity.”¹⁶ For this reason, James wrote, we will count a new idea as true if we can use it to assimilate a new experience to our old beliefs without disturbing them too much”:¹⁷

That new idea is truest which performs most felicitously its function of satisfying our double urgency. It makes itself true, gets itself classed as true, by the way it works; grafting itself then upon the ancient body of truth, which thus grows much as a tree grows by the activity of a new layer of cambium.¹⁸

something general, and therefore something potentially applicable to future cases that are relevantly similar to the one by means of which it was produced. Unlike the alleged knowledge... studies by most epistemologists... warranted assertibility is claimed to be neither certain nor permanent. The best it can offer is a measure of stability in an otherwise precarious world.” at 207.

¹⁴ John Dewey, “The Development of American Pragmatism” in John Dewey, ed, *Philosophy and Civilization* (New York: Peter Smith Editions, 1968) at 24-25, cited in West, *supra* note 9 at 91.

¹⁵ Brian Z Tamanaha, *Realistic Socio-Legal Theory* (Oxford: Clarendon Press, 1997) at 27, quoting William James, *Pragmatism and the Meaning of Truth* (Cambridge: Harvard University Press, 1975) at 275; See Grey, “Legal Pragmatism”, *supra* note 10 at 787, for Thomas Grey’s discussion of Oliver Wendell Holmes on the relationship between abstraction and legal pedagogy.

¹⁶ *Ibid.*

¹⁷ Margaret Radin, “The Pragmatist and the Feminist” (1990) 63 (6) S Cal L Rev 1699 at 1709.

¹⁸ James, *Pragmatism*, *supra* note 13 at 36, cited in Radin, *ibid* at 1709.

The ability to rely upon the truth of generally agreed-upon habitual thoughts also facilitates action, especially collective action (actions that require individuals to work together). Agreed-upon truths are essential to organizing social practices in a way that will achieve a particular objective.¹⁹ The “great mass” of habitual thoughts are therefore *social*, collectively held, and embedded in “social practice.”²⁰ The courts’ reliance on medical affidavits as establishing capacity without further examination (despite the often “desultory” nature of those reports)²¹ may be understood in these terms: the “truth” of the bio-medical account provides an efficient and justified basis for legal action, eliminating the need for more extended and expensive inquiry (except on the rare occasions where that account is challenged, generally by a rival would-be guardian).

The significance of “habitual thought” and “repose” in pragmatist philosophy raises the question of how the pragmatists themselves were able to break so dramatically with the key tenets of enlightenment thought: the essentialist idea of truth as a “mirror of nature” and the idea of thought as an individual, rather than social, phenomena. According to Thomas Grey, the pragmatists were *able* to think outside of the enlightenment paradigm because of the connections they made between Darwin’s theory of evolution and natural selection (developed as a way of describing biological phenomena) and the philosophical discourse of truth, reality, social life and social change.²² The pragmatists, in other words, were inter-disciplinary thinkers. These “outside” ideas were integral to the development of the pragmatist paradigm.²³

¹⁹ John Dewey, *Logic: Theory of Inquiry* (New York: Henry Holt & Co., 1938) at 101.

²⁰ Grey, “Legal Pragmatism”, *supra* note 10 at 798.

²¹ *British Columbia (Public Trustee) v Batiuk*, [1996] BCJ No 2382 (“[p]etitions by the Public Trustee for orders declaring elderly people incapable of managing themselves or their affairs and appointing committees are not uncommon. The medical affidavits required by the *Act* to support the application are usually brief and desultory. Few applications are contested because the vast bulk of them are brought in cases where it is obvious that the appointment of the Public Trustee or a close relative as committee is in the best interests of the person who is the subject of the proceedings” at para 3).

²² Grey, “Legal Pragmatism”, *supra* note 10 at 796.

²³ As Thomas Kuhn’s “outsiders” are essential to the processes of paradigm revolution, and paradigm shift (as discussed in Chapter 6). See Thomas Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 1962).

3.2.3 Truth, doubt, and the methodology of pragmatic inquiry

Habitual thoughts are both practically useful on a social level and psychologically comfortable for the individual. Change will generally be resisted, if possible. It is only when actions based on habitual thoughts fail to produce the expected or desired results, or are indeed generative of fresh problems, that the thinker experiences the “irritation of doubt.”²⁴ That irritation sets off a “struggle to retain a [new] state of belief” or habit of thought that can be relied on as true, without the need for constant inquiry into its veracity.²⁵ “Pragmatic inquiry” refers to the process developed by the pragmatist philosophers for testing the “validity and value” of ideas that have become doubtful in this way, and for testing potential alternatives through which doubt can be removed and repose restored.

Charles Saunders Pierce and William James described both the “irritation of doubt” and the attainment of a new state of belief in psychological terms. Doubt was experienced psychologically as a state of unease and anxiety, experienced by the individual within her mind. The objective of pragmatic inquiry was the restoration of psychological “repose” through the transformation of belief, rejecting or refining old truths to resolve the source of doubt.²⁶ John Dewey, in contrast, understood both doubt and inquiry in terms of what he called a “situation” i.e. a field of practice as it is organized by an idea or conceptual frame:²⁷

We are doubtful because the situation is inherently doubtful. Personal states of doubt that are not evoked by and are not relative to some existential situation are pathological; when they are extreme they constitute the mania of doubting. Consequently, situations that are disturbed and troubled, confused or obscure, cannot be straightened out, cleared up and put in order by manipulation of our personal states of mind. The attempt to settle them by such manipulations involves what psychiatrists call ‘withdrawal from reality’.... The habit of disposing of the doubtful as if it

²⁴ Grey, “Legal Pragmatism”, *supra* note 10 at 797, discussing Charles Sanders Pierce, “The Fixation of Belief” in Charles Hartshorne & Paul Weiss, eds, vol 5, *Collected Papers of Charles Sanders Pierce* (Cambridge: Harvard University Press, 1935).

²⁵ *Ibid.*

²⁶ Isaac Levi, *Pragmatism and Inquiry: Selected Essays* (Oxford: Oxford University Press, 2013) at 1.

²⁷ Dewey defined a “situation” as “an interaction or transaction between the agent’s point of view and the agent’s objective circumstances.” See Levi, *ibid* at 1.

belonged only to *us* rather than to the existential situation in which we are caught and implicated is an inheritance of subjectivist psychology.”²⁸

For Dewey the “objects to be transformed” through inquiry were “situations” rather than beliefs—although the transformation of situations depended on the transformation of beliefs about that situation (especially beliefs held by actors/participants in that situation).²⁹

Dewey described doubt about a situation as arising where persistent problems could not be adequately resolved on the terms of the current organizing idea, or where changes in the broader social context generated doubt about an idea previously believed in as true in an unexamined or taken-for-granted way. Doubt leads to “deliberation” “as to what is *better* to do”³⁰ for the purpose of establishing “some new situation in which the difficulties and troubles which elicited the deliberation are done away with; in which they no longer *exist*”.³¹ “Inquiry” refers to this process of deliberation, and involves three distinct phases or tasks. The first involves the formation of ideas; the second is the “experimental testing” of those ideas in the context of the situation or environment under consideration. The third task is “judgment,” an “assertion” about the relative “validity”³² of one theory as preferable to another in terms of re-organizing the situation in a way that “replace[s] doubtful situations by situations that [are] non-problematic.”³³ The objective of inquiry is to transform the situation in accordance with that assertion.

3.3 Pragmatism in Law

3.3.1 Law as experience: the legal pragmatism of Oliver Wendell Holmes

The well-known jurist and legal theorist Oliver Wendell Holmes is considered one of the founding fathers of American pragmatism alongside Pierce and James (the three were members

²⁸ See Levi, *supra* note 26 at 109, 111, citing John Dewey, *Logic: The Theory of Inquiry* (New York: Henry Holt, 1938) at 12.

²⁹ Levi, *supra* note 26 at 1. Dewey described situations as either “determinate” (free from doubt) or “indeterminate” (where “its constituents do not hang together”); indeterminate situations were “open to inquiry”, defined as the “active and ongoing reconstruction of experienced situations.”

³⁰ See Levi, *supra* note 26 at 63, citing John Dewey, *Logic: The Theory of Inquiry* (New York: Henry Holt, 1938) at 12.

³¹ *Ibid.*

³² Described by Dewey as “strong/effective” vs “weak/ineffective”. See Levi, *supra* note 26 at 88.

³³ Levi, *ibid.*

of the Metaphysical Club, a conversational philosophical club formed in Cambridge Massachusetts in 1872 and considered to be the crucible of American pragmatism).³⁴ Holmes' development of a distinctive *legal* pragmatism combined the central pragmatist theme of anti-essentialism with a focus on judicial actors and the judicial decision making process as the site of law (as opposed to legal rules). Anti-essentialism, in law, translated into Holmes' famous dictum that "[t]he life of the law has not been logic; it has been experience."³⁵ "Law" was not located in legislation or common law rules, but in the decision of a judge in a particular case. The wise judge, having undergone legal education, would draw on the rules (without being controlled by them) to produce a result that furthered the policy objectives of her historical time and place. For Holmes, "[t]he law embodies the story of a nation's development through many centuries, and it cannot be dealt with as if it contained only the axioms and corollaries of a book of mathematics."³⁶ The "truths" of law, in other words, are not immutable abstractions but *plastic* ideas that should be applied, and therefore developed, for the purpose of achieving socially desirable ends. Law is "a reaction between tradition on the one side [the "accretion of situated experience"] and changing desires and needs of a community on the other,"³⁷ "an indefinite mixture of habit, instrumental reason, and the search for internal coherence."³⁸ "Continuity with the past is no duty but only a necessity" Holmes wrote; "there is no ground zero to set out from; the only starting point is where you actually find yourself."³⁹ It is therefore the responsibility of judicial actors to take ownership of this role and consciously make law that is "shaped mainly by considerations of what is expedient for the community concerned."⁴⁰

The case of *Buck v Bell*⁴¹ is Holmes' most notorious decision, illustrating his perception of the judge's role and responsibility. The case concerned the *Virginia Sterilization Act of 1924*. The legislation would enable the forced sterilization of the plaintiff in the case, Carrie Buck, on the

³⁴ See Menand, *supra* note 7; Max Fisch "Justice Holmes, the Prediction Theory of Law, and Pragmatism" (1942) 39:4 J Philosophy 85.

³⁵ Oliver Wendell Holmes, *The Common Law* (Boston: Little, Brown & Co., 1881) at 1.

³⁶ *Ibid.*

³⁷ Grey, *supra* note 10 at 807, quoting Holmes, *ibid* at 123.

³⁸ *Ibid* at 815.

³⁹ *Ibid* at 809.

⁴⁰ Phillip P Wiener, *The Dictionary of the History of Ideas: Studies of Selected Pivotal Ideas*, vol 3 (New York: Scribner, 1973) at 567.

⁴¹ 247 US 200 (1927).

grounds that she was mentally defective; Ms. Buck argued that the statute was unconstitutional. Justice Holmes, upheld the legislation, reasoning as follows:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute their degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover Fallopian tubes ... Three generations of imbeciles are enough.⁴²

Buck v Bell demonstrates the risks of instrumentalist legal pragmatism, disconnected from justification in underlying principle.

Holmes' theory of pragmatism as a theory of *law* is primarily concerned with the case by case use of legal rules by human actors- the individual judge as the creator of law. The pragmatist philosophers, in contrast, were interested in the operation of *social* environments or fields of practice, and the role of shared or social ideas in organizing those environments. As discussed further in Chapter 4, judicial decision-makers do not control the process of adult guardianship in a way that "fits" Holmes' judge-centric model; the inter-disciplinary nature of adult guardianship, in which medical professionals arguably exert the more controlling influence, is more coherently understood as the kind of "environment" or field of social practice in which organizing ideas play a more decisive role.⁴³ To be recognised as true in this legal context, an organizing idea must not "jar" with other truths, "grafting itself then upon the ancient body of truth, which thus grows much as a tree grows by the activity of a new layer of cambium."⁴⁴ Another way of saying this is that a legal "situation,"⁴⁵ to be valid, must be rooted in and justified by existing legal principle.

⁴² *Ibid.*

⁴³ Organizing ideas in this kind of setting must co-ordinate interdisciplinary action, and so be intelligible across professions (to both medical and legal actors).

⁴⁴ James, *Pragmatism*, *supra* note 13 at 36, cited in Radin, *supra* note 17 at 1709.

⁴⁵ Levi, *supra* note 26 at 1, referring to Dewey's concept of the "situation".

3.3.2 Legal pragmatism after Holmes: legal realism, brass tacks, and inclusive pragmatism

The legal scholar Richard Posner has described pragmatism as an “umbrella term for diverse tendencies,” united by a rejection of the “formalist idea... of law as a body of immutable principles”⁴⁶:

“a distrust of metaphysical entities (‘reality,’ ‘truth,’ ‘nature,’ etc.) viewed as warrants for certitude whether in epistemology, ethics or politics... an insistence that propositions be tested by their consequences, by the difference they make- and if they make none, set aside... an insistence on judging our projects, whether scientific, ethical, political or legal, by their conformity to social or other human needs rather than to objective impersonal criteria.”⁴⁷

Perhaps the most influential of these “tendencies” in law has been the American school of legal realism⁴⁸ or “brass tacks” pragmatism that incorporates the “mistrust of metaphysical entities” described by Posner together with an empirical approach to ascertaining what law “really” is (ie. getting down to brass tacks, “import[ing] a notion of moving past idle chatter to what is genuine and important... the notion that being pragmatic in one’s thinking involves getting past mere appearances to what is “really’ going on in law.”)⁴⁹ For Karl Llewellyn, getting down to brass tacks meant confining the study of law to the empirical study of conduct- “what officials and citizens do, not the reasons they give for doing what they do.”⁵⁰ Thomas Grey dismissed legal realism as a “cult of the concrete” that “denies all practical importance to generalisation or

⁴⁶ Posner, *supra* note 2 at 1656, 1663 (“[l]egal formalism is the idea that legal questions can be answered by inquiry into the relation between concepts and hence without need for more than a superficial examination of their relation to the world of fact”).

⁴⁷ Richard Posner, “What Has Pragmatism to Offer Law?” in Michael Brint & William Weaver, eds, *Pragmatism in Law and Society* (Boulder: Westview Press, 1991) at 35-36.

⁴⁸ The legal philosopher HLA Hart described legal realism as the view “that talk of rules is a myth, cloaking the truth that law consists simply of the decisions of courts and the prediction of them.” See HLA Hart, *The Concept of Law*, 2nd ed (Oxford: Oxford University Press, 1994) at 136.

⁴⁹ John P Goldberg, “Pragmatism and Private Law” (2012) 125:7 Harv L Rev 1640 at 1641-1645.

⁵⁰ Goldberg, *ibid* at 1643, citing Karl Llewellyn, “Some Realism about Realism: Responding to Dean Pound” (1931) 44:8 Harv L Rev 1222 at 1248.

abstraction”,⁵¹ a “freestanding” pragmatism disconnected from the epistemological concerns of classical philosophical pragmatism:

Law so conceived is a set of practical measures for cooperative social life, using signals and sanctions to guide and channel conduct. More precise and determinate general theories of the nature and function of law should be viewed with suspicion, at least when put forward to control practice... law itself imposes no absolute moral claims, though the rule of law is a political ideal worthy of respect and thus to be weighed in any individual’s deliberations about what he or she finally should do.⁵²

Ronald Dworkin has criticized legal pragmatism as a theory that judges “do and should make whatever decisions seem to them best for the community’s future [as in *Buck v Bell*], not counting any form of consistency with the past as valuable for its own sake”.⁵³ A judge who was pragmatic in this sense would not really believe that individuals had rights, for example, but merely act as if they did if and when doing so was conducive to a desired end. Readers “must have been shocked,” Dworkin asserts, at the idea that “anyone would propose pragmatism [so defined] as an eligible interpretation of our present practice.”⁵⁴ According to Dworkin, pragmatism fails as a description of what legal actors “really” do: legal actors *do* craft arguments on the basis of precedent, which they treat as binding, and really do believe themselves to be controlled by rules and principles.

Steven Smith, considering Dworkin’s critiques together with what he identifies as the major “themes” in legal pragmatism (the priority of experience; “intuition” as a method of theorizing and decision making; the prudent and sceptical pragmatist temperament) concluded that the “verdict on legal pragmatism” was, in the end, “an ambivalent one.” “We can benefit from pragmatism” according to Smith “only if we do not expect too much from it... It is a mistake to

⁵¹ “[N]o pragmatist” Grey asserts, “would endorse such an antipathy to generalization. All the major pragmatist figures accepted and asserted the importance of general principles and systematic thought; they insisted only that the test of abstractions must be their usefulness for action and concrete inquiry.” See Grey, “Legal Pragmatism”, *supra* note 10 at 824.

⁵² Thomas Grey, “Freestanding Legal Pragmatism” (1996) 18:1 *Cardozo L Rev* 21 at 41-42.

⁵³ Ronald Dworkin, *Law’s Empire* (Cambridge: Harvard University Press, 1986), at 95.

⁵⁴ Dworkin, *ibid* at 151. Steven D Smith suggests that, despite these protestations, Dworkin was himself a pragmatist, if we accept Thomas Grey’s account of Holmes’ classical legal pragmatism, as discussed above, “Legal Pragmatism”, *supra* note 10, (in which all thinking, including legal thinking, is inevitably historically situated). Steven D. Smith, “The Pursuit of Pragmatism” (1990 100(2) *Yale LJ* 409.

expect legal pragmatism to take us very far; it cannot solve our problems, nor even provide us with a method for solving our problems... [but is] valuable primarily as an “admonishment to avoid theoretical pretentiousness,” including its own.⁵⁵

Daniel Farber, rejecting the equation of pragmatism in law with brass tacks pragmatism/legal realism, has called Dworkin’s criticism of pragmatism a mistake (shared even by those “sympathetic” to pragmatism) that over-looks the conceptual underpinnings of classical pragmatist philosophy.⁵⁶ “The pragmatist philosophers” Farber notes “were keenly sensitive to the importance of tradition... as a necessary ingredient in all human reasoning” and, therefore, “the essential foundation for intellectual and social progress.”⁵⁷ Nor did the philosophical pragmatists reject generalised systems of theory and principle in law; writing about law, John Dewey “stressed the importance of systems in law, so as to make law as coherent and predictable as possible.”⁵⁸ “The pragmatist”, Farber concludes, “would like as much system as possible but is agnostic about how much this will really turn out to be.”⁵⁹ The feminist legal scholar Margaret Radin has called Dworkin’s critique an “irresponsibl[e] gerrymander[ing] of the word “pragmatism” to mean crass instrumentalism.”⁶⁰

The best critical spirit of pragmatism recommends that we take our present descriptions with humility and openness, and accept their institutional embodiments as provisional and incompletely entrenched. Pragmatism recommends this openness in the only way pragmatism can- because it seems to work best for human beings. It is time for the openness and critical spirit of pragmatism to infiltrate pragmatist legal theory. Feminism can lead the way.⁶¹

⁵⁵ Smith, *ibid* at 449.

⁵⁶ Richard Rorty described pragmatism as applied to the law as “banal”. See Richard Rorty, “The Banality of Pragmatism and the Poetry of Justice” (1990) 63:6 S Cal L Rev 1811 (“I think it is true that by now pragmatism is banal in its application to law.... everybody seems to now be a legal realist. Nobody wants to talk about a “science of law” any longer. Nobody doubts that what Morton White called “the revolt against formalism’ was a real advance, both in legal theory and in American intellectual life generally.” at 1811).

⁵⁷ Daniel A Farber, “Legal Pragmatism and the Constitution” (1987) 72:6 Minn L R 1331 at 1344.

⁵⁸ John Dewey, “Logical Method and Law” (1924) 10:1 Cornell LQ 17 at 24-25, cited in Farber, *ibid* at 1349.

⁵⁹ Farber, *supra* note 57 at 1349. “[T]he only way to answer this question is to decide cases, try to construct theories, and determine what level of generality works best.” *Ibid*.

⁶⁰ Radin, *supra* note 17 (“it is clear that he [Dworkin] is a pragmatist of sorts. Pragmatism is reflected in his commitment to the ubiquity of interpretation, and his concomitant commitment to finding meaning in assembling concrete events (institutional coherence and fit), rather than to measuring correspondence with abstract truth or justice” at 1722).

⁶¹ *Ibid* at 1726.

Radin identifies pragmatism's "core concern" as a "commitment to finding knowledge in the particulars of experience... It is a commitment against abstract idealism, transcendence, foundationalism, and atemporal universality; and in favor of immanence, historicity, concreteness, situated-ness, contextuality, embeddedness, narrativity of meaning."⁶²

If feminists largely share the pragmatist commitment that truth is hammered out piecemeal in the crucible of life and our situated-ness, they also share the pragmatist understanding that truth is provisional and ever-changing. Too, they also share the pragmatist commitment to concrete particulars. Since the details of our life are connected with what we know, those details matter. Thus, the pragmatist and the feminist both arrive at an embodied perspectivist view of knowledge.⁶³

John P. Goldberg has called for a rejection of brass tacks pragmatism in favour of what he calls "inclusive pragmatism" in law:

Inclusive pragmatism supposes that reality is complex and that it will not advance the cause of knowledge to assume that one comes to understand reality by stripping away superstructure to get to the base. Whereas the brass tacks pragmatist impatiently demands that we cut to the chase, the inclusive pragmatist calls for a patient exploration of the many facets of a phenomenon or problem.⁶⁴

Being an inclusive pragmatist means recognising that law includes both "concepts and action", acknowledging the ideological conflict between individualism and altruism without reducing the complexity of the law to this "simple dyadic opposition."⁶⁵ This inclusive, complex pragmatism is "linked to a commitment to engage legal doctrine in a constructive rather than deconstructive manner."⁶⁶

⁶² *Ibid* at 1707.

⁶³ *Ibid*.

⁶⁴ Goldberg, *supra* note 49 at 1650.

⁶⁵ *Ibid* at 1651.

⁶⁶ *Ibid* at 1655. "The general demotion of doctrinal analysis to lesser status within the modern US legal academy is in part a symptom of the dominance of brass tacks pragmatism and its commitment to getting behind mere appearances" *ibid* at 1656.

3.4 Pragmatism, bio-ethics and health law

The distinctive legal pragmatism described in the previous part has roots in the Metaphysical Club and the 19th century origins of pragmatism as a school of thought. The development of pragmatism as a distinct approach in the field of bio-ethics is a more recent development. Susan Wolf describes the “pragmatic turn” in bio-ethics as a rejection of “principlism”⁶⁷ (the idea that medical practice is ethical to the extent that it accords with antecedent abstract principles, and that the bio-ethicist’s task is to evaluate practice in terms of its accordance with or deviation from those principles.)⁶⁸ The rejection of essentialist, abstract principles in the context of bio-ethics, as in the legal context, has led to a focus on the empirical; “the rejection of deduction from grand and universal principles in favour of detailed attention to context, empirical realities, and differences among individuals and groups.”⁶⁹

As the legal pragmatist locates the law in the work of judges and other courtroom actors, the pragmatic approach in bio-ethics locates medical ethics in the work of clinical actors, and in the experience of the particular and contextualised patient (as opposed to a generic and abstract “patient” to whom abstract ethical principles refer). This attention to the detail of embodied experience has expanded the focus of bio-ethics beyond the generic patient “without problems of race, gender or resources,” creating what Wolf describes as a bio-ethics for the “privileged patient ... strong on proclaiming individual autonomy to choose, but weak on insisting on access to health care and the creation of choices for those who have few.”⁷⁰

“Health law” (defined by Wolf as concerning “mid-level” rules or laws operating in the medical context as opposed to the “high level” set of abstract principles set out in Beauchamp and Childress’ *Principles of Bio-Medical Ethics*) has, according to Wolf, taken a similar “pragmatic

⁶⁷ Susan Wolf, “Shifting Paradigms and Bioethics and Health Law: The Rise of a New Pragmatism” (1994) 20:4 Am J L & Med 395. See also, Glen McGee, 2nd ed, *Pragmatic Bioethics* (Boston: MIT Press, 2003); Eric Racine, *Pragmatic Neuroethics: Improving Understanding and Treatment of the Mind-Brain* (Boston: MIT Press, 2010); and John D Arras “Rorty’s Pragmatism and Bio-ethics” (2003) 28:5 J Medicine & Philosophy 597.

⁶⁸ Wolf describes principlism as a “post hoc rationalization that is often not an accurate reflection of actual decisional processes in bio-ethics.” See Wolf, *supra* note 67 at 403.

⁶⁹ *Ibid* (“John Dewey, William James, and Charles Sanders Pierce have come to the clinic and find much to criticize” at 398).

⁷⁰ *Ibid*.

turn”, rejecting the analysis of abstract, antecedent and controlling rules to “demand that health law be evaluated empirically to see how it works or does not work in the clinic.”⁷¹

We see health law now as a process only one part of which is middle-level rules and nicely drafted documents, statutes, and judicial decisions. That part is health law on paper. But all of that paper will be perceived, misperceived, or ignored by actors in health care settings. Further pressures will be brought to bear on how legal documents and dictates are understood. At the end of this long Rube Goldberg-like process will be a patient in a bed whose care will be influenced (or whose care will fail to be influenced) by the written law. Health law as a field is now more interested than ever in this entire process, the entire Rube Goldberg machine. The bottom line is not pretty documents or elegant opinions, but what happens to the patient in the bed. What we are learning now about what happens to that patient is de-stabilizing established legal approaches. That is the paradigm shift.⁷²

John Arras has described both legal pragmatism and pragmatism in bioethics and health law in terms of what he calls “freestanding pragmatism”, un-tethered to the “classical canon” of the philosophical pragmatists.⁷³ Freestanding pragmatism in bio-ethics “bears a remarkable resemblance to... freestanding pragmatism in legal studies”,⁷⁴ perhaps because both law and bio-ethics are fundamentally practical enterprises in which decisions affecting real people must be made.”⁷⁵ These freestanding pragmatisms are distinct from philosophical pragmatism that, for Arras, the two need not intersect:

[A] legal theorist can embrace all of the central tenets of freestanding pragmatism without committing herself in any way with regard to philosophical pragmatism, old (e.g. Dewey, James) or new (Rorty, Putnam). Conversely, one can embrace the original pragmatist and neo-pragmatist assaults on epistemological and metaphysical

⁷¹ *Ibid* at 410.

⁷² *Ibid* at 410.

⁷³ John D Arras “Freestanding Pragmatism in Law and Bioethics” (2001) 22 *Theoretical Medicine* 69 [Arras, “Freestanding Pragmatism”].

⁷⁴ Arras, “Freestanding Pragmatism”, *ibid* at 78, citing Richard Posner “Pragmatic Adjudication” in Morris Dickstein, ed, *The Revival of Pragmatism: New Essays on Social Thought, Law and Culture* (Durham: Duke University Press, 1998) at 235; Grey, “Legal Pragmatism”, *supra* note 10 at 787

⁷⁵ Arras, “Freestanding Pragmatism”, *supra* note 73 at 70.

foundationalism without necessarily being led to FLP [freestanding legal pragmatism].⁷⁶

Arras concludes that if pragmatism in law and bio-ethics is understood as freestanding pragmatism, “we are all pragmatists now: and it is “unclear how much of a distinctive contribution pragmatism can make to contemporary methodological discussions within bioethics.... [freestanding pragmatists] “[s]ometimes... sound as though their pragmatism amounted to little more than paying attention to factual details.”⁷⁷

In sum, although pragmatism has been applied to law from the earliest days of the Metaphysical Club, the methodology of pragmatic inquiry has not. Pragmatism in law and, more recently, in bio-ethics, has generally eschewed the epistemological concerns of philosophical pragmatism, a freestanding pragmatism that “emphasizes ... the richness of factual detail in which moral problems are embedded, achieving the ‘best results’ in concrete circumstances, an eclecticism with regard to competing philosophical ‘grand theories,’ flexibility with regard to the use of moral principles, the denial of foundationalism, and in some instances a stance of solidarity with the marginalized and oppressed sectors of society. [*Bell v Buck* aside].”⁷⁸ By incorporating the epistemological framework and structure of philosophical pragmatism and pragmatic inquiry, together with the “richness of factual detail” described above and what Radin called a “commitment to finding knowledge in the particulars of experience,” the methodology used in this study is a distinctive approach in legal research.

3.5 Pragmatic Inquiry: Research Structure and Design

Consistent with the methodology of pragmatic inquiry (incorporating an “appreciation for the factual detail in which moral problems are embedded”) this research study consists of three inter-related parts or phases:

- A theoretical examination of the nature of the mental capacity construct as a coherent “organizing idea” in the adult guardianship context, and the ethical implications of that idea as implemented in the particular context of guardianship in relation to dementia in

⁷⁶ *Ibid* at 73.

⁷⁷ *Ibid* at 70-71.

⁷⁸ *Ibid* at 70.

old age; examination and articulation of vulnerability an alternative organizing idea in this field of practice;

- An empirical examination of the mental capacity construct as understood and “used” by legal and medical actors playing a role in the implementation of adult guardianship, together with an inquiry into the idea of “vulnerability” as understood by those actors;
- A judgment regarding the validity of mental capacity in the context of guardianship for persons experiencing dementia in old age in comparison to the vulnerability model set out in the first stage, and tested/refined through the second (a focus justified by the continuing role for guardianship, as opposed to supported decision making, in this context).

The first phase examines the “continuity” of the mental capacity construct in the guardianship context with existing “truths” in a system of belief, followed by an analysis of the theoretical coherence of the mental capacity construct as an organizing idea in the context of guardianship in relation to dementia in old age. On the basis of this theoretical examination, I propose an alternate idea or theory of vulnerability as a potentially more effective, adequate, and coherent organizing idea, resolving the doubt created by mental capacity in the adult guardianship field in a way that “increase[s] *sensitivity*, increasing responsiveness to the needs of a larger and larger variety of people and things”- “moral progress”, as defined by Rorty.⁷⁹

The second phase of this research study is an empirical examination of the mental capacity construct examined in the first phase, and the preliminary theory of vulnerability set out at the conclusion of that phase. Data was collected through semi-structured interviews carried out among the following two sets of participants:

Set A: 11 health professionals whose work involves the evaluation of mental capacity for older adults (members of interdisciplinary health teams)

Set B: 7 retired judges

⁷⁹ Richard Rorty, *Philosophy and Social Hope* (London: Penguin Books, 1999) at 81.

Data collected from each set was analyzed independently to generate categories/themes specific to that set; the categories/themes generated from Set A and from Set B were then compared to one another, and additional themes or categories identified on the basis of that comparison. The empirical research design and applied thematic analysis method used are described in more detail in Chapter 4.

The number of research participants involved in the second phase was sufficient for the purposes of saturation, despite their relatively small number (especially in Set A), given the subject matter and interview participants. “Saturation” in qualitative research (the standard through which sampling size or number of interviews is determined) refers to the point at which no new information or themes are observed in the data.⁸⁰ Relatively small samples have been found to be sufficient for saturation where participants possess expertise about the domain of the inquiry (“cultural competence”) and where both participants and the subject of the inquiry are located within a particular cultural context;⁸¹ samples of four interviews have been found to yield extremely accurate information with a high confidence level if the interviewees possess a high level of expertise or “competence” in the subject of inquiry.⁸² Small sample saturation is also enhanced where participants answer questions independently of one another; where interview questions comprise a coherent domain of knowledge (as opposed to unstructured and highly exploratory interviews), and where participant-sets are homogenous.⁸³ Both sets of interview participants met all of these requirements. Each set was culturally⁸⁴ homogenous (in terms of professional culture), and interview questions were narrowly focussed in this particular cultural domain.

The interview data collected through the empirical research carried out in the second stage was analyzed using the method of “applied thematic analysis” (discussed further in Chapter 5).

⁸⁰ See, Janice M Morse, “Designing Funded Qualitative Research” in Norman Denzin & Yvonna Lincoln, eds, *Handbook for Qualitative Research* (Thousand Oaks: Sage, 1994) 220 at 220.

⁸¹ Greg Guest, Arwen Bunce & Laura Johnson, “How Many Interviews Are Enough? An Experiment with Data Saturation and Variability” (2006) 18:1 *Field Methods* 59; A Kimball Romney, William Batchelder & Susan Weller “Culture as Consensus: A Theory of Culture and Informant Accuracy” (1986) 88:2 *American Anthropologist* 313.

⁸² Batchelder & Weller, *ibid* at 326.

⁸³ *Ibid.*

⁸⁴ “Culture” here referring to professional culture.

Thematic analysis “mov[es] beyond counting words and phrases to focus on identifying and describing both implicit and explicit ideas within the data, that is themes.”⁸⁵ *Applied* thematic analysis is carried out for the “common end purpose of solving practical problems”⁸⁶ rather than “pure” research (“oriented towards furthering existing knowledge for the sake of curiosity and knowledge itself.”)⁸⁷ This approach may be contrasted with grounded theory, in which the researcher approaches the data without objective (ie. something she wants to know, or a theory she wants to test) but, rather, analyses data “to construct theories that are “grounded” in the data itself.”⁸⁸ In this way, applied thematic analysis is consistent with the objectives of pragmatic inquiry: to examine and resolve specific problems arising in a particular environment or “situation” creating doubt about the validity of the organizing idea at work.

The third stage of pragmatic inquiry is *judgment*; as between the organizing idea under examination (ie. the mental capacity construct in medico-legal adult guardianship) and the alternative idea of vulnerability developed through this research. The judgment phase is set out in Chapter 7.

The deeply interdisciplinary nature of this research study underlies all aspects of this research design. I have approached adult guardianship, the subject of this research, as an interdisciplinary practice in which legal and medical actors work together, within an over-arching legal framework, to produce a legal response to a problem that is primarily conceptualized in bio-medical terms. The theoretical and empirical phases of pragmatic inquiry in this study have therefore considered information from both legal and medical sources in order to understand and evaluate the current organization of adult guardianship and a potential re-organization that is both theoretically coherent (from both a legal and a medical perspective) and capable of consistent implementation. The choice of Dewey’s theory of pragmatic inquiry (distinct from “free-standing” legal pragmatism) is also consistent with the inter-disciplinary nature of the subject matter under consideration. Dewey’s focus on “situations” rather than individual

⁸⁵ Greg Guest, Kathleen M MacQueen & Emily E Namey, *Applied Thematic Analysis* (Los Angeles: Sage, 2012) at 10.

⁸⁶ *Ibid.*

⁸⁷ Kathy Charmaz, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (Thousand Oaks: Sage, 2006) at 2.

⁸⁸ *Ibid.*

decision-makers, and the role he ascribes to ideas in terms of organizing and re-organizing those situations, makes Dewey's methodology particularly appropriate in relation to an inter-disciplinary field of practice such as adult guardianship.

I came to this project as a lawyer and legal academic; my frame was, very much, a legal frame. My legal knowledge includes private law, and my work in that area has given me a fairly deep understanding of equity and the common law in addition to adult guardianship and those areas of health law dominated by legislation. This knowledge and understanding has been helpful to me in terms of situating or rooting the ideas developed through this research in fundamental legal principle; that rooting was, for the pragmatist philosophers, essential to the workability of new ideas. The *non*-legal knowledge that I have been exposed to through this study (including both methodology and information) has been crucial to my ability to see outside of that legal frame, to think in a different way about long familiar subjects. This inter-disciplinary looking outside of one's own conceptual framework is another tenet of the epistemology of philosophical pragmatism.

Chapter 4. Theoretical Inquiry (Pragmatic Inquiry Phase 1): Mental Capacity, Vulnerability, and Guardianship for the Old

4.1 Introduction

This chapter is the first phase of the pragmatic inquiry carried out in this research study, including:

- a theoretical examination of the mental capacity construct as a coherent “organizing idea” in the law, including adult guardianship
- an examination the mental capacity construct as implemented in the particular context of guardianship in relation to dementia in old age; and
- on the basis of that examination, proposal of a vulnerability theory as an alternative organizing idea in this context. The vulnerability theory set out in this chapter will be tested and refined through the empirical research described in Chapters 5 and 6, and restated (as refined) in Chapter 7.

The first part of this Chapter examines the nature of the mental capacity construct as a rhetorically constructed idea, its function in the law, and its relationship to the idea of autonomy in legal discourse and liberal/philosophical theory. The second part of this Chapter examines how the mental capacity construct works, as a legal mechanism, to resolve specific autonomy-problems arising in several (civil)¹ legal contexts: agreements, bequests, and transactions; health care consent; advance planning; and adult guardianship. This part includes an overview of critiques of mental capacity with respect to each of these contexts. The third part of this Chapter examines the mental capacity construct in the context of guardianship for the old (where a guardian is appointed for the first time as a response to the *loss* of mental capacity in old age). This focus incorporates philosophical pragmatism’s “commitment to finding knowledge in the particulars of experience.” As noted by William James, while abstractions (such as a category of

¹ The mental capacity construct is also used, in a particular way and for a particular purpose, in the criminal law context. The criminal law is beyond the scope of this study.

the mentally incapable) are useful as a means of organizing experience they should never be ascribed “a higher grade of reality.”²

The fourth and final part of this chapter examines vulnerability as an idea with multiple meanings and connotations within and outside of the law, and considers whether a theory of vulnerability can provide the basis for a coherent post-capacity adult guardianship paradigm. I suggest that this theory of vulnerability has begun to take shape in alternate theories or models of mental capacity developed outside of legal discourse. These mental capacity models are more coherently understood as *de facto* theories of vulnerability, connecting with concepts of vulnerability that have developed in equity and the common law. That intersection situates vulnerability within the broader legal context, rooting vulnerability theory in legal principle in a way that creates the “minimum of jolt, a maximum of continuity”³ identified by William James as essential to the truth of a new idea.

4.2 The mental capacity construct: law, autonomy, and the bio-medical self

Adult guardianship is “organized,” in Dewey’s sense of that word, by a medico-legal construct of mental capacity.⁴ The mental capacity construct underlies and structures the processes through which a guardian is appointed (following a legal finding relating to capacity); the requirement of medical evidence as the basis for that finding (in accordance with the fundamentally bio-medical nature of the mental capacity construct); and the scope/nature of the guardian’s authority and task (which follows the scope/nature of the capacity finding). The mental capacity construct also justifies the interference with autonomy that guardianship entails by tying autonomy to a mental capacity threshold. On one side of the threshold, the interference with autonomy created by

² Brian Z Tamanaha, *Realistic Socio-Legal Theory* (Oxford: Clarendon Press, 1997) at 27, quoting William James, *Pragmatism and the Meaning of Truth* (Cambridge: Harvard University Press, 1975) at 275. See also Thomas Grey, “Holmes and Legal Pragmatism” (1989) 41:4 *Stan L Rev* 786 at 787, for Thomas Grey’s discussion of Oliver Wendell Holmes on the relationship between abstraction and legal pedagogy.

³ Tamanaha, *supra* note 2 at 275.

⁴ John Dewey, *Reconstruction in Philosophy* (Boston: Beacon Press, 1948) (“[i]f ideas, 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, eliminate defects, if they increase confusion, uncertainty and evil when they are acted upon, then are they truly false” at 156).

guardianship is never justified; on the other side, the mentally incapable individual has no autonomy to interfere with.⁵

4.2.1 The mental capacity construct

A “construct” is an idea or theory containing various conceptual elements.⁶ These complex ideas are produced or “constructed” through social practices of different kinds, including discourse: “meanings, metaphors, representations, images, stories, statements and so on that in some way create a particular version of events.”⁷ The construction of ideas through discourse “allows us to see things that are not ‘really’ there, and once an object has been elaborated in a discourse it is difficult not to refer to it as if it were real.”⁸ *Rhetorical* discourse (“a discourse used to bolster particular versions of the world and protect them from criticism”) constructs a particular version of truth as “solid and factual while simultaneously undermining alternative descriptions”.⁹ Rhetorical discourse explains past truths as mistakes attributable to the ignorance and unsophistication of previous generations; the emergence of “real” truths is explained as part of a more general social progress.

The medico-legal construct of mental capacity is this kind of complex idea, in which a particular bio-medical theory about the relationship between brain function and decision-making is inextricably intertwined with fundamental legal principles of autonomy, liberty, and dignity. These legal principles are themselves of-a-piece with the philosophical idea of autonomy as located in the process of decision-making, as opposed to the substantive nature of decisions made. The power of the mental capacity construct as a real or “out-there”¹⁰ truth has derived from its connection with these ideas, and the intersection of two culturally powerful and

⁵ The supported decision making model, by removing the interference of guardianship, would make this kind of threshold determination irrelevant.

⁶ Vivien Burr, *Social Constructionism*, 3rd ed (London: Routledge, 2015). Richard Rorty famously described William James and John Dewey as “waiting at the end of the road” which Foucault and other post-modern constructivists were “currently travelling.” See Richard Rorty, *Consequences of Pragmatism* (Minneapolis: University of Minnesota Press, 1982) at xviii.

⁷ Burr, *supra* note 6 at 3-8. Burr describes discourse as a “system of statements which constructs an object.” The “finding” of mental capacity through the medical and legal processes discussed in this research study are additional “social practices” through which “mental capacity” is constructed.

⁸ Ian Parker, *Discourse Dynamics: Critical Analysis for Social and Individual Psychology* (London: Routledge, 1992) at 5.

⁹ *Ibid* at 107.

¹⁰ Existing outside of human interference. See Jonathan Potter, *Representing Reality: Discourse, Rhetoric and Social Construction* (London: Sage, 1996) at 105.

authoritative rhetorical discourses: the naturalizing discourse of the bio-medical and the powerful legal rhetoric of individual autonomy as negative liberty or “freedom from”¹¹ interference by the state and by others.

As a bio-medical theory about how the brain works, mental capacity refers to the ability of the human brain to engage in the process of making a “decision,” defined in the *Oxford English Dictionary* as “a conclusion or resolution reached after consideration.” “Consideration” involves foreseeing and understanding the consequences of making a particular decision, and weighing those consequences against one another in connection with one’s own interests and priorities. This medico-legal idea of mental capacity is therefore synonymous with decision-making ability. The decision that results from this process will be considered the individual’s “own” true decision; the person whose brain cannot carry out this process is incapable of making real or true decisions. This *cognitive* decision-making process cannot be apprehended or seen directly but only through its manifestation in the performance of thinking tasks such as judging, comprehending and remembering. The medical assessment of mental capacity is, therefore, carried out through the evaluation of that performance as indicating those internal cognitive processes.

4.2.2 Autonomy and the mental capacity construct

The bio-medical account of decision-making described above parallels the “process” theory of autonomy in modern philosophy; the idea that “autonomy”, as the definitive characteristic of personhood, is located in and produced by the process of decision making (and not the substantive character of the decisions made).¹² Conversely, individuals who cannot engage in the process of autonomous decision-making are not, truly, persons. Harry Frankfurt used the term “wanton” to describe humans who do not have the capacity to think rationally and (therefore)

¹¹ Isaiah Berlin, “Two Concepts of Liberty” in *Four Essays on Liberty* (Oxford: Oxford University Press, 1969) 118.

¹² See for example, Gerald Dworkin, “The Concept of Autonomy” in John Christman, ed, *The Inner Citadel: Essays on Individual Autonomy* (New York: Oxford University Press, 1989) at 54 [Dworkin, “Concept of Autonomy”]; Harry G Frankfurt, “Freedom of the Will and the Concept of a Person” (1971) 68:1 *J Philosophy* 5; This theory of autonomy has been challenged by the emerging theory of relational autonomy, as discussed further in Chapter 5. See e.g. Natalie Stoljar, “Autonomy and the Feminist Intuition” in Catriona Mackenzie & Natalie Stoljar, eds, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000).

autonomously; Frankfurt described the class of wantons as “includ[ing] all nonhuman animals that have desires and all very young children. Perhaps it also includes some adult human beings as well [such as the “senile”].”¹³ The philosopher Joel Feinberg has suggested 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.”¹⁴ Even the *mis-*ruled individual (i.e. the person who makes substantively poor decisions), “like a badly governed nation, may retain his sovereign independence nevertheless” excluding only individuals incapable of “rule” of any kind (because incapable of rational thought): “infants, insane persons, the severely retarded, the senile, and the comatose.”¹⁵ Martha Fineman has drawn on this metaphor of the autonomous self as sovereign state to describe the “liberal subject” for and around whom the legal system has been constructed:

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.¹⁶

The individual who is incapable of making her “own” decisions has no autonomy to be violated; a *lawless* as opposed to a mis-ruled state.

Legal capacity, referring to an individual’s ability to make “true” decisions that the law will recognise as valid and enforceable,¹⁷ is inextricably intertwined with this bio-medical idea *and* with the philosophical process theory of autonomy (i.e. the idea that personal autonomy is located in and exercised through the decision-making process). Liberty and autonomy are intertwined, in turn, with a particularly legal idea of dignity. The “right to make personal decisions without interference by the state” was identified by the Supreme Court of Canada as

¹³ Frankfurt, *supra* note 12 at 12.

¹⁴ Joel Feinberg, “Autonomy” in Christman, *supra* note 12 at 27 [Feinberg, “Autonomy”]; See also Frankfurt, *supra* note 12; Gerald Dworkin, “Autonomy and Behaviour Control” (1976) 6:1 *Hastings Center Report* 23 at 25; Gerald Dworkin, “Concept of Autonomy”, *supra* note 12 at 54.

¹⁵ Feinberg, “Autonomy”, *ibid.* at 28.

¹⁶ Martha Fineman, *The Autonomy Myth: A Theory of Dependency* (New York: New Press, 2005) at 18 [Fineman, *The Autonomy Myth*].

¹⁷ Law Commission of Ontario, “A New Paradigm for Protecting Autonomy and the Right to Legal Capacity”, by Michael Bach & Lana Kerzner (Toronto: LCO, 2010) online: <https://www.lco-cdo.org/wp-content/uploads/2010/11/disabilities-commissioned-paper-bach-kerzner.pdf>.

“an aspect of the respect for human dignity on which the *Charter* is founded” (the “basic theory underlying the *Charter*, namely that the State will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating those choices to any one conception of the good life”)¹⁸ and a “critical component of the right to liberty” protected by section 7 of the *Canadian Charter of Rights and Freedoms*.¹⁹ In *Re Koch* (cited by the Supreme Court of Canada in *Starson v Swayze*)²⁰ Quinn J. described “a right knowingly to be foolish” and to “voluntarily assume risks”; [t]he dignity of the individual is at stake.”²¹ The idea of mental capacity as objective (because scientific) is essential to its justification of autonomy-interference, protecting individual decisions from “subordination” “to any one conception of the good life.”²²

4.2.3 Autonomy problems in legal context

The autonomy construct described above is an abstraction. Autonomy is given concrete meaning and effect in a number of legal contexts in which impaired mental capacity justifies interferences of specific kinds. Each context engages a different kind of autonomy interest: the autonomy interest engaged in the law of wills is testamentary freedom; in the law of contracts, contractual freedom;²³ the doctrine of trespass protects the person’s right to exclusive possession of her or his body. Of the legal contexts discussed in the following section, adult guardianship engages the broadest range of autonomy interests: controlling one’s own body without unconsented to interference (including medical interference); the ability to make valid/enforceable agreements and transactions; “everyday” relationships and decisions (what to eat, what to wear, whether to smoke or drink, for example); deciding where to live and with whom.

Laws applying in each of these contexts (including the *Canadian Charter of Rights and Freedoms*) protect the autonomy interests described above and provide for interference with that interest where the autonomy interest engaged comes into conflict with a counter-vailing legal

¹⁸ *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, Appendix II of RSC 1985 (the idea of autonomy as a right to freedom from interference by others [private individuals and the state] also underlies the common law trespass torts [trespass to the person, trespass to property, false imprisonment, and assault]).

¹⁹ *Ibid.*

²⁰ 2003 SCC 32 at para 76; (2003) 1 SCR 722.

²¹ *Koch (Re)* (1997), [1997] OJ No 1487 at 17, 33 OR (3d) 485 [ONSC], Quinn J.

²² *Ibid.*

²³ e.g. The freedom to contract.

principle or value. In relation to agreements, the countervailing principle is *fairness*: it would not be fair to hold an individual to the consequences of a decision that was not, truly, her own. In relation to will-making, the countervailing principle is fairness of a different kind; enforcing a non-genuine bequest would violate the fundamental principle in the law of wills, to effect to testator's intent. The default rules of intestacy are assumed to provide a closer approximation of testamentary intent than a bequest that was not truly intended. The mental capacity construct works together with the doctrines of equitable fraud (undue influence and unconscionability)²⁴ to resolve the autonomy problem arising in these contexts (distinguishing genuine from non-genuine decisions, protecting the former, and requiring interference with the latter). In the context of medical treatment, the mental capacity construct enables medical treatment on the basis of the common law doctrine of necessity where the individual cannot understand the consequences of refusing consent or where she is unable to express or effect any choice (the person in a coma, for example).²⁵ In the case of *In Re F*, Lord Griffiths described necessity (as a defence to an interference that would otherwise be a trespass to the person) as “inextricably inter-related” with the public interest, and with the “humane development” of the law:

Why is it necessary that the mentally incompetent should be given treatment to which they lack the capacity to consent? The answer must surely be because it is in the public interest that it should be so. In a civilised society the mentally incompetent must be provided with medical and nursing care and those who look after them must do their best for them.²⁶

The necessity-based justification for interference at common law has been codified as the “emergency exception” in modern health care consent legislation providing for health care treatment without consent. Undue influence applies to consent to health treatment as in other contexts (on the basis that it would be unfair to hold the individual to the consequences of a decision that was not “really” her own).²⁷ The nature of what is being consented to- interference

²⁴ As discussed further, *infra*, the common law applying to “insane delusions” also applied in the wills context.

²⁵ The common law defence of necessity underlies the health care consent legislation discussed *infra*.

²⁶ *In Re F*, [1991] UKHL 1, [1990] 2 AC 1 at 19 [*In Re F*].

²⁷ See, *Re T (Adult: Refusal of Medical Treatment)*, [1992] 4 All ER 649, [1992] 3 WLR 782 (CA) [*Re T*]; *Mrs U v Centre for Reproductive Medicine*, [2002] EWCA Civ 565.

with one's body- means that undue influence is used infrequently in relation to health care consent despite its theoretical applicability, however.

The autonomy problem in adult guardianship is often articulated as a conflict between autonomy and "protection," resonating with the language and conceptual paradigm of the *parens* based guardianship. Protection is a problematic justification for the broad interference with autonomy that guardianship entails: as discussed in Chapter 2, the over-arching objective of the 20th century reforms to medico-legal adult guardianship was to replace the *parens patriae* paradigm. As described in Chapter 2, guardianship reform was intended to re-invent guardianship as a mechanism for *enabling* autonomy to the fullest possible extent on the other side of the mental capacity threshold (the substitute enacting the autonomous decisions the person would have made if capable of doing so). Post-guardianship reform, the autonomy problem in adult guardianship is more coherently understood in terms of a conflict between the broad and multifaceted autonomy interest engaged in that context, the complex public interest based necessity principle described in *In Re F*, and the fairness/public interest principles engaged by the doctrines of equitable fraud.

4.3 Mental capacity in legal context

In each of the legal contexts discussed below, the mental capacity construct works to resolve one or more autonomy problems specific to that context. In each of these contexts- with the exception of adult guardianship- the doctrines of equity²⁸ provide an alternate explanation for how and why a person's apparent decisions (her mere choices) can be un-genuine; not really her own. Where this is the case, equity provides for these mere choices to be over-ridden. The equitable analysis is missing from adult guardianship although, I suggest, it may be covertly folded into the mental capacity determination on an *ad hoc* and unprincipled basis (and not on the principled basis the doctrines prescribe).

As discussed below, mental capacity appears to work most successfully (without significant critique) in private law contexts in which the contextual analysis provided by the doctrines of

²⁸ Undue influence and unconscionability.

equity applies: wills, transfers, and agreements.²⁹ I suggest that the inadequacy/instability of mental capacity in the guardianship context, in particular, flows in part from the absence of these complimentary equitable doctrines.

4.3.1 Agreements, bequests, transactions

Within and for the purposes of the law relating to wills, agreements, and transactions (including contracts and gifts) the mental capacity construct appears to “succeed in its office” without controversy or confusion. The mental capacity question in these contexts goes to the validity (and therefore enforceability) of the individual’s decision to enter into the agreement, make the bequest, etc.; if the person is not mentally capable of making the decision in question, the decision is a mere choice (not a true decision) and will not be enforced. The test in each context is whether the person is mentally capable of understanding and appreciating the nature and consequences of the decision in question at the time that decision is made. In relation to will-making, for example:

To lack testamentary capacity does not mean that the testator must be in a perpetual state of substandard competence. Seemingly rational persons may be without it, while seemingly compromised persons may possess it. A testatrix’s cognitive and psychological state is amorphous and seldom static. It may change and fluctuate slightly or wildly, such that at times she is not of sound mind, while at other times she is perfectly lucid. Accordingly, a will made by a compromised testatrix executed during a lucid interval may still be valid.... The standard of mental capacity required to make a valid will does not exclude eccentric, frivolous, capricious, absurd or unfair wills.³⁰

These observations apply equally to other kinds of agreements (and are particularly apposite in the context of dementia in old age, as discussed *infra*). Where a person is found to have been incapable of making the decision in question, the agreement, testamentary disposition or transaction based on that decision will be set aside.

²⁹ Marriage is the exception; the non-applicability of equity in this context has also been identified as a source of problems.

³⁰ *Laszlo v. Lawton*, 2013 BCSC 305 at paras 191-193, 45 BCLR (5th) 125 [*Laszlo*].

The doctrines of equitable fraud (undue influence and unconscionability) provide another basis for setting decisions aside in these contexts (with the exception of marriage, to which undue influence does not apply). Unlike the bio-medical mental capacity construct, these equitable doctrines are concerned with vulnerability arising through the intersection between the individual and his or her relationship context. This kind and quality of vulnerability is not restricted to members of “vulnerable populations” (as discussed later in this Chapter); a person may be vulnerable to undue influence in the context of her relationship to a spouse³¹ or adult child,³² for example, but not outside of that relationship.

The two doctrines of equitable fraud are related, but distinct, protecting different interests (both public and private). Undue influence refers to one person’s influence over another to the extent that the person’s decision is not truly her own. Influence may be exerted intentionally through manipulation, threats or coercion but it may also be exercised unintentionally, where the influence arises by reason of a relationship between the parties “in which the potential for domination is inherent in the relationship itself”³³ giving rise to a presumption of undue influence where the weaker person in the relationship confers a benefit on the stronger. That presumption can be displaced by evidence (usually independent legal advice) that the weaker person freely chose to confer a benefit on the stronger person in the relationship. The presumption effectively places responsibility on the stronger party to ensure that a decision to benefit her was freely made; the court “interferes not on the ground that any wrongful act has been committed by the donee but on the ground of public policy and to prevent the relations which existed between the parties and the influence arising therefrom from being abused.”³⁴

The purpose of the doctrine of unconscionability, in contrast, is to prevent persons from deriving benefit through the deliberate exploitation of power imbalance. Birks and Chin define the distinction in terms of “wicked exploitation” (unconscionability) and “impaired consent” (undue

³¹ See *Royal Bank of Scotland v Etridge No. 2*, [2001] UKHL 44.

³² See *Avon Finance Co. v Bridger*, [1985] 2 All ER 281 (CA).

³³ *Geffen v Goodman Estate*, [1991] 2 SCR 353 [*Geffen v Goodman Estate*].

³⁴ *Lloyd’s Bank v Bundy*, [1974] 3 All ER 757 (CA) [*Lloyd’s Bank*]. “Abuse” is used by Sir Sachs in this passage (quoting from the judgment of Lord Justice Cotton in *Allcard v Skinner* (1887), 36 Ch D 145 [*Allcard v Skinner*]) to describe failure by the dominant person in the relationship to carry out this responsibility (“that word in the context means no more than that once the existence of a special relationship has been established, then any possible use of the relevant influence is, irrespective of the intentions of the persons possessing it, regarded in relation to the transaction under consideration as an abuse- unless and until the duty of fiduciary care has been shown to be fulfilled or the transaction is shown to be truly for the benefit of the person influenced. This approach is a matter of public policy” at 171).

influence).³⁵ The first is “defendant sided” (focused on the behaviour of the defendant); the second is “plaintiff sided” (concerned with the experience of the plaintiff).³⁶ Equity intervenes in cases of unconscionable transactions to preventing exploiters from using the mechanisms of the law to benefit themselves at the expense of others, deterring future exploitation which is socially harmful in addition to the harm caused to individuals.

The law of wills also provides that “insane delusions” will invalidate a will or part of a will where the delusion causes the will-maker to make a gift she would not have made if free from that delusion. Insane delusions are distinct from mental capacity more generally, and an individual might be mentally capable in all other respects yet subject to an insane delusion distorting her will-making decisions. A delusion has been defined as “insane” for this purpose where the will-maker “persistently believes supposed facts (which have no real existence except in his perverted imagination) against all evidence and probability and conducts himself however logically upon the assumption of their existence.”³⁷ “[I]f insane suspicion and aversions takes the place of natural affection, if reason and judgment are lost and the mind becomes prey to insane delusions *calculated to interfere with and disturb its functions* and to lead to a testamentary disposition due only to their baneful influence, in such a case it is obvious that a will made under such circumstances should not stand.”³⁸ Insane delusions of this kind must be distinguished from eccentricity or testamentary decisions that seems unkind or that we might not approve of (a decision to disinherit a son married to a Norwegian because of an extreme aversion to Norwegians, for example, is not commendable but it is not the product of an “insane delusion”).³⁹

The evaluation of mental capacity, equitable fraud, insane delusions, etc. in these contexts is made by legal actors at the point of transaction (the lawyer making the agreement or will, the marriage officiant)⁴⁰ and retrospectively where an action is brought to have the

³⁵ Peter Birks and Chin Nyuk Yin “On the Nature of Undue Influence” in Jack Beatson & Daniel Friedman, eds, *Good Faith and Fault in Contract Law* (London: Clarendon Press, 1995) 57.

³⁶ *Ibid.*

³⁷ *Boughton v Knight* (1873), LR 3 P&D 64, per Sir James Hannen.

³⁸ *Banks v Goodfellow* (1870), 565 LR 5 at 549 per Cockburn CJ; See also, *Skinner v Farquharson*, (1902) 32 SCR 58.

³⁹ *Dynna v Grant* (1980), 6 ETR 175 (Sask CA).

⁴⁰ Although transactions such as wills and sales, for example, do not *require* legal input.

agreement/transaction/bequest set aside.⁴¹ These legal evaluations may but need not include a consideration of medical evidence; this is more likely in cases of retrospective evaluation, less likely at the point of transaction (when the will, agreement or transaction is made or carried out). It is the responsibility of the legal gatekeeper effecting the transaction to determine whether the individual's apparent decision is non-genuine mere choice (in which case he or she must not proceed).⁴² Where a retrospective evaluation a person's mental capacity (or undue influence, insane delusions etc.) is made, the consequence of a finding that the person's decision was not valid is the setting aside of the impugned sale, marriage, bequest, etc.

Mental capacity, insane delusions (regarding wills) and the doctrines of equitable fraud are used in the context of wills, agreements and transactions with respect to a particular kind of autonomy problem: what to do about the *mere* choice of an individual who, while capable of effecting that mere choice cannot make a genuine decision (as opposed to the person who cannot effect choice of any kind).⁴³ As a matter of theory and legal doctrine, mere choices of this kind are problematic *because* they are not true or real decisions and therefore have no legal meaning. In practice, mere choices will become problematic only where they produce results that are perceived as harmful to the individual's interests and/or (in the case of wills) harmful to the interests of others in ways that the individual would not have genuinely adopted as her own in the absence of her incapacity, insane delusions, or undue influence. These legal and equitable rules have both a public and a private aspect; to protect the true autonomy of the individual by refusing to enforce false (because non-genuine) mere choices and to dis-incentivize exploitation by others. The public has an interest in actively dis-incentivizing exploitation of this kind that intersects with but is distinct from the private interest in fairness and autonomy.

⁴¹ In the case of wills, the default dispositions set out in the intestacy hierarchy (as a default, the dispositions the law presumes a person would have made unless otherwise specified) will apply, an outcome more likely to coincide with the genuine /autonomous decisions the will-maker would have made if able to do so.

⁴² Regarding wills, the courts have emphasised the nature of evaluation at the point of transaction as a legal determination, a responsibility that cannot be delegated/offloaded onto medical opinion. See *Laszlo*, *supra* note 30; *Kournosoff Estate v Chapman*, 2000 BCSC 1195; *Duschl v Duschl Estate* (2008), 39 ETR (3d) 229 (ONSC).

⁴³ If the person was not capable of effecting any kind of choice, she or he would not have been able to make or attempt the will, agreement or transaction in question..

The mental capacity construct has not been a source of controversy regarding wills, agreement and transactions; in Dewey's terms, it appears to have "succeeded in its office" in terms of resolving the autonomy problems arising in these contexts. The mental capacity construct has been more troublesome with respect to marriage, to which the law relating to agreements generally applies with the exception of undue influence. The very low threshold of capacity for valid marriage, combined with the exclusion of undue influence, has created a fertile ground for exploitation through marriage. I suggest that one reason for the success of mental capacity in these contexts (excluding marriage) is the embedding of mental capacity in a broader body comprised of legal and equitable doctrines that, taken together, provides a more subtle and varied account of what it means to be an autonomous decision-maker.

4.3.2 Health care decision-making

At common law, medical treatment (as a form of interference with the person) is a trespass to the person unless the individual has consented to that interference. Mental capacity, as the capacity to consent, is engaged in the health care context because of this rule. Medical treatment without consent was justified in the common law (where the person was incapable of giving consent) by the doctrine of necessity; "[o]therwise they would be deprived of medical care which they need and to which they are entitled."⁴⁴ Necessity justified what would otherwise be trespass to the person in both emergency situations (the unconscious accident victim, for example) and where the individual's inability to consent was longer lasting or permanent. The theoretical justification in either context was the same.

The operation of these common law rules has been replaced in all Canadian provinces by legislation relating to health care consent (by enabling substitute decision-makers for health treatment, creating advance directives,⁴⁵ providing a default list of substitute decision-makers, and/or codifying the common law doctrine of necessity to enable treatment without consent in emergency situations).⁴⁶ Despite significant differences between the provinces, the over-arching scheme is the same: direct consent if possible (including advance directives); substitute consent

⁴⁴ *In Re F*, *supra* note 26 at 4.

⁴⁵ In which the individual provides or with-holds her consent to treatment "in advance."

⁴⁶ In British Columbia, see the *Representation Agreement Act*, RSBC 1996, c 405, and the *Health Care Consent and Care Facility Admission Act* RSBC 1996, c 181. With regards to health care decision making, note that a guardian appointed under adult guardianship legislation, as discussed below, may be appointed as a substitute/supporting decision-maker. Where this is the case, the legislative scheme pertaining to guardianship applies.

where direct consent is not possible; emergency treatment with no consent as a last resort. A substitute can both “over-rule” mere choices (so long as the person was not capable of decision-making)⁴⁷ and make decisions where the person is unable to make any kind of choice at all. If the individual is assessed as cognitively capable of making the decision in question her choice is her “own” and must be carried out, whatever the content, even if that decision results in the patient’s death.

The evaluation of mental capacity for the purpose of health care consent is the responsibility of the medical professional providing treatment, just as evaluating mental capacity before executing a legal agreement, transfer or will is the responsibility of the legal professional involved. Legal involvement in the determination of capacity is possible but unlikely (where the medical assessment of capacity is challenged),⁴⁸ either before or after treatment has been carried out. As in the contexts discussed in the preceding section undue influence can also vitiate/invalidate an individual’s consent to health care treatment. Concerns about undue influence are much less likely to arise with respect to health care consent, however, because of the different relationship to benefit: it is clear to see how the stronger person in a relationship can benefit from a bequest, gift, or an agreement to sell property. It is much less clear how analogous questions of benefit are engaged in health care consent. Medical gatekeepers of consent are also much less likely to be aware of undue influence and any potential responsibility to take it into account in deciding whether true consent has been given such that treatment can proceed. One exception in this context is end of life decision-making (including decisions around medically assisted dying), where concerns that vulnerable persons may be “induced to commit suicide” have been raised,⁴⁹ although no case involving undue influence in end of life decision-making has been brought at this time.

Critiques of the mental capacity construct in the health care consent context have noted its incompleteness or inadequacy as a way of describing the way in which patients actually make decisions about medical treatment. Schneider’s empirical study of patients views’ led him to conclude that, although “some people may behave as autonomists imagine.... an imposing

⁴⁷ Treatment without consent is also possible where the person has no substitute and is incapable of making a real decision.

⁴⁸ See e.g. *Collier v. Freeland*, 2011 HRTO 399 (CanLII) (Ont).

⁴⁹ See *Carter v Canada* 2015 SCC 5 at paras. 76 and 116.

number of them act quite differently. Their desire for information is less equivocal than the model assumes; their taste for rational analysis is less pronounced; their personal beliefs are not as well developed, relevant or strong; and their desire for control is more partial, ambivalent and complex.⁵⁰

Medical treatments and the health crises that proceed them can be frightening and disorienting, increasing reliance on the advice and opinions of physicians and others, such as family members. The “power and prestige” and superior knowledge of physicians makes it more likely that patients will rely on their guidance and, as Schneider notes, patients often *choose* to rely on physicians’ advice rather than make the decision themselves. As noted by Susan Wolf, “a sizable number of people do not want to make treatment decisions for themselves.”⁵¹ “[L]ife circumstances, such as the need to get back to a job that will not tolerate long medical absences” may effectively decide *for* the individual.⁵² Jill Craigie has noted that certain disorders by their nature (anorexia for example) distort the individual’s ability to perceive her future, thereby distorting the process of decision-making even where the individual is cognitively capable of carrying out that process. In sum, a central thesis of these critiques is that mental capacity in the medical decision-making context operates to create an illusion of free choice that masks the complex factors involved and evades tough questions about how genuine patient autonomy can be facilitated in light of those factors.⁵³

The special role of medical actors in this context (assessing capacity for the purpose of determining their own future course of action) has also been the subject of critique. Despite the formal ascendancy of autonomy as the pre-eminent value in medicine (as in law), the traditional medical principle of beneficence makes it less likely that a physician will assess a patient as “capable” if the patient’s decision is not in the patient’s best interests (as understood by the

⁵⁰ Carl E Schneider, *The Practice of Autonomy: Patients, Doctors and Medical Decisions* (New York: Oxford University Press, 1998) at 229.

⁵¹ Susan Wolf, “Shifting Paradigms and Bioethics and Health Law: The Rise of a New Pragmatism” (1994) 20:4 *Am J L & Med* 395 at 404.

⁵² Paul Root Wolpe, “The Triumph of Autonomy in American Medical Ethics: A Sociological View” in Raymond DeVries & Janardan Subedi, eds, *Bioethics and Society: Sociological Investigations of the Enterprise of Bioethics* (Englewood Cliff: Prentice Hall, 1998) 38.

⁵³ See also, Susan Sherwin & Barbara Parish, eds, *Women, Medicine, Ethics and the Law* (Aldershot: Ashgate, 2002); Jocelyn Downie & Jennifer J Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012); Mark S Komrad, “In Defence of Medical Paternalism: Enhancing Patient Autonomy” (1983) 9:1 *J Medical Ethics* 38.

physician). The elasticity of mental capacity and its assessment facilitates this kind of interpretation; a “wrong” decision may be taken as irrational, and therefore an indicator of impaired decision-making capacity.⁵⁴ A number of capacity assessment “tools” have been developed in the health care consent context (as in adult guardianship) with the objective of bringing greater rigour to this process;⁵⁵ Kapp and Mossman’s search for a “perfect capacimeter” that would at last remove subjectivity and value judgment from the assessment process, “resonat[ing] powerfully with relevant scientific findings and with modern society’s sometimes uncritical faith that human problems can be mastered through quantification.”⁵⁶ On a theoretical level, the doctrines of equitable fraud- undue influence and unconscionability- are applicable to health care decision-making as to other kinds of agreements.⁵⁷ The English case of *Re T (Adult: Refusal of Medical Treatment)*,⁵⁸ considered the undue influence of family members on a patient’s apparent consent. The case concerned a young woman’s refusal of blood products in the presence of and, it was argued, under the influence of her mother (a practising Jehovah’s Witness). When the patient subsequently became unconscious, her father and boyfriend sought a court order to allow for a life-saving blood transfusion. Discussing undue influence in the situation, Lord Donaldson observed:

A special problem arises if at the time the decision is made the patient has been subjected to the influence of some third party. This is by no means to say that the patient is not entitled to receive and indeed invite advice and assistance from others in

⁵⁴ See, Geneva Richardson, “Autonomy, Guardianship, and Mental Disorder: One Problem, Two Solutions” (2002) 65:5 Mod L Rev 702; Michael Perlin, “Pretexts and Mental Disability Law: The Case of Competency” (1993) 47:3 U Miami L Rev 625.

⁵⁵ 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; See Laura B Dunn et al, “Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments” (2006) 163:8 American J Psychiatry 1323; 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; Astrid Vellinga et al, “Competence to Consent to Treatment of Geriatric Patients: Judgments of Physicians, Family Members and the Vignette Method” (2004) 19:7 Intl J 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 R 954.

⁵⁶ Marshall B Kapp & Douglas Mossman, “Measuring Decisional Capacity: Cautions on the Construction of a ‘Capacimeter’” (1996) 2:1 Psychol Pub Pol’y & L 73. (“[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” at 79).

⁵⁷ Cameron Stewart & Andrew Lynch, “Undue Influence, Consent and Medical Treatment” (2003) J Royal Society Medicine 96:12 598.

⁵⁸ *Re T*, *supra* note 27.

reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient...The real question in each such case is, does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?⁵⁹

In deciding whether influence is undue, the strength of the patient (whether she or he is in pain, depressed, tired, or being treated with drugs) will be a significant factor together with the patient's relationship to the influencer. A close family relationship increases the likelihood of undue influence, especially in cases where religious beliefs are the reason for refusing treatment. "The stronger the relationship the greater the ability of the persuader to override the decision-making process of the patient."⁶⁰ Benefit to the influencer in this context is connected to that person's interests and desires.

4.3.3 Advance planning

"Advance planning" instruments (in British Columbia, representation agreements and enduring powers of attorney) provide alternatives to guardianship; as alternatives, these mechanisms perform similar, but not identical functions.⁶¹ Enduring powers of attorney and representation agreements, like guardianship, create ongoing relationships of substitute and (in some jurisdictions) supported decision-making for persons with diminished mental capacity with regard to both "everyday" and punctuate decisions and provide for the ability to over-ride mere choices within the scope authority granted by the instrument.⁶² Unlike guardianship, however, there are no requirements around the determination of mental capacity by either a medical or a legal actor prior to these relationships coming into effect. The legal relationship is created by the individuals concerned in private and in advance i.e. while the individual is mentally capable of understanding the kinds of decisions the substitute will make in the future after the donor loses

⁵⁹ *Ibid* at 662.

⁶⁰ Stewart & Lynch, *supra* note 56.

⁶¹ The scope of authority of a representative or attorney is relatively narrow as delimited by the applicable legislation in comparison to the potentially broad powers of plenary guardianship (provided for in all provincial legislation). Powers of attorney have authority with respect to finances and property; representatives (with the section 7 routine financial management exception noted below) with respect to health and personal decision-making.

⁶² Powers of attorney in British Columbia related to financial property decision-making; representation agreements relate to health care and "personal" decision-making.

capacity.⁶³ With the partial exception of “springing” powers of attorney⁶⁴ the determination of when a donor is no longer capable of decision making, thus requiring substitute decision-making, is also private (i.e. between donor and decision-maker).

Mental capacity may therefore become a legal issue in the advance planning context in exactly the same way as in the other agreement/transaction contexts discussed in the section above ie. where the appointment of the representative/attorney is subsequently challenged on the basis that the donor was not mentally capable of making that appointment at the relevant time. That retrospective assessment of capacity will be carried out by a legal decision-maker on the basis of all relevant evidence (including medical evidence where available but not requiring it) in the same way as the other private contexts discussed in this chapter. Where a court finds that the person was mentally incapable of making the instrument in question at the time that it was created the advance planning instrument (and all transactions made pursuant to it) will be set aside. The equitable doctrines of undue influence and unconscionability also apply in the same ways to the execution of advance planning documents (and therefore their validity) as to other agreements. Lawyers and notaries executing powers of attorney and representation agreements must be satisfied that the person is mentally capable of executing the document, and that undue influence/unconscionability is not involved.

Unlike guardianship (as discussed in Chapter 2 and in the following section) advance planning instruments can be executed with no professional input; where this is the case, no assessment of mental capacity, undue influence, or unconscionability will be carried out at the point the advance planning relationship is created. Even where a lawyer or notary executes instrument, the kind of public input and oversight built into the structures of guardianship are missing in this context. The advanced planning donor chooses the substitute or supporting decision maker appointed in an advance planning instrument with no outside or public inquiry into the fitness or

⁶³ The distinction between section 7 and section 9 agreements regarding the capacity of the donor is discussed in more detail in Chapter 3. Section 7 has a significantly “lower” requirement – accordingly, the scope of authority conferred is narrower than a section 9 with the exception of the authority to manage routine finances (which a section 9 representative would not have). This is because a person making a section 7 agreement may well not have the capacity to appoint a power of attorney to manage her finances and property.

⁶⁴ In a “springing” powers of attorney a donor provides that a power of attorney shall not take effect until she loses capacity (otherwise the power of attorney takes effect on execution, with the parties agreeing between themselves when it will be used). Where this is the case, the donor may provide in the document who will determine whether it has “sprung” (this could be the person appointed as attorney); if nothing is specified, the loss of capacity must be established by a medical physician.

appropriateness of that person,⁶⁵ and the decision-making relationship is carried out with no ongoing public oversight by a court or public office such as the Public Guardian and Trustee. The relative privacy of advance planning relationships is key to their appeal: quicker, easier, cheaper, less intrusive. On the other hand, the potential for exploitation that privacy creates has been widely noted.⁶⁶

4.3.4 Adult guardianship

The purpose of the modern law of adult guardianship⁶⁷ is to appoint a decision-maker (substitute or shared, where provided for in legislation) for an individual who is found to be incapable of making certain kinds or classes of decisions independently⁶⁸ on an ongoing basis. A guardian will not be appointed where the individual's capacity problems are transitory, although all guardianship legislation provides for the possibility that the individual may recover capacity. As explained in *Re Zurif*, "The whole scheme of the *Patients Property Act*, as of that of the *Lunacy Act*... which preceded it, is based upon the premise that the condition of the patient may improve. That possibility may be remote, or even miraculous; but it is always there while the patient lives."⁶⁹

The assessment of mental capacity preceding appointment of a guardian is, therefore, concerned with the projected course of decision making capacity. For this reason, the precise nature of the multiple decisions in question will be unknowable at the time capacity is assessed, unlike the discrete past decisions or the immediately pending decisions at issue in the contexts discussed above. Dementia adds another layer of un-knowability; the person's performance of thinking processes will foreseeably decline although the exact progression of that decline (including "shifting sands" in the earlier stages of dementia) is not foreseeable. The purpose for which

⁶⁵ Powers of attorney have authority with respect to finances and property; representatives (with the section 7 routine financial management exception noted above) with respect to health and personal decision-making.

⁶⁶ Jane A Black, "The Not-so-Golden Years: Power of Attorney, Elder Abuse, and Why Our Laws are Failing a Vulnerable Population" (2008) 82:1 St. John's L Rev 289; Carolyn Dessin, "Financial Abuse of the Elderly" (2000) 36:2 Idaho L Rev 203; Robert Gordon, "Material Abuse and Powers of Attorney in Canada: A Preliminary Examination" (1993) 4:1-2 J Elder Abuse & Neglect 173; John Bond et al, "The Financial Abuse of Mentally Incompetent Older Adults: A Canadian Study" (2000) 11:4 J Elder Abuse & Neglect 23; Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Final Report* (Toronto: LCO, March 2017).

⁶⁷ The development of adult guardianship legislation from its origins in the "mists of time" receding the common law to the present are explained further in Chapter 4.

⁶⁸ These categories generally pertain to decisions about the individual's property/finances, and decisions about the individual's "person" (decisions about health, care and support, living arrangements, etc.).

⁶⁹ (1983) 46 BCLR 175 at 175 (BCSC).

guardianship is used and the nature of the guardianship task will change accordingly over the course of the guardianship relationship, perhaps especially in the context of dementia.

Guardianship for persons exhibiting the signs and symptoms of dementia in old age is frequently initiated because of concerns about exploitation where an individual's ability to effect mere choice is being used by another person for his or her own benefit. The guardianship task, at this stage, is more likely to involve over-riding mere choice to disrupt relationships of exploitation. Over time, as the person becomes less capable of effecting/expressing choice of any kind (including mere choice), she or he will require assistance with "everyday" decision-making and the activities of daily living- a qualitatively different kind of "decision-making."

The finding or determination of mental capacity in the adult guardianship context is also distinct in terms of when, how and by whom it is carried out. The determination of mental capacity is a legal one⁷⁰ but medical evidence of incapacity (providing a basis for that legal determination) *must* be provided. In practice, medical evidence (even where "brief and desultory") is highly likely to be accepted and acted upon by the legal decision-maker⁷¹ unless a rival medical finding is provided, compelling a contest between the two.⁷² Rival capacity cases of this kind are by far more likely to involve a contest between competing would-be guardians than the individual herself *vis a vis* the guardianship application.

From the standpoint of legal decision-makers, the medical "finding" of capacity appears to function as a (seldom contested) opaque and authoritative bio-fact. This point was addressed by Judge Marion Allen in the case of *Public Trustee of British Columbia v Batiuk*:

"Petitions by the Public Trustee for orders declaring elderly people incapable of managing themselves or their affairs and appointing committees are not uncommon. The medical affidavits required by the *Act* to support the application are usually brief and desultory. Few applications are contested because the vast bulk of them are brought in cases where it is obvious that the appointment of the Public Trustee

⁷⁰ Although, in the context of "statutory guardianship" regimes in British Columbia and Ontario, as discussed in Chapter 3, that determination may be made by a non-legal actor (the Health Authority designate).

⁷¹ Glyn Davies & Leslie Taylor, "Private Committeeship in British Columbia: A Study of Due Process" (1989) 8:1 Can J Fam L 185.

⁷² *British Columbia (Public Trustee) v Batiuk*, [1996] BCJ No 2382 (BC Sup Ct) per Allan J [*Batiuk*].

or a close relative as committee is in the best interests of the person who is the subject of the proceedings.”⁷³

Critique of the way in which the mental capacity assessment bio-fact is *produced* (for the purposes of both guardianship and the health care decision making) has come primarily from the medical community. That critique has focused on the adequacy of assessment instruments of various kinds and their ability to distinguish between different kinds of decision-making, calling for the development of new instruments that would further minimise the space for subjective judgement (the language of “tools” and “instruments” suggesting a technical and scientific objectivity).⁷⁴ The development of “functional” methods of capacity assessment for the purpose of adult guardianship is positioned within this broader critique as providing a more objectively accurate and decision-specific measure. “Functional” in this context refers to a method of assessment that includes the individual’s ability to perform a particular kind of decision-making in everyday life (financial decision making, for example) in addition to cognitive testing scores (as produced the kinds of instruments described above).⁷⁵

⁷³ *Ibid* at para 3. In the case of *Batiuk*, involving rival guardians of a wealthy and elderly widow, “the application [was] strenuously resisted” with “[c]ounsel... amass[ing] extensive conflicting evidence on the issue of Mrs. Batiuk's competence”.

⁷⁴ Dunn et al, *supra* note 56; Thomas Grisso & Randy Borum et al, *Evaluating Competencies: Forensic Assessments and Instruments*, 2d ed (New York: Springer, 2003) at ch 2; Vanessa Raymond et al, “The Inter-rater Reliability of Mental Capacity Assessments” (2007) 30:2 Intl 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) 164:4 Archives 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 & L 40; James M Lai et al, “Everyday Decision-Making Ability in Older Persons with Cognitive Impairment” (2008) 16:8 American J 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 J Geriatric Psychiatry 101; Mathy Mezey et al, “Decision-Making Capacity to Execute Health Care Proxy: Development and Testing of Guidelines” (2000) 48:2 J American Geriatrics Society 179.

⁷⁵ See, Jennifer Moye et al, “A Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship” (2007) 47:5 Gerontologist 591 at 594-97 [Moye et al, “Capacity Evaluation in Adult Guardianship”]; US, American Bar Association Commission on Law of Aging & American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, Jennifer Moye, ed (Washington, DC: ABA, APA, 2005) at 9-11; Public Guardian and Trustee of British Columbia, *Guidelines for Issuing a Certificate of Incapability Under the Patients Property Act*, (British Columbia: 3 October 2011) at 3, online: <http://www.trustee.bc.ca/pdfs/STA/Certificate_of_Incapacity_Package.pdf> [Public Guardian and Trustee of BC, Guidelines for Incapability Assessments]; Andrea M Newberry & Arlin K Pachet, “An Innovative Framework for Psychosocial Assessment in Complex Mental Capacity Evaluations” (2008) 13:4 Psychology, Health & Medicine 438. See also, Public Guardian and Trustee of British Columbia, *Incapacity Assessments: A Review of Assessment and Screening Tools*, by Deborah O’Connor, Final Report, (20 April 2009), online: <http://www.trustee.bc.ca/documents/STA/Incapacity_Assessments_Review_Assessment_Screening_Tools.pdf>; Grisso & Borum et al, *supra* note 75, ch 3; Functional approaches to capacity assessment are discussed further in Chapter 5.

The legal critique of mental capacity in the guardianship context, in contrast, has focused on the equality implications of capacity based guardianship. The characterisation of impaired mental capacity as mental disability is key within this critique, placing it within the broader social disability discourse. From this perspective, guardianship (allowing for substitute decision-making) is a form of discrimination on the basis of disability,⁷⁶ and the failure to provide for supported decision-making actively *dis-ables* individuals in the same way that non-accessible public spaces disable persons with sensory or mobility limitations.⁷⁷ This location of disability in social and legal structures (the social disability model)⁷⁸ was expressed as legal principle by the Supreme Court of Canada in *Eaton v. Brant County Board of Education*:

[I]t is the failure to make reasonable accommodation, to fine-tune society so that its structures and assumptions do not result in the relegation and banishment of disabled persons from participation, which results in discrimination against them. ... It is recognition of the actual characteristics, and reasonable accommodation of these characteristics which is the central purpose of s. 15(1) in relation to disability.⁷⁹

This analysis and critique underlies the interpretation of Article 12 of the *United Nations Convention on the Rights of Disabled Persons* (“Equal recognition before the law”) as abolishing the legal concept of mental capacity on the basis of its fundamental incompatibility with legal principles of equality and human rights (as discussed in Chapter 2).⁸⁰

⁷⁶ See, Steven J Schwartz, “Abolishing Competency as a Construction of Difference: A Radical Proposal to Promote the Equality of Persons With Disabilities” (1993) 47:1 Miami L Rev 867.

⁷⁷ See, Leslie Salzman, “Rethinking Guardianship (Again): Substituted Decision-Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act” (2010) 81:1 U Colo L Rev 157.

⁷⁸ See Michael Oliver “The Social Model of Disability: Thirty Years On” (2013) 28:7 Disability & Society 1024; Sally French, “Disability, Impairment or Something In Between” in John Swain et al, eds, *Disabling Barriers, Enabling Environments* (London: Sage Publications, 1993) at 17; Tom Shakespeare “The Social Model of Disability” in Leonard J Davis, ed, *The Disability Studies Reader* (London: Routledge, 2013) 214.

⁷⁹ *Eaton v Brant County Board of Education*, [1997] 1 SCR 241 at para 67, 142 DLR (4th) 385.

⁸⁰ See, CRPD, *General Comment No. 1 (2014)*, 11th Sess, adopted 11 April 2014, UN Doc C/GC/1, online: <<https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>> [CRPD, *General Comment No. 1*]. The text of Article 12 is broad and relatively open to different interpretations. Most comment has adopted the interpretative approach set out in comment No. 1; See, Eilionoir Flynn & Anna Arstein-Kerslake, “Legislating Personhood: Realising The Right to Support In Exercising Legal Capacity” (2014) 10:1 Intl J L in Context 81.

The discriminatory impacts of the mental capacity construct are dissociated from the accuracy of the capacity assessment or determination within this legal critique (unlike the medical critique discussed above). From this perspective (and within this discourse) the scientific objectivity of assessment is not the fundamental problem with the mental capacity construct; even if the holy grail of the perfect capacimeter could somehow be obtained, the discriminatory nature and effect of medico-legal guardianship and the mental capacity construct would remain.

4.3.5 Conclusions

In this Chapter, I have described how the mental capacity construct is used to resolve autonomy problems arising in several areas of the law, including adult guardianship. The way that mental capacity works or is used in the law of guardianship is distinct, however, in terms of its relation to the structure and mechanisms of guardianship and in terms of the justification it provides through the intersection of mental capacity (as the cognitive ability to make decisions) and autonomy, and the mental capacity/autonomy threshold. The medical and the legal critiques of mental capacity in the adult guardianship context described in this part have raised different kinds of doubts (in the Deweyian sense) about the validity or “warranted assertibility” of the mental capacity construct as the organizing idea in the situation of adult guardianship. The medical discourse (the search for the perfect capacimeter) indicates doubt about the validity of mental capacity as an objective bio-fact and, therefore, the mental capacity threshold (on which the legal justification for guardianship depends).⁸¹ The legal critique creates doubt about the validity of that justification in and of itself (regardless of prove-ability); guardianship on the basis of impaired mental capacity is characterised, in this account, discriminatory. This critique underlies and is part of the supported decision-making paradigm (rejecting adult guardianship) discussed in Chapters 1 and 2. As discussed in Chapter 1, however, the gaps in that paradigm have precluded a true paradigm shift; those gaps have particular application to in the context of dementia in old age. The continuing role for guardianship is primarily in relation to those gaps.

⁸¹ By virtue of the mental capacity autonomy threshold described in the first part of this Chapter.

4.4 Mental capacity, adult guardianship, and dementia in old age: troubles and implications

The supported decision-making paradigm was developed through the legal critique of medico-legal guardianship discussed above together with a contextualized examination of the specific problems caused by medico-legal guardianship for persons with intellectual/developmental disabilities:

- the discriminatory *de facto* identification of intellectual/developmental disability itself as impaired decision-making capacity providing the basis for guardianship⁸²;
- the illusion of “substitute” decision making for persons never considered capable of decision making (making the guardian a replacement and not substitute decision-maker);⁸³
- the anti-therapeutic impact of guardianship on persons with intellectual/developmental disabilities as an enforced, perpetual childhood precluding the development of autonomy, decision-making skills and psychological well-being;
- and the devastation caused by the death of parent-guardians for persons who have been deprived of the opportunity to develop autonomy.⁸⁴

This section sets out a contextualized examination of the specific problems caused by medico-legal guardianship in the context of dementia in old age. The adult guardianship model developed through this research (as an alternative to medico-legal guardianship and supported decision-making) must be responsive to any particular problems identified through this examination.

4.4.1 Mental capacity, adult guardianship, and dementia in old age

Biological processes are at the roots of the [many perplexing] problems [now attendant on old age] and of the methods of solving them, but the biological processes take place

⁸² Even where guardianship legislation calls for a “decision-specific” capacity assessment.

⁸³ See, Louise Harmon, “Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment” (1990) 100:1 Yale LJ 1.

⁸⁴ Nina A Kohn, Jeremy A Blumenthal & Amy T Campbell, “Supported Decision-Making: A Viable Alternative to Guardianship” (2013) 117:4 Penn St L Rev 1111 at 1113, 1117-120; See also, Kristin Booth Glen, “Changing Paradigms: Mental Capacity, Legal Capacity Guardianship, and Beyond” (2012) 44:1 Colum HRLR 93; Harmon, *supra* note 85; Bach & Kerzner, *supra* note 16.

in economic, political and cultural contexts. They are inextricably interwoven with these contexts so that one reacts upon the other in all sorts of intricate ways. We need to know the ways in which social contexts react back into biological processes as well to know the ways in which the biological processes condition social life.⁸⁵

The “processes and contexts” described by Dewey in the passage above intersect to make up the experience of old age for each individual. Standardized age markers such as 65 are used for some purposes as a kind of shorthand for the experience of old age. Age markers do not in and of themselves *cause* a person to become old in any substantive sense, however, and persons on the far side of the marker may be more or less “old” in the sense described by Dewey. Age markers can and do inform an individual’s “economic, political and cultural context” (discussed in this section) by providing access to public benefits, for example, or barriers to employment. No one “turns old” on his or her 65th birthday, however, and the old age is not universally experienced in the same way (as noted by Seneca the Younger in 44 BC); “[t]here is not one type of old age for all people.”⁸⁶ The discussion in this part is informed by this approach to and understanding of old age.

Strong empirical evidence indicates that guardianship is used, in the great majority of cases, in relation to persons losing capacity in old age.⁸⁷ The loss of mental capacity in old age is most frequently characterised as dementia, a “deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing.”⁸⁸ The examination set out in this section will consider the following factors arising from dementia and the physiological

⁸⁵ John Dewey, “Introduction” in Edmund Vincent Cowdry, ed, *Problems of Ageing: Biological and Medical Aspects* (Baltimore: Williams & Wilkins, 1939) at xxiii-xxvi.

⁸⁶ Attributed to *Consolation ad Marciam*, 1 AD; Tim Parkin “The Ancient Greek and Roman Worlds” in Pat Thane, ed. *The History of Old Age* (London: Thames & Hudson, 2005) 31 at 31.

⁸⁷ Specifically, the “older-old” age 80 and over; See Israel Doron, “Mental Capacity, Guardianship, and the Elderly: An Exploratory Study of Ontario’s Consent and Capacity Board” (2003) 18:1 Can JL & Soc 131 (“guardianship and mental capacity are not only about the elderly, but are rather about the ‘older-old’” at 138).

⁸⁸ World Health Organization, *Dementia*, Fact Sheet (World Health Organization, April 2016), online: <<http://www.who.int/mediacentre/factsheets/fs362/en/>> (“[dementia] affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. Dementia is not a disease but may be caused by a variety of diseases and injuries that primarily or secondarily affect the brain, such as Alzheimer’s disease or stroke.”) [WHO Dementia Fact Sheet].

processes and social contexts of old age, and their intersection with medico-legal guardianship and the mental capacity construct at its conceptual core:

- The loss of capacity after a long period of autonomous/decision-capable adulthood (significance of the strong prior self);
- Patterns in relationship context: parent and adult child (continuation of provider/leadership role in connection with increasing physical and mental frailty); relevance of spousal relationships;
- Fluctuating changes in thinking processes (associated with dementia) together with coterminous physical changes (physical changes connected with the underlying cause of dementia ie. Alzheimer's disease or stroke; changes arising from the aging process generally);
- The accumulation of assets after long capable life; and
- Social and individual ageism, including the “greedy geezer” meme.
- The nature of dementia and its relationship to normal ageing and the medicalization of old age

4.4.2 Troubles and implications: relationship context, accumulation of resources, and the former capable self

The following sections describe distinctive (if not universal) “processes and contexts” associated with the loss of capacity in old age, and the ways in which they “react upon” the process of medico-legal guardianship and the mental capacity construct.

4.4.2.1 Relationship context

Relationship context refers to the network of family and inter-personal relationships in which an individual is embedded. Persons losing capacity in old age after a long capable adulthood are especially likely⁸⁹ to be spouses and parents of adult children, family roles creating a distinctive relationship context. The individual may have played the role of provider and family leader over a long period of time, and shifting family roles (including contention between the players involved about those shifts) are characteristic of dementia in old age (the King Lear syndrome).

These distinctive relationship contexts are an important source of strength and support for many individuals. Indeed, strong and healthy relationships may obviate the need for guardianship where health professionals and others are able to “work with the family” to resolve everyday decision-making problems.⁹⁰ The person experiencing dementia in the context of strong family relationships is also likely to have made workable advance planning arrangements for substitute and/or supported decision-making (prior to or in the early stages of dementia). For this reason, persons with a spouse or adult child they can confidently rely on to act as a representative or attorney under a power of attorney will be less likely to need guardianship. At the same time, court-appointed guardianship requires at least one healthy family relationship (court appointed guardians are most likely to be family members).

The distinctive relationship contexts of old age are also a source of vulnerability to abuse, neglect, and financial/material exploitation. The intersection of family dynamics, increasing physical dependence, and the material dependence of adult children (with the older person retaining her identity as family leader/provider) creates the context for the archetypal exploitation scenario (involving both financial and emotional abuse): the adult son, often with a substance abuse problem and/or mental illness, living with his mother, who he controls and exploits. The accumulation of assets, in the connection with social ageism (as discussed below) increases this vulnerability in relation to family members and others.

⁸⁹ More likely than other persons within the category of the mentally incapable to whom guardianship applies (persons with developmental disabilities or losing capacity through brain injury, generally at an earlier life stage).

⁹⁰ Paying bills, arranging for homecare, etc.; health care decisions may be facilitated through the “default” temporary decision-makers provided for in health care consent legislation such as BC’s *Health Care Consent and Care Facility Admission Act*, *supra* note 48.

4.4.2.2 Accumulation of assets in the context of social ageism

Like the family relationship context discussed above, the accumulation of assets after a long life of capable adulthood is a source of both support and vulnerability/risk.⁹¹ Assets enable the purchase of support; assets also attract exploitation, together with intimidation, isolation, and the other forms of abuse that accompany exploitation.⁹² Social ageism- the idea of visible old age as a sign of weakness and foolishness- stereotypes the visibly old as “easy marks” in a way that creates/increases vulnerability to exploitation both within and outside of the family context. The “greedy geezer” meme (the old “boomer” as the undeserving beneficiary of decades of relative prosperity, rising property values, and public benefits that less fortunate others are denied), has also contributed to a social context that makes exploitation more likely. The “greedy geezer” caricature may provide the basis for a rationalising self-narrative: she has so much; she doesn’t need it the way that I do; the world has changed in a way that, unfairly, now prevents me from making my own way. Increased vulnerability to exploitation and abuse is created by the confluence of these social and biological processes (i.e. it is not internal to the individual or a product of aging in and of itself). At the same time, social attitudes towards persons with dementia in old age evince greater solidarity, sympathy and support than towards younger persons with mental illnesses or disorders. Paternalistic attitudes are part of this dynamic, providing a potential source of both support and harm. These attitudes are associated with prejudice, stereotypes and discrimination, referred to collectively as “stigma”.⁹³ Stereotypes describe collective judgments about groups of people such as people with dementia; prejudice refers to emotional reactions to a stereotyped person (a complex mixture including pity and distaste) and discrimination refers to behaviours that are associated with prejudice, including avoidance, coercion and segregation.⁹⁴

⁹¹ Not all persons developing dementia in old age will have significant assets, but this is much more likely to be the case for persons losing capacity late in life than for other classes of incapable persons (persons with lifelong mental disabilities or losing capacity through brain injury at an earlier stage of adulthood).

⁹² See, National Institute for the Care of the Elderly (NICE), “Preventing and Intervening in Situations of Financial Abuse: Ontario” (Toronto: NICE), online: <<http://www.nicenet.ca/tools-preventing-and-intervening-in-situations-of-financial-abuse-ontario>>. Financial abuse has been identified as the “most common form of elder abuse”.

⁹³ S.M. Benbow & David Jolley “Dementia: Stigma and its Effects” 2012 2(2) *Neurodegenerative Disease* 165.

⁹⁴ Benbow & Jolley, *ibid.* See also, Perla Werner & Issi Doron “Alzheimer’s disease and the law: positive and negative consequences of structural stigma and labeling in the legal system” (2017) 21(11) *Aging & Mental Health* 1206.

In the context of dementia in old age, dementia-stigma intersects with the stigma associated with old age and the aging body more generally (as a deviation from the healthy adult norm in ways that connote increasing dependence and a loss of social value, including beauty).⁹⁵ The stigma of dementia may lead to its under-identification by physicians⁹⁶ and, in a similar way, a reluctance on the part of legal gatekeepers to find an older adult incapable of making a will or property transaction (by implication, because of concerns about dementia). Benbow & Jolley observe that people living with dementia may be well aware that they are “vulnerable” and concerned about it, but reluctant to seek help or access service because of concerns about labelling and the stigma that would follow.⁹⁷ Conversely, the signs and symptoms of dementia or a more formal dementia diagnosis may be read by professionals and others (including family members) as entailing a global inability to participate in decision-making of any kind. This kind of “over-protective”⁹⁸ response is both a response to stigma and an element of it (that the person with dementia can no longer contribute to their own life, a burden to those who must do everything for them including decision-making).

Dementia, as a disorder of thinking processes, impacts decision making but it must be emphasized that a finding of dementia is not equivalent to a global or even limited impairment of mental capacity or decision-making ability. Nor is a person living with dementia necessarily vulnerable (as explained further in this Chapter and in Chapter 7, *infra*). The potential vulnerability arising from dementia may be absorbed by a supportive social and relationship context, enabling the individual to guide or otherwise participate in all aspects of her life including decision-making. In other circumstances, however, the intersection between the distinctive physiological processes and social contexts of old age and the impact of dementia on thinking processes creates vulnerabilities that are not absorbed in this way. These special vulnerabilities include exploitation (as explained below) and an inability to perceive the need for assistance coupled with an extreme need for care resulting in avoidable harm and/or suffering. The “over-protective” response referred to above may be triggered by the fear and pity these circumstances arouse, and the stereotype that dementia always creates this kind of vulnerability.

⁹⁵ See discussion, M.I.Hall “‘Old age’: or, do we need a critical theory of law and aging?” (2014) 35 Windsor Review of Legal and Social Issues 1,

⁹⁶ Benbow & Jolley, *supra* note 95

⁹⁷ *Ibid* at 168.

⁹⁸ *Ibid*

The failure to contemplate/provide a response to exploitation and abuse is the most significant gap in the supported decision-making paradigm. This gap does not exclusively impact the old but, for the reasons explained above, it is especially likely to. Kerzner and Bach describe the different response of older persons to supported decision making in terms of their “different lived experience”, especially in relation to “abuse and neglect” (including exploitation as “financial abuse”):

Older adults, too, want their voices heard, and to be able to make decisions for themselves... [but] their fundamentally different lived experience, differing as it does from people with disabilities, results in a different vision of how the law would best achieve their goals.

Supported decision-making, so important to people with intellectual disabilities and their advocacy organizations, is not on the radar of older adults. Older Adults’ experiences of isolation significantly influence their views on legal capacity laws. With isolation comes a lack of people with whom they interact, including people who could potentially support them. At the same time, often with isolation also comes abuse. Thus, the significant issue for older adults is abuse and neglect.⁹⁹

I would suggest that abuse and exploitation are not always (or even primarily) a result of isolation; that indeed the opposite is true, with exploitation and abuse flowing from interdependence and *enmeshment* in relationship context, in particular, unhealthy older parent/adult child dynamics. I do agree with Bach and Kerzner that the significance of exploitation in the context of dementia in old age is a core reason why the supported decision-making paradigm is not “on the radar of older adults.” Indeed, supported decision-making in this context has the potential to exacerbate that vulnerability, where the decision-making capability enabled by the supporter results in decisions that benefit the supporter at the expense of the individual (depleting

⁹⁹ Bach & Kerzner, *supra* note 16. The authors describe this “difference in vision” as having “unfortunate” and “destructive results”, attributing the failure to implement legislation associated with British Columbia’s guardianship reforms of the 1990s to, “at least part”, a clash between disability rights theory and seniors’ rights theory” at 37). See also Canadian Centre for Elder Law Studies, *A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario*, CCLES Report No. 4, BCLI Report No. 46 (Vancouver: Canadian Center for Elder Law Studies, October 2006).

her resources). In this way, the supported decision-making relationship resembles the kind of relationship described in the doctrine of undue influence as giving rise to a presumption of undue influence (a presumption that can be displaced by establishing that the decision in question was, truly, the person's "own" genuine decision). Supported decision-making (like relationships giving rise to a presumption of undue influence) are, like the other contextual factors discussed in this part, simultaneously a source of both strength and increased vulnerability. That potential vulnerability is not exclusive to the context of dementia in old age, but is heightened in that context for the reasons described above.

4.4.2.3 Guardianship and the former capable self

The loss of mental capacity after a long capable adulthood presupposes the existence of a strongly developed *prior* self with a track-record of genuine decision-making. On the one hand, this prior capable self creates a baseline against which to measure changes in the performance of thinking processes and the identification of dementia (as discussed below). The prior capable self also provides a basis for making the kinds of decisions the individual would have made if capable of doing so herself (the *sine qua non* of substitute decision-making in the modern reform adult guardianship model).

On the other hand, subjecting the choices of the current self to the past (no longer existent) self is problematic in a number of ways: first, by equating change in old age with dementia and the loss of capacity; second, by constructing the changed self as non-autonomous and, therefore, a non-person (the "wanton" described by Feinberg). Both consequences are antithetical to fundamental legal principles of equality and non-discrimination.

The idea of the self-with-dementia as a non-self (that the person is "not really there") would apparently resolve this tension between the past and current self. The idea of substitute decision-making as protecting the autonomy of the former self *from* the current self is predicated on this idea of a bright line (drawn by disease) between the real and false self. The ambiguous and complex relationship between dementia and old age, described below, troubles this apparent resolution.

4.4.2.4 Dementia, aging, and the physiological self: intersections with medico-legal guardianship

The physiological nature of dementia and its relationship to old age gives rise to special problems related to the assessment of mental capacity (or “decision-making ability”) and to the task of guardianship (what a guardian does). Both are discussed in this part.

As discussed in Chapter 2, dementia is defined by the World Health Organisation as a *syndrome*, “usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing.”¹⁰⁰ The dementia diagnosis and the mental capacity finding are not equivalent, and a diagnosis of dementia is possible without a finding that the individual is incapable of decision making (and of course, *vice versa*). The dementia diagnosis and mental capacity assessment do overlap, however: both are concerned with the individual’s performance of thinking processes, and what that performance indicates about brain/cognitive function. Dementia will frequently be identified as the source or cause of a loss of capacity for the first time in old age; indeed, the definition provided above defines dementia in relation to “normal aging.” In this respect, the dementia diagnosis plays an integral role in medico-legal guardianship and the mental capacity construct by providing a bio-medical explanation for diminished capacity, apparently removing subjectivity and value judgment from that process.

Diagnosis and assessment

The sometimes ambiguous relationship between dementia and “normal aging” complicates the apparent neutrality of the dementia diagnosis, however (a neutrality that is rhetorically essential to the success of the mental capacity construct, as explained earlier in this Chapter). The “exact location” of the line between dementia and normal aging is “is a matter of evaluative judgment

¹⁰⁰ WHO Dementia Fact Sheet, *supra* note 88.

based on correlations between neuro-pathology and symptoms and signs.”¹⁰¹ In this respect, the dementia diagnosis parallels the mental capacity assessment. Both involve an assessment of the individual’s performance of thinking processes (remembering, thinking, comprehending, calculating, understanding/speaking, and judging), more like an IQ test than a blood test or cell on the slide. “At this most objective end of mental illness (that is, in the field of “organic” dementias), it turns out there is no hard scientific boundary between disease and normality.... How much forgetfulness is pathological? What counts as normal aging?”¹⁰² The social context of ageism in which both the dementia diagnosis and the mental capacity assessment takes place further complicates both findings in similar ways.¹⁰³ Pervasive social ageism makes it more likely that behavior or performance will be read by medical professionals as dementia and as diminished mental capacity; the occasions for such readings increase as the aging process makes interaction with and scrutiny by medical professionals more frequent. I would emphasise that this observation is not intended to suggest that medical professionals intentionally discriminate against older patients. Rather, like everyone else, medical professionals are embedded in a culture in which social ageism is pervasive- the water in which we swim. The association between the physiological phenomenon of dementia and old age (as described in Chapter 2), despite the age-neutral rhetoric of the Alzheimerization of dementia, also increases the likelihood of this reading. At the same time, however, the stigma associated with dementia may make some physicians less likely to make a diagnosis. Either way, the diagnosis is subject to influence by social and attitudinal factors in addition to objective medical assessment.

Ambiguity in and of itself does not make the dementia diagnosis or mental capacity assessment meaningless, however. Both can provide information about the individual, and her current and projected needs that is essential to crafting an adequate and effective response to those needs. Where the assessment of mental capacity or “decision-making ability” provides the sole factor on which guardianship turns, however (without the complimentary context-focused doctrines of

¹⁰¹ Julian Hughes, Stephen Louw & Steven R Sabat, eds, *Dementia: Mind, Meaning and the Person* (Oxford: Oxford University Press, 2005). See also, Murna Downs, Linda Clare & Jenny Mackenzie, “Understandings of Dementia: Explanatory Models and their Implications for Persons with Dementia and Therapeutic Effort” in Hughes, Louw & Sabat, *supra* note 94 at 240; Jonathan Herring “Entering the Fog: On the Borderlines of Mental Capacity” (2008) 83:4 *Ind LJ* 1619; Nancy H Harding & Colin Palfrey, *The Social Construction of Dementia* (London: Jessica Kingsley, 1997).

¹⁰² Hughes, Louw & Sabat, *supra* note 102 at 87.

¹⁰³ See, Israel Doron, “A Judicial Rashomon: On Ageism and Narrative Justice” (2012) 27:1 *J Cross Cultural Gerontology* 17.

equitable fraud), and where the objective neutrality of that assessment provides the justification for guardianship's interference with autonomy, the tangled and often blurry lines between dementia, aging, and mental capacity undermine the integrity and coherence of medico-legal guardianship in this context.

The guardianship task

The physiological nature of dementia as a waxing and waning condition with a long-term arc of declining mental and physical ability (in association with the underlying cause of dementia and the physiological aging process itself), terminating in death, has significant consequences for the task of guardianship. That task is likely to change, possibly significantly, between appointment and death. Early signs and symptoms of dementia/impaired mental capacity frequently manifest as bad (mere)¹⁰⁴ choices, often involving exploitation, in respect of which the guardianship task is one of mere choice-over-ruling. As described above, guardianship is often sought during these earlier stages in response to concerns about exploitation. As dementia progresses in connection with its cause (Alzheimer's disease for example), the guardian's task is likely to become one of "everyday" and "big-decision" decision-making as the individual loses the ability to make any kind of choice at all. The final task of guardianship (carried out directly or delegated to another) is likely to be one of caregiving or care facility admission. The idea of developing the skills of autonomous decision-making through (supported) practice is less coherent in the context of dementia in old age, in which the goal of decision-making skill building plays out very differently; the challenge is to maintain or maximise decision-making ability for as long as possible, within a broader arc of progressive decline.¹⁰⁵

4.4.3 Conclusions

To summarise, the factors discussed above intersect with medico-legal guardianship and the mental capacity construct to produce the following, context specific problems:

¹⁰⁴ Non-decisions, e.g. not the product of an autonomous "decision-making process."

¹⁰⁵ Mary Donnelly, "A Legal Overview" in Charles Foster, Johnathan Herring & Israel Doron, eds. *The Law and Ethics of Dementia* (Oxford: Hart Publishing, 2014) 271.

- The ambiguity of mental capacity in relation to dementia, in the context of social ageism and the medicalization of the aging body, problematizes the mental capacity “bio-fact” (as the sole guardianship determinant) in the context of dementia in old age. The assessment of both dementia and mental capacity is evaluative, a fact that is denied by medico-legal guardianship and the objective scientific measure it requires. That evaluative process is complicated by the relationship between dementia and normal aging, in the context of social ageism and stigma;
- The intersection of family/relationship context, the accumulation of assets and social ageism creates an increased vulnerability to exploitation and abuse; the ostensible focus on mental capacity formally excludes exploitation and abuse from the medico-legal guardianship analysis;
- Where a guardian is appointed, the changing nature and “shifting sands” of mental capacity in the context of dementia in old age means that the guardianship task can be expected to change, as problems in the performance of thinking processes change in nature and intensity

These problems are inseparable from medico-legal guardianship as organised by the mental capacity construct. The following section considers and sets out a theory of vulnerability as a potential alternative organizing idea that would be responsive to the problems identified above while filling the gaps in the supported decision-making paradigm

4.5 After capacity: vulnerability theory

4.5.1 But what does it mean? defining vulnerability

“Vulnerability” is a broad term with multiple meanings and connotations. The *Oxford English Dictionary* provides two definitions for the word “vulnerable.” In the first, “vulnerable” is defined as “exposed to the possibility of being attacked or harmed, either physically or

emotionally.”¹⁰⁶ In the second, “vulnerable” is defined in terms of a vulnerable person, “a person in need of special care, support, or protection because of age, disability, or risk of abuse or neglect”.¹⁰⁷

The first definition is consistent with Martha Fineman’s theory of vulnerability as a “universal, inevitable and enduring aspect of the human condition”¹⁰⁸; vulnerability as a function of human embodiment. Every human body is exposed to injury or illness- although some bodies are more exposed than others by reason of individual physiology and personality in connection with the social, economic, and relationship contexts in which each person is situated. Vulnerability is also a function of our nature as social beings. This social aspect of the “human condition” includes Kennedy’s “fundamental contradiction”: that the exercise of individual liberty is dependent on and can only be exercised in social context.¹⁰⁹ As discussed in the preceding section, the relationship and social contexts in which we are enmeshed may be sources of security and strength but also of exploitation and harm. This multi-dimensional human vulnerability manifests in different ways, at different points, for different people; while “undeniably universal, human vulnerability is also particular: it is experienced uniquely by each of us and this experience is greatly influenced by the quality and quantity of resources we possess or can command.”¹¹⁰

The idea of vulnerability incorporated in the second definition is “typically associated with victimhood, deprivation, dependency, or pathology”; the vulnerable person as “stigmatized subject,” a member of a so-called “vulnerable population”¹¹¹ in contrast to an *invulnerable* norm

¹⁰⁶ *The Oxford English Dictionary*, 2015, *sub verbo* “vulnerable”.

¹⁰⁷ *Ibid.*

¹⁰⁸ Martha Fineman, “The Vulnerable Subject: Anchoring Equality in the Human Condition” (2008) 20:1 *Yale JL & Feminism* 1 (“[v]ulnerability initially should be understood as arising from our embodiment, which carries with it the ever-present possibility of harm, injury, and misfortune from mildly adverse to catastrophically devastating events, whether accidental, intentional, or otherwise. Individuals can attempt to lessen the risk or mitigate the impact of such events, but they cannot eliminate their possibility. Understanding vulnerability begins with the realization that many such events are ultimately beyond human control” at 8) [Fineman, “The Vulnerable Subject”].

¹⁰⁹ John P Goldberg, “Pragmatism and Private Law” (2012) 125:7 *Harv L Rev* 1640 at 1645, citing Duncan Kennedy, “Form and Substance in Private Law Adjudication” (1976) 89:8 *Harv L Rev* 1685 at 1766 (“only one side can be taken in this irresolvable ideological conflict” at 1766). See also, Duncan Kennedy, “Distributive and Paternalistic Motives in Contract and Tort Law, with Special Emphasis on Compulsory Terms and Unequal Bargaining Power” (1982) 41:4 *Md L Rev* 563 at 638.

¹¹⁰ Fineman, “The Vulnerable Subject”, *supra* note 109 at 8.

¹¹¹ *Ibid* at 8, citing Caroline Knowles, *Family Boundaries: The Invention of Normality and Dangerousness* (Toronto: University of Toronto Press, 1997) at 108-109. See also, Fineman, *The Autonomy Myth*, *supra* note 15.

(the “adult liberal subject”). Fineman has described this non-vulnerable individual as “stand[ing] not only outside of the passage of time, but also outside of human experience,” “captur[ing] only one possible developmental stage- the least vulnerable- from among the many possible stages an actual individual might pass through if s/he lives a “normal” lifespan.”¹¹²

Both ideas of vulnerability are present in the law. The second idea of vulnerability underlies and justifies the (now limited) *parens patriae* jurisdiction: the idea that certain classes of persons are by definition vulnerable and therefore in need of protection. A key objective of the reform movement in adult guardianship was to remove the vestiges of *parens patriae* from adult guardianship legislation, in response to abuses and human rights violations flowing from that model. The vulnerability theory set out here as an alternative to the mental capacity construct is not a revival of *parens patriae* or the vulnerability construct on which it rests.

The idea of vulnerability as a universal consequence of human embodiment/social embeddedness, experienced differently by individuals, at different stages of their lives, is integral to the doctrines of equity and tort law. Tort scholar Jane Stapleton has identified vulnerability as the “golden thread” and “central organizing feature” of tort law generally, and of negligence law in particular, the duty of care comprising “the most extreme form of vulnerability: namely, where a person is exclusively dependent on another to take care, even if that person is a total stranger.”¹¹³ The requirements for duty- reasonable foreseeability and other elements of proximity- may be understood in terms of creating vulnerability, justifying compensation for loss where the duty is breached and damage flows from that breach. Membership in an identified “vulnerable population” group might be one of several factors giving rise to proximity, but it is not essential. The doctrine of necessity as a defence to the trespass torts (as discussed earlier in this chapter) responds to a similarly universal vulnerability consequent on embodiment that

¹¹² Fineman “The Vulnerable Subject”, *supra* note 109 at 11-12.

¹¹³ Jane Stapleton, “The Golden Thread at the Heart of Tort Law: Protection of the Vulnerable” (2003) 24:2 Austl. Bar Rev 135 (“[o]ver the past 20 years, the court has identified this as a core moral concern of tort law and whatever limits may govern this vulnerability concept it certainly has a powerful convincing core” at 142). See also, Carl F Stychin, “The Vulnerable Subject of Negligence Law” (2012) 8:3 Intl J L Context 337.

arises in certain situations or contexts. As described in *Re F*,¹¹⁴ the public interest is justifiably engaged by vulnerability arising in this way.

Justice LaForest, in the case of *Hodgkinson v Simms*, described “vulnerability” as “the ‘golden thread’ that unites such related causes of action as breach of fiduciary duty, undue influence, unconscionability and negligent misrepresentation.”¹¹⁵ In each case vulnerability arises/is intensified through the relationship context in which the parties are situated: relationships of reliance in the case of negligent misrepresentation and breach of fiduciary duty; relationships of power imbalance and oppression in the doctrines of equitable fraud (undue influence and unconscionability). “Vulnerable population” personal characteristics may contribute to, but do not comprise, the intensified quality of vulnerability required by each of these doctrines (the beneficiary is “vulnerable” to the trustee by virtue only of the property or financial relationship in which they are enmeshed, for example, with no reference to her or his personal characteristics).¹¹⁶

The doctrines of equitable fraud (undue influence and unconscionability) provide, I contend, the most complete and sophisticated account of universal vulnerability in the law. In both cases, vulnerability is created through the interaction of individual characteristics (including the social performance of thinking processes, physiological factors, education and knowledge) and relationship context. In the case of undue influence (either intentionally exercised or arising through relationship dynamics)¹¹⁷ equity “interferes not on the ground that any wrongful act has been committed by the donee but on the ground of public policy and to prevent the relations which existed between the parties and the influence arising therefrom from being abused.”¹¹⁸ Equity intervenes in cases of unconscionability, in contrast, to prevent individuals from deriving benefit through the deliberate exploitation of relationships of power (where it would be

¹¹⁴ *Supra* note 26.

¹¹⁵ *Hodgkinson v Simms*, [1994] 3 SCR 377, 117 DLR (4th) 161, La Forest J. The first three of these are doctrines of equity; the fourth is a doctrine of tort.

¹¹⁶ *Cf.* Margaret Isabel Hall, “Intuitive Fiduciaries: The Equitable Structure of Family Life” (2002) 19:2 Can J Fam L 345.

¹¹⁷ *Geffen v Goodman Estate*, *supra* note 33 (“[where] the potential for domination inheres in the nature of the relationship itself” at para 43).

¹¹⁸ *Lloyd’s Bank*, *supra* note 34. “Abuse” is used by Sir Sachs in this passage (quoting from the judgment of Lord Justice Cotton in *Allcard v Skinner*, *supra* note 34, to describe failure by the dominant person in the relationship to carry out this responsibility (“that word in the context means no more than that once the existence of a special relationship has been established, then any possible use of the relevant influence is, irrespective of the intentions of the persons possessing it, regarded in relation to the transaction under consideration as an abuse- unless and until the duty of fiduciary care has been shown to be fulfilled or the transaction is shown to be truly for the benefit of the person influenced. This approach is a matter of public policy” at 171).

“unconscionable” to allow the stronger party to retain the benefit).¹¹⁹ Private and public interests are therefore engaged in situations of both undue influence and unconscionability.

In sum, the vulnerability theory developed through this research (building on the accounts of vulnerability discussed in this part) is rooted in existing legal and equitable principle in the way described by the pragmatists as essential to the workability of new ideas or truths. This research study does not propose the creation of a new “vulnerable population” through the equation of chronological age with vulnerability-status, extending guardianship to a new class of persons- “the vulnerable”- in addition to (or instead of) the mentally incapable. Rather, this research asks whether vulnerability in the first sense (vulnerability as a universal human condition becoming more or less acute where certain factors coincide) provides a more appropriate basis for the kind of interference or intervention that guardianship provides, and whether this idea of vulnerability as a basis for guardianship can be articulated and practiced in a way that is consistent and fair. Unlike mental capacity, which sets out a universal/abstract theory of the relationship between brain function and decision-making (a universal test applicable in theory to all individuals in the same way), the vulnerability described in the doctrines of equitable fraud and tort law are grounded in the particulars of embodied experience; unlike mental capacity, it is difficult to reduce this contextualised approach to a uniform abstract formula. This difficulty creates problems in terms of legislation describing and responding to vulnerability in a way other than the vulnerable populations approach. This difficulty also creates challenges in terms of developing a consistent and principled approach to the assessment of vulnerability on the ground by non-legal actors: how can vulnerability be tested and measured? Unlike mental capacity, vulnerability is transparently not analogous to the cell on the slide; vulnerability is a fundamentally social phenomenon. As explained in the preceding section, however, the mental capacity bio-fact is an illusion, an illusion that is complicated further by its relationship to dementia and the physiological processes and social contexts of old age.

¹¹⁹ See, *Norberg v Wynrib* [1992] 2 SCR 226.

4.5.2 Assessment and the development of meaning: functional capacity, relational capacity and “Liberty for the Old”

The “quest for the perfect capacimeter” described earlier in this Chapter has given rise to numerous assessment models, including the three models discussed in the following section. I suggest that, although these models are articulated as providing a more accurate measure of mental capacity/decision-making ability, they are more coherently understood as providing for a coherent assessment of contextualised vulnerability. The articulation of these models in terms of mental capacity is consistent with current legislation and avoids the need to challenge the theoretical or principled basis on which guardianship is justified; on the terms of the mental capacity construct, however, the incorporation of non-cognitive scientific/objective factors within these models increases the risk of subjectivity and value judgment (factors which the mental capacity construct/threshold was intended to remove). Understanding the approaches to capacity assessment discussed in the following sections in terms of vulnerability is more coherent and, in turn, further develops a legal theory of vulnerability in the context of adult guardianship (including mode of assessment) that is rooted in equity theory and the common law doctrine of necessity. A preliminary articulation of that theory is set out at the conclusion of this Chapter; that preliminary articulation is further examined and developed through the empirical research described in Chapters 5 and 6.

Of the three models considered in this section, two (Moye’s functional capacity assessment model and the approach set out in “On Liberty for the Old”) were written with the participation of legal co-authors, although published outside of the legal literature. The “relational capacity” model discussed in the section (“Personhood and Dementia: Toward a Relational Framework for Assessing Decisional Capacity”) was developed by the social work scholar Deborah O’Connor. Interestingly, both “On Liberty for the Old” and Moye’s “Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship” (produced in consultation with the American Bar Association-American Psychiatric Association Capacity Assessment of Old Adults Working Group) are explicitly concerned with the assessment of mental capacity in old age (rather than a more abstract category of the “mental capacity”). Dr. O’Connor is concerned with the nature of mental capacity and mental capacity assessment in the more specific context of dementia in old age, and the examples she provides are rooted in that experience. O’Connor’s

examples concern the assessment of capacity under Part 3 of the *Adult Guardianship Act* (the abuse and neglect legislation in BC) and, therefore, the capacity to refuse and offer of services and support; the analysis of mental capacity she provides is equally applicable to the guardianship context.

Capacity Evaluation in Adult Guardianship (Moye et al)

Jennifer Moye and her colleagues have proposed a capacity assessment model and “template” to be used by medical actors in the production of mental capacity assessment for use in guardianship proceedings.¹²⁰ The authors describe their work as a response to current “sketchy” and “substandard” approaches to capacity assessment containing “written descriptions that provide limited functional data and include conclusory findings.”¹²¹ The template was produced in consultation with the American Bar Association-American Psychiatric Association Capacity Assessment of Old Adults Working Group with the objective of “integrate[ing] sound legal approaches to capacity within guardianship with best practices in clinical capacity assessment.”¹²²

The template is structured around six “domains” (including but not limited to “cognition”):

- medical condition;
- cognition;
- everyday functioning;
- individual values, preferences, and patterns;
- risk of harm and level of supervision needed;
- means to enhance capacity.

The complete assessment of “capacity” would require an assessment of all domains in relation to one another.

“On Liberty for the Old” (Blake, Browne, Donnelly, and Herbert)

The kind of contextual and embodied approach to vulnerability described in the doctrines of equitable fraud is incorporated within the model set out by Mary Blake, Alistair Browne, Martha

¹²⁰ Moye et al, “Capacity Evaluation in Adult Guardianship”, *supra* note 74 at 594-97.

¹²¹ *Ibid* at 592.

¹²² *Ibid*.

Donnelly, and Deidre Herbert in “On Liberty for the Old.”¹²³ In this piece the authors take John Stuart Mills’ famous question “To what extent, and for what purposes, can others interfere with the liberty of the individual?” to provide guidance for those who “must make decisions about intervening in the lives of the old.” Noting that interference is (as per Mill) an evil to which the old are especially vulnerable, and how easy it is for the young to “tyrannize the old” (proceeding from Mills’ idea of the “tyranny of the majority”) the authors conclude that an interference with the liberty of the old would be justified only where the following conditions are met:¹²⁴

- Where the individual is putting herself a significant risk;
- Where the individual is “encumbered”, i.e. are mentally incapable of making a decision or subject to some other judgement-distorting condition,
- and where the interference will be:
 - effective,
 - not generative of evils greater than those it prevents,
 - the mildest possible to curb the evil,
 - not discriminatory (ie the individual in old age is not subject to higher standards than non-old persons similarly situated), and
 - unless the interference has utility approaching absolute necessity, thought justified by the individual.

If the risk is to other (and not self) proof of encumbrance will not be required. With this exception, all requirements must be met in order for interference to be justified.

“Encumbrances”, for the purpose of the test, “may be analysed in terms of five conditions”:¹²⁵

- Cognitive capacity;
- Mental illness;¹²⁶

¹²³ Alister Browne et al, “On Liberty for the Old” (2002) 21:2 Can J Aging 283.

¹²⁴ *In Re F*, *supra* note 26. (Lord Goff described a simple rule of no interference, ever is not feasible for reasons that may ultimately be located in the same “public interest”).

¹²⁵ Alister Browne et al, *supra* note 116 at 287, referencing Joel Feinberg “Legal paternalism” (1971) 1:1 Can J Philosophy 105.

¹²⁶ *Ibid.* (“[p]ersons may be perfectly able to understand the nature and consequences of decisions, but still have their autonomy compromised because their judgement is distorted by mental illness” at 287).

- Emotional states;¹²⁷
- Manipulation, Duress, Coercion;
- Information.¹²⁸

Personhood and Dementia: Toward a Relational Framework for Assessing Decisional Capacity” (O’Connor)

Deborah O’Connor has developed a theory of “relational capacity”, arguing “that the performance and behaviour of persons with dementia are determined not only by neuropathology, but also by their personal histories, their interactions with others, and by how they are perceived within their social contexts.”¹²⁹ O’Connor’s point is that the failure to acknowledge the relational context of capacity results in the over-identification of capacity impairment; choices that would otherwise appear irrational could appear competent when considered in relationship context. O’Connor uses the story of Mrs. Dobbs, a 77 year old widow living with her son Victor, who is described as having “longstanding mental health and addictions problems and a history of physical aggression,” to illustrate this point. Victor had recently assaulted his mother, smashing her wrist, breaking her ankle, and causing Mrs. Dobbs severe facial bruising and a cracked rib. Despite this, O’Connor describes Mrs. Dobbs as “reluctant to take any action to protect herself from her son.” Mrs. Dobbs is quoted as explaining that taking care of Victor is “100%” more important than having someone “step in” to protect her, and that having Victor involved in her life was more important than anything, including her personal safety. O’Connor explains the exchange as illustrating how a decision that might otherwise appear irrational (and so evidence of mental incompetence) was understandable as a genuine or capable decision when viewed in relationship context; “without understanding her

¹²⁷ *Ibid* (“[o]ne may be competent and free from mental illness but still be subject to varying degrees of distortion from emotional states such as nervousness, passion, agitation, excitement, pain, shock, and fatigue. These can be induced by such things as disease, injury, alcohol, narcotics, abuse, and bad news, and warp judgement as much as incompetency or mental illness” at 287).

¹²⁸ *Ibid* (“Persons who are unimpaired by any of the above may have their actions compromised by inaccurate or incomplete information. For example, one who gives another joint tenancy in her house, or enters into an exploitative relationship not knowing what alternative opportunities for socialization are available, is subject to a judgement-distorting condition as much as one who labours under incompetence, mental illness, adverse emotional states, or undue influence” at 288).

¹²⁹ Deborah O’Connor, “Personhood and Dementia: Toward a Relational Framework for Assessing Decisional Capacity” (2010) 5:3 J Mental Health Training & Practice 22 at 22.

value system, [Mrs. Dobbs'] ability to cognitively appreciate the current situation [the ability to appreciate risk]- a common standard for determining capacity- becomes suspect.”

I suggest that O'Connor's theory of relational capacity and the other capacity models discussed above are not really theories of mental capacity at all. By mandating an assessment of the individual's demonstrated cognitive ability (through her performance of thinking processes) together with and in relation to social and contextual factors, these models are more coherently understood in terms of vulnerability. This disconnect between these models and their coherent theoretical foundation *matters* as a potential source of problems. Conceptualised as a question of mental capacity, for example, Mrs. Dobb's choice is capable and so cannot be interfered with. From one perspective this may be seen as respecting Mrs. Dobbs' autonomy by refusing to impose a value judgment on her choice (and this is consistent with the frame provided by the mental capacity construct). Drawing on the equitable analysis of decision-making (as articulated in the doctrines of equitable fraud), however, Mrs. Dobb's decision is not genuine and therefore *not* truly autonomous; it may not be possible for her (or for Victor) to make different choices so long as the relationship context between them remains unbroken. In the same way, Mrs. Dobbs may be capable of genuine decision making where that context is disrupted. The focus then shifts on the kind of response that will provide the most effective response to Mrs. Dobb's vulnerability under the circumstances.

Consider the case of Dorothy, an elderly woman 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.¹³⁰ Dorothy had previously been admitted to the hospital on several occasions to be treated 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 a social worker 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

¹³⁰ Louise Holland, *Abandonment or Autonomy: How Do Social Workers Know the Difference?* (MSW Thesis, University of Northern British Columbia, 2010) [unpublished].

that she was “incapable” of speaking out about the abuse because of shame and guilt, feeling that she had brought it on herself because of 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.”

Dorothy’s case, like Mrs. Dobbs’, concerns mental capacity and the refusal of services and support in relation to *Adult Guardianship Act* (Part 3). On the terms of that legislation, if Mrs. Dobbs (applying O’Connor’s relational autonomy lens) and Dorothy are capable their decisions are autonomous and therefore “free.” Interference with the decision to remain in an abusive relationship context would be a violation of both women’s right to autonomy. From the perspective of equity theory, however (the idea of genuine decision-making underlying the doctrines of equitable fraud), the decisions made by Mrs. Dobbs and Dorothy are not free at all; the relationship contexts in which they are embedded impairs their autonomy i.e. their ability to make genuine choices about their own well-being. The law relating to wills, agreements, and transfers would have no problem recognising and responding to this kind of dynamic and the different way in which relationship context can vitiate decision-making to the extent that an apparently free decision is not, truly, the individual’s own. Where mental capacity is the only metric- in the adult protection cases discussed above as in medico-legal guardianship- that analysis is precluded. Responding to the situation of either woman would require a finding of incapacity which, for the reasons described by O’Connor, is problematic.

I contend that the problems posed by these stories cannot be resolved by the mental capacity threshold and binary. They do suggest another way of thinking about the relationship between self, context, and genuine decision-making that provides a more accurate account of why people behave in apparently irrational ways; a theory of vulnerability as a way of being in the world that waxes and wanes over the life-course through the intersection between context and self. The next question is whether social response of some kind is justified to absorb or ameliorate heightened vulnerability and if so, what kind.

4.5.3 Vulnerability theory in the adult guardianship context: a preliminary model

As described in Chapter 3, the methodology of pragmatic inquiry consists of three phases. This Chapter is the first phase: a theoretical examination of the current “situation” (medico-legal

guardianship) as structured by the “organizing idea” of the mental capacity construct, focusing on guardianship in the context of dementia in old age. The purpose of that examination has been to identify “specific troubles and perplexities” arising from medico-legal guardianship and the mental capacity construct in relation to dementia in old age. Any new model developed through this research study must be responsive to those troubles. The next step in this first phase is to identify and theoretically examine a new idea with the potential to re-organise the field of practice in a way that would resolve these problems without giving rise to fresh ones.

A preliminary theory and model of vulnerability, informed by the pre-ceding theoretical examinations of vulnerability and the mental capacity construct, is set out in this part as a potential, new “organizing idea.” The second, empirical phase of pragmatic inquiry (set out in Chapters 5 and 6) is essential to further development of this preliminary theory/model, particularly with regard to operational detail. The phase 2 research findings, together with the conclusions drawn from the phase 1 theoretical examination (which includes the preliminary model set out below), provide the basis for the theory and model set out at the end of Chapter 7 (including operational steps). The model set out below provides a basis for the next two phases of pragmatic inquiry and the more complete (although still preliminary) model set out in Chapter 7.

Drawing on the non-traditional approaches to mental capacity assessment described above, and grounded in the doctrines of common law and equity discussed in this chapter, I propose a theory of vulnerability in which the traditional indicia of impaired mental capacity- the individual’s performance of thinking processes together with medical evidence indicating (non-transitory) cause - is embedded in/part of a broader contextual vulnerability that is assessed through a consideration of the following:

- Coping/functioning in “everyday” life
- The kind and complexity of the decisions the individual must make in the short, medium and long-range (and the real risk of harm to self or others associated with those decisions)
- Real risks created to self and others through coping problems and decision-making
- A real risk of exploitation by others

The idea of “real risk” in this context (rooted in common law doctrine) requires a reasonable weighing of: the likelihood of harm; the gravity of harm should it materialise; the ability of the individual to individual to avoid the risk (by recognising it and modifying her behaviour).

Embedded in the assessment of contextual vulnerability, the indicia of mental capacity would be required but not sufficient as a basis for an order for guardianship. Assessment of contextual vulnerability would also provide the basis for the appropriate form of guardianship on a continuum that includes both substitute and supported decision-making. If a current “organic” supporting relationship is sufficient to obviate vulnerability (in terms of the factors listed above), guardianship is unnecessary and cannot be justified. If a suitable supported decision-maker is available and if appointment of a supported decision-maker would adequately respond to contextual vulnerability, that option is preferable (optimizing genuine decision-making). If a suitable supported decision-maker is not available and/or if appointment of a supported decision-maker would not adequately respond to contextual vulnerability, substitute decision-making (through appointment of a private or public guardian) may provide the appropriate response. The model proposed above would not address the problem so poignantly described by Dorothy; the situation of the person who meets the criteria for contextual vulnerability but not the criteria relating to the indicia of mental capacity. The model set out in “On Liberty for the Old” would address that gap by including other “encumbrances” such as manipulation, duress, or coercions. I suggest that these other encumbrances are the source of a qualitatively different kind of vulnerability that justifies a different kind of response- but not guardianship. As indicia of relationship context, manipulation, duress, and coercion are remediable and can be treated by disrupting that relationship context, allowing the individual to recover/rebuild her autonomy. This analysis has been applied by the English Court of Protection in connection with its exercise of the inherent jurisdiction of the court.¹³¹

4.6 Conclusions

As discussed in this Chapter, mental capacity is an abstract construct: a universal, a-temporal, and essentialist idea applying across several areas of the law. The mental capacity construct

¹³¹ Margaret Isabel Hall, “The Vulnerability Jurisdiction: Equity, *Parens Patriae*, and the Inherent Jurisdiction of the Court” (2016) 2:1 Can J Comparative & Contemporary Law 185.

works most successfully in relation to wills, agreements, and transactions, where it works together with the complimentary theories of autonomy impairment provided by the doctrines of equitable fraud. The mental capacity construct is most problematic in the context of guardianship. Without the complimentary contextual analysis provided by equity, mental capacity is overloaded in the guardianship context; the projected and un-knowable nature of decision-making in this context generates further problems. At the same time, the idea of mental capacity as the sole, scientifically based threshold for interference (displacing subjective considerations or value judgments) is essential to the justification of medico-legal guardianship in terms of autonomy-interference.

Consistent with the pragmatist point of view- “the pragmatist commitment that truth is hammered out piecemeal in the crucible of life and our situated-ness”-the next phase of pragmatic inquiry examines mental capacity and vulnerability (as ideas and as bases for action) in the adult guardianship “situation” or field of practice. This second phase is described in the following chapter

Chapter 5. Empirical Inquiry (Pragmatic Inquiry Phase 2): Research Structure and Design

5.1 Introduction

The methodology used in this research study is John Dewey's theory of pragmatic inquiry, as discussed in Chapter 3. Dewey's theory of pragmatic inquiry proceeded from his concept of the "situation": a field of practice as structured by an organizing idea.¹ All practical social endeavours (adult guardianship, special education, city planning, etc.) were, for Dewey, situations in this sense. Resolving situations that have become problematic or doubtful² therefore requires both an understanding of the conceptual framework or idea by which a field is organized and the nature of practice within the field (as it is organized by that idea). The examination and analysis carried out in Chapter 4 is the first phase in this process of pragmatic inquiry; an examination of the mental capacity construct, as the organizing idea in the field or environment of adult guardianship. That Chapter concluded by setting out a preliminary theory of vulnerability as an alternative organizing idea, resolving the doubts that have arisen in the adult guardianship situation- particularly, in the context of dementia in old age.

The empirical research described in this Chapter and Chapter 6 is the second phase of pragmatic inquiry. This empirical inquiry was carried out for the purpose of understanding how the concepts examined in Chapter 4- mental capacity and vulnerability- are understood and used by medical and legal actors involved in the implementation of guardianship for the old. This research phase has been guided by the following overarching questions:³

- To what extent is the mental capacity construct coherent as the "organizing idea" (in the pragmatist sense) in the guardianship "situation," particularly in the context of dementia in old age?
- To what extent is the mental capacity construct capable of consistent enactment by medical and legal actors implementing that idea in guardianship related practice, particularly in the context of guardianship in old age?

¹ See Chapter 3.

² In Dewey's terminology, as discussed in Chapter 3.

³ See Chapter 1.

- To the extent that it is not, what kinds of problems or difficulties are generated by this lack of coherence/workability?
- Does a principled theory of vulnerability (grounded in principles of equity and the common law) provide a more coherent and workable “organizing idea” (in terms of both theoretical coherence and potential for consistent implementation) for guardianship, particularly in the context of dementia in old age?

These guiding research questions underlie/frame the open-ended interview questions used in this phase of the research. The research questions also guided the researcher’s identification of themes in the research data using the method of applied thematic analysis, as discussed below.

This Chapter describes the structure and design of the empirical research carried out as the second stage of pragmatic inquiry in this study. The results of that research phase are set out in Chapter 6.

5.2 Empirical research: structure and design

The empirical research described in this Chapter and Chapter 6 was carried out through semi-structured interviews conducted with two sets of participants (Set A and Set B). Participants in Set A were retired judges of the British Columbia Supreme Court, as the decision-makers in the court appointed guardianship process. Participants in Set B were members of inter-disciplinary older adult mental health teams within a single health authority in the Lower Mainland of British Columbia. Participants were asked to describe elements of their practice relating to adult guardianship and, in particular, adult guardianship for the old; to describe their understanding of the concepts of mental capacity and vulnerability; and to describe the ways in which those concepts related to or informed their practice. Participants were also asked about the extent (if any) that their work had involved decision-making about admittance to a care facility. Care facility admission can be an alternative response to guardianship in the context of dementia in old age (a guardian of person is also authorised to admit a person to a care facility), and the extent to which participants were involved in decision-making around that alternative was important contextual information (care facility admission may be conceptualised as an

alternative to guardianship or public form of guardianship).⁴ The data collected through these interviews was analysed by the researcher using the qualitative method of applied thematic analysis.

The first part of this Chapter describes the participants involved in the study, the research settings, the basis on which recruitment pools were identified, and the process through which participants were recruited. In the second and third parts of this Chapter I describe the open ended interview technique and interview process used in this research. The fourth part of this Chapter describes the method through which the data collected through these interviews was analysed: applied thematic analysis.

5.3 Participants and research settings

As described in Chapters 2 and 4, adult guardianship is carried out through the work of medical⁵ and legal actors within an over-arching legal framework. The conceptual basis or organizing idea of adult guardianship- the medico-legal mental capacity construct- is also interdisciplinary in nature, as described in Chapter 4. The structure of the empirical research described in this chapter, involving interviews with two sets participants drawn from the disciplines of law (the retired British Columbia Supreme Court judges in Set A) and medicine (the interdisciplinary mental health team participants in Set B) respectively, is consistent with the interdisciplinary nature of the subject under inquiry.

5.3.1 Limitations

In terms of participation, the research design described in this part had three meaningful limitations. The limitation of legal participation to retired Supreme Court judges restricted this research to court appointed guardianship (excluding statutory guardianship). This limitation also excluded lawyers; the responses received from Set A participants through this research process indicated that lawyers would have provided a rich source of knowledge and information (as

⁴ Margaret Isabel Hall, “Mental Health Law for the Old: Defining the Category, Identifying the Issues” in Jennifer Chandler & Colleen Flood, eds. *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016) 371.

⁵ “Medical actors” is used broadly here to refer to a range of health professionals and is not restricted to physicians.

described below). Third, this phase of the research inquiry did not include participation by guardians themselves, or by persons subject to guardianship orders.

As described in Chapter 2, the mechanisms of statutory and court appointed guardianship in British Columbia are very different from one another, in terms of legislation (*Patients Property Act* and *Adult Guardianship 2.1*), processes, and identity/role of the participants in those processes. Statutory guardianship involves appointment of the Public Guardian and Trustee as guardian of finance/property (only) on issuance of a certificate of incapability by a Health Authority Designate following a two part capacity assessment (as described in Chapter 2). Part 1 of that assessment, carried out by a medical practitioner, consists of “one or more examinations and all resulting diagnoses and prognoses relevant to the adult's incapability to manage that adult's financial affairs.” Part 2, carried out by a medical practitioner or by a “qualified health provider” consists of “one or more evaluations of the adult's understanding of, and ability to manage, that adult's financial affairs.” Nurses, psychiatric nurses, occupational therapists, psychologists and social workers may become qualified health providers for this purpose (on meeting standards set by their professional organisation).⁶ This second stage assessment includes the following inquiries:

- whether the person can understand the risks and benefits associated with taking/not taking a particular action;
- whether the person can understand the decisions and actions necessary for the reasonable management of her affairs;
- whether the person can understand the nature and extent of her property and finances, and her obligations to dependents (if any),
- and the person's ability to manage her financial affairs (whether she is able to implement or direct others to implement decisions and actions with regard to her financial affairs).⁷

As described above, legal involvement in the statutory guardianship process is limited to the role of the Public Guardian and Trustee. That role is very different from the role of a judge in the court appointed guardianship process.

⁶ *Statutory Property Guardianship Regulation*, BC Reg 115/2014, Part 2.

⁷ *Ibid.*

During the planning phases of this research, I approached the Public Guardian and Trustee about participating in this research study. That Office declined to be involved. For this reason, participation in this study by legal decision-makers in the statutory guardianship process was not possible.

The restriction to legal participants in the court appointment process can also be justified by the generalizability of those processes across jurisdictions. Court appointed guardianship is broadly similar across jurisdictions (despite the variations discussed in Chapter 2); the statutory guardianship process in British Columbia (following reforms brought into force in 2014 as the *Adult Guardianship Act 2.1*) is, in contrast, unique. This research study is an examination of adult guardianship, broadly understood, as a practice shaped by a particular conceptual framework (as opposed to an examination of distinctive procedures in one jurisdiction). The focus on court appointed guardianship is consistent with this subject and with the methodology used in this study. A subsequent study focusing in a discrete way on the new statutory guardianship process in British Columbia would be another important contribution to knowledge in this field.

My initial decision to focus on judges (rather than lawyers) in the court appointed guardianship process was made on the basis of the judge's role as the decision-maker in that process. The judge's task of impartially applying the law is different from the lawyers' task of using the law to achieve a particular end. I was interested in knowing the extent to which judges made decisions on the basis of mental capacity and their understanding of that concept; how judges understood vulnerability and whether vulnerability was ever relevant to judicial decision-making about guardianship; and judges' understanding of the role played by medical evidence in this context. Lawyers participate in the guardianship process and undoubtedly have a role in settling disputes outside of court but do not play the same role in terms of interpreting and implementing the law. On the basis of the responses that I received from Set A participants during this phase of the research, however, I understood that it would have been helpful to include experienced lawyers working in this area in a third participant set. Lawyers would have more familiarity with and knowledge of their clients, and I anticipate that their recollection of guardianship cases would be significantly better than the Set A participants. I was not expecting the judge participants to recall so little about adult guardianship cases, and I feel that the information lawyers could

provide would usefully supplement the responses I received, especially given the low number of retired judges who agreed to participate in the research study. Lawyers would also be able to comment on the willingness of physicians to provide affidavit evidence in guardianship cases, a point that emerged through the empirical research (and which I did not anticipate when designing this phase).

My decision not to include guardians and persons subject to guardianship was made on the basis of the methodology I used in this research, pragmatic inquiry. Dewey's pragmatic inquiry is concerned with the way in which a field of practice is (and could be) organized by a particular framing idea as that idea is implemented or carried out by the professional actors in that field. Dewey was interested in changing organizing ideas because he was interested in changing the way that people do things, as part of a situation. The limitation of research participation to professionals can be justified on this methodological basis although it would have enriched the research findings to investigate the experiences of individuals on the receiving end of the guardianship process: persons for whom a guardian is appointed, and those acting as guardians. Incorporating this other, distinct set of participants into this research study would have expanded the parameters of the study considerably however, bearing in mind that the empirical research carried out in phase two is one phase of a three phase inquiry. Further testing and development of the preliminary model set out in Chapter 7 through qualitative research carried out with guardians and persons subject to guardianship would be an important next step in developing the subject of this research.

5.3.2 Set A (retired judges): inclusion criteria, recruitment, and interview setting

The selection of retired judges of the British Columbia Supreme Court as the legal actor participant group was made on the basis of their role in the adult guardianship process under the *Patients Property Act*, as described above. With the exception of the Public Guardian and Trustee's involvement in the statutory guardianship process (also described above) legal decision-making in the adult guardianship field happens only at the point of court appointment- a process carried out by judges and masters in the British Columbia Supreme Court.⁸ Active judges and masters are unable to comment publicly on legal processes in a way that is or could

⁸ Judges and masters hear non-contested applications in Chambers. Retired Judges and Masters were approached to participate in the study, but retired judges only responded.

be perceived to be critical. The decision to approach retired judges and masters as potential participants was made on the basis that they would be able to comment more freely on those processes and the judicial role in them.

Thirty five letters of invitation were sent to retired judges and masters of the British Columbia Supreme Court care of the Court. These letters explained the nature of the research project, the identity of the researcher, and the kind of participation that would be required (an open-ended interview of approximately 60 minutes in duration). Prior to sending out these letters, the researcher contacted the Court and received approval from the Chief Justice and Associate Chief to have the letters forwarded to the persons to whom they were addressed. The names of retired judges and masters were obtained from the British Columbia Supreme Court website. Seven judges responded expressing interest in participating. Interviews with all seven were arranged. Four were carried out at the Allard Hall School of Law at the University of British Columbia in Vancouver British Columbia; two interviews were carried out at private residences, one in Vancouver and one outside the Lower Mainland, at the participants' request.

As retired judges, all members in the group had lengthy experience on the bench. Three had served on the British Columbia Court of Appeal in addition to serving as Supreme Court judges, one had served in the County Court and one in the British Columbia Provincial Court prior to joining the British Columbia Supreme Court. The Set A participants are summarised in the table below:

Table 1: Set A Participants (Supreme Court Judges)

Judge 1	Judge 2	Judge 3	Judge 4	Judge 5	Judge 6	Judge 7
12 years experience (BCSC)	22 years experience (BCSC)	20 years experience (BCSC and BCCA)	34 years experience (BC Provincial Court and BCSC)	11 years experience (BCSC)	28 years experience (BCSC and BCCA)	31 years experience (BCSC and BCCA)

Participants were asked open ended questions about their experience with guardianship issues generally and, specifically, with respect to guardianship in relation to older adults. Participants were also asked to describe their understanding of the concepts of mental capacity and

vulnerability, and how those concepts influenced and impacted their practice. As open ended interviews, there was considerable space in the process for participants to expand on their answers if they wished and some of the Set A participants did so, providing lengthy interviews. The interview process is described more fully in the following section.

5.3.3 Set B (health team members): inclusion criteria, recruitment, and interview setting

Identifying the recruitment pool for medical/health professionals was more complicated. The court appointment process set out in the *Patients Property Act* requires that two physicians provide affidavit evidence stating their opinion that the individual is incapable of managing her estate (finance/property), her person (health care and personal matters/decisions) or both. Physicians providing affidavit evidence need not be psychiatrists or specialists of any kind and, theoretically, any physician in British Columbia can provide affidavit evidence for this purpose. Two kinds or groups of physicians are most likely to do so, however. The first group is family doctors (general practitioners). Members of this group are frequently asked to provide affidavit evidence of capacity. Family doctors generally have the most contact and familiarity with individuals, and will be in a position to see any changes in patient behaviour over time. For many people, moreover, the family doctor is their only medical contact making this person the only physician who *can* provide evidence, even where she is not particularly familiar with the individual. Psychiatrists, geriatric psychiatrists in particular, are the second group of physicians who are most likely to provide medical evidence in the court appointment process. Most persons who become involved in the guardianship court appointment process later in life (i.e. where issues around the loss of capacity arise for the first time in old age) will not have regular contact with psychiatrists; unlike family doctors, psychiatrists will tend to become involved either as specialists brought in where the capacity is contentious, or where the assessment is made by the psychiatrist in her capacity as a member of an interdisciplinary health team (in which case other team members will have contributed to the final assessment). Where psychiatrists become involved in this way, they are likely to be specialists within that profession i.e. geriatric psychiatrists.

Two broad criteria were applied in selecting the group from which participants would be drawn for this study: the likelihood that members of the group would have a deep experience/familiarity with the processes of adult guardianship in relation to older adults, and the likelihood that

members of the group would work with the ideas of mental capacity and vulnerability (the conceptual subjects of this research) on a regular basis. A participant group meeting these criteria would be more likely to provide the kind of rich, focused interview data required for pragmatic inquiry. On the basis of these criteria, family doctors/general practitioners were found to be unsuitable for this purpose. Although family doctors as a collective are important medical players in adult guardianship, an individual family doctor may have no or little experience/familiarity in working with the practices and concepts under consideration. Attempting to identify and recruit individuals within the relatively large family doctor pool with the relevant practical and conceptual experience/familiarity would be difficult and very possibly fruitless.⁹

Psychiatrists, as physicians, were another potential recruitment group. Despite the smaller size of the pool, however, similar difficulties arise with respect to psychiatrists as with family doctors. Individual non-specialist psychiatrists (unless working in a specific context such as older adult mental health teams), like family doctors, may have no or limited experience with capacity assessments for older adults (either in general or in association with adult guardianship). Non-specialist psychiatrists, as a collective, are likely to have a greater familiarity in thinking about and working with the concepts of vulnerability and mental capacity outside of the context of guardianship for older adults i.e. in relation to persons identified as mentally ill (for whom guardianship is much less likely to be sought than for persons identified with dementia).¹⁰ As a smaller, sub-group within this category, geriatric psychiatrists will have a very high level of familiarity with and experience of capacity assessment and guardianship processes, and of thinking about and working with concepts of mental capacity and vulnerability in relation to persons experiencing dementia in old age. As a potential pool of research participants, however, the small number of geriatric psychiatrists raises problems in terms of adequate participation and also the potential for identification.¹¹

⁹ Focus group research with members of this pool may be useful in the future, to augment the information obtained through the individual open ended interviews conducted for this study.

¹⁰ The extent to which dementia should or should not be classified as mental illness is contentious, but generally mental illness and dementia are treated as distinct phenomena within the medical profession.

¹¹ Medical-actor recruitment and/or participation was limited to a single British Columbia health authority, exacerbating these problems.

After consideration of these criteria, members of community based older adult mental health teams (including psychiatrists, nurses, occupational therapist, psychologists and social workers working in the specific context of older adult mental health) were chosen as the most suitable recruitment pool for participants in Set B.¹² While only physician members of these teams would be able to provide affidavits, all team members would be familiar with the guardianship process and with providing the kind of evidence required for that process. Members of this pool could be expected to have a familiarity and expertise with the practices associated with adult guardianship (court appointed and statutory) and with thinking about and working with the concepts of vulnerability and mental capacity, particularly in relation to dementia in the context of old age. Despite the differences between the professional groups involved on mental health teams, I determined that their engagement in a common enterprise within a single unit created sufficient homogeneity for the purposes of this research. To note differences where they do arise, participants were identified by their specific professional affiliation within Set B and the analysis of themes arising from the Set B data includes the identification of any meaningful distinctions between professional groups (where a participant linked his or her response to their professional identity).

Participants were recruited from three older adult mental health teams within a single health authority in the Lower Mainland of British Columbia. The researcher contacted each team by email through the health authority, providing a general description of the project and the researcher's contact information. Team members interested in participating in the project then contacted the researcher directly. A hospital based psychiatrist (mental health older adult assessment and treatment) was also interviewed (identified as MH4 on the table below). I believed that it was important to have adequate psychiatrist representation, and the participant met the criteria outlined above. The psychiatrist was contacted and provided with a general description of the project and the researcher's contact information by a physician associated with one of the health teams participating in the project. The psychiatrist (MH4) then contacted the researcher and the interview was arranged.

¹² Community based old adult mental health teams are units that may be created by and operate in one of the provincial health authorities. Teams carry out individualised assessment of the individuals they serve, organise services as necessary, and make referrals. There were several old adult mental health teams operating in the lower mainland at the time this research was carried out.

The teams are identified as MH1, MH2, and MH3 in the Table below. Team members were interviewed in the offices of the MH1, 2 and 3 respectively. The interview with MH4 took place in MH4's office. The Set B participants are summarised in the table below:

Table 2: Set B Participants (Health Professionals): Inclusion Criteria and Recruitment

MH1	MH1	MH1	MH2	MH2	MH2
Geriatric Psychiatrist	Neuropsychologist	Clinical Social Worker	Occupational Therapist Case Manager	Family and Social Support Mental Health Practitioner	Case Manager

MH3	MH 3	MH3	MH3	MH4
Occupational Therapist	Case Manager	Clinical Supervisor	Occupational Therapist	Geriatric Psychiatrist

5.4 Professional identity, cultural homogeneity, and saturation

The research participants in Set A (retired judges) and Set B (health professionals involved in older adult mental health team work) were drawn from two professional groups engaged at different stages of the adult guardianship process. The work of the professionals represented by each Set is essential to court appointed guardianship, as a legal process dependent on medical input.

Important distinctions exist between the two groups, however, in ways that impact the nature of each Set in terms of professional identity and the homogeneity of each professional group. British Columbia Supreme Court judges are a professionally homogenous group of legal generalists, hearing and making decisions about a wide range of legal issues. The health professional participants in Set B, in contrast (and for the reasons set out in the previous part), are drawn from members of different health-related disciplines working together in a comparatively focused subject area: specialists, rather than generalists. In this role, the work of Set B participants is always engaged with broad concepts of mental capacity and vulnerability in relation to the old, unlike the generalist judges (who, as indicated by the data, seldom deal with these concepts/issues). The data indicates that the particular professional perspectives brought

by individual participants within Set B to the common task of the interdisciplinary teams (as social worker, occupational therapist, or psychiatrist for example) was seldom visible. No meaningful distinctions emerged between the responses provided by team members drawn from particular professions; very occasionally, respondents would refer to their professional perspective as an OT, social worker, etc. and this is indicated in the quotations from the data.

The professional identities and degree of (professional) cultural homogeneity among the two Sets of interview participants is relevant to the question of “saturation.” Saturation in qualitative research (the standard through which sampling size or number of interviews is determined) refers to the point at which it can be expected that no new information or themes are will be discovered through the collection of further data.¹³ Relatively small samples have been found to be sufficient for saturation where participants possess expertise about the domain of the inquiry (“cultural competence”) and where both participants and the subject of the inquiry are located within a particular cultural context;¹⁴ samples of four interviews have been found to yield extremely accurate information with a high confidence level if the interviewees possess a high level of expertise or “competence” in the subject of inquiry.¹⁵ Small sample saturation is also enhanced where participants answer questions independently of one another (ie. interviews rather than focus groups); where interview questions comprise a coherent domain of knowledge (as opposed to unstructured and highly exploratory interviews), and where participant-sets are homogenous.¹⁶

Both Sets of interview participants satisfied these requirements for saturation. Each Set was sufficiently culturally¹⁷ homogenous, and interview questions were narrowly focussed in this particular cultural domain. Set A (the retired judges) was, in particular, smaller than I anticipated. Given that a sample size of four has been found sufficient where professional participants possess a high level of expertise in the subject of inquiry (as described above), the

¹³ See, Janice M Morse, “Designing Funded Qualitative Research” in Norman Denzin & Yvonna Lincoln, eds, *Handbook for Qualitative Research* (Thousand Oaks: Sage, 1994) 220 at 220.

¹⁴ Greg Guest, Arwen Bunce & Laura Johnson, “How Many Interviews Are Enough? An Experiment with Data Saturation and Variability” (2006) 18:1 *Field Methods* 59; A Kimball Romney, William Batchelder & Susan Weller “Culture as Consensus: A Theory of Culture and Informant Accuracy” (1986) 88:2 *American Anthropologist* 313.

¹⁵ Romney, Batchelder & Weller, *supra* note 14 at 326.

¹⁶ *Ibid.*

¹⁷ “Culture” here referring to professional culture.

Set A size of 7 was sufficient, although a greater number of participants (similar to Set B) would have enhanced my research findings.

5.5 Interview procedure

The empirical research described in this Chapter used the technique of semi-structured interviews. A semi-structured interview does not restrict participants to the interview questions, but creates a dialogue by allowing the researcher to respond to participants' answers through follow up questions, or by changing the order in which questions are asked. The interviewer is positioned within a semi-structured interview as a discussion guide or facilitator rather than an interrogator. The nature of the semi-structured interview, and the roles of the interviewer/participant within it, are intended to provide rich, detailed data relating to the individual's experience in relation to the subject matter under inquiry as opposed to the highly directed questions used in quantitative research. The objective is to generate nuanced data about the nature of the subject under consideration rather than statistical information regarding pre-determined aspects of that subject of the kind generated by a yes/no/scale of 1-10 questionnaire, for example.

Prior to the interview (via email) participants were provided with a copy of the informed consent document (including a description of the project and the way in which data would be used). On the day of the interview and prior to the interviewer proceeding, another copy of the consent form was provided to the participant, which the participant and the researcher went through together. After the participant signed the consent form, the interview began. Participants in Set A were asked how long they had served as a judge, and when they retired; Participants in Set B were asked to identify their profession, how long they had worked in that profession, their current position, how long they had worked in that position, and the extent to which their work (current and past) involved working with older adults.

Following these preliminary questions, participants in Set A were asked to discuss the following 10 questions in sequence (i.e. the researcher asked the first question and then, after the participant had fully answered it and was ready to move on, proceeded to the second and so on):

1. Over the course of your career, how frequently would you estimate that you were called upon to consider the mental capacity of an older adult in a case concerning the appointment of a committee under the *Patients Property Act*?
2. Over the course of your career were you ever called upon to consider whether an older adult was properly admitted to a care facility? If so, please explain.
3. What in your opinion is the purpose or objective of appointing a committee for an older adult, or for a younger person? Do you understand these purposes to be different in any way, and if so how?
4. Please explain your understanding of the role of health professionals in the determination of mental capacity for the purpose of appointing a committee.
5. Please explain your understanding of the court's role in the determination of mental capacity for the purpose of appointing a committee.
6. What is your understanding of the concept of "mental capacity"? Please explain what you understand that term to mean generally, and as it relates to older adults.
7. Can you describe a case example in which you found mental capacity to be a difficult or problematic concept to apply when considering the appointment of a committee for an older adult? Can you describe a case example in which you found mental capacity to be a straightforward and useful concept to apply when considering the appointment of a committee for an older adult?
8. What is your understanding of the concept of "vulnerability"? Please explain what you understand that term to mean generally, and as it relates to older adults.

9. Did you ever consider the vulnerability of an older adult when making a decision about the appointment of a committee for that person? If the answer is no, please explain why not. If the answer is yes, please describe (as applicable):
 - a) a case example in which you found vulnerability to be a difficult or problematic concept to apply in this kind of case
 - b) a case example in which you found vulnerability to be a straightforward and useful concept to apply in this kind of case

10. In what circumstances would you, if ever, base your decision in a case involving the appointment of a committee on your perception of the vulnerability of an older adult, rather than his or her mental capacity?

Following the preliminary questions identified above, health team members were invited to discuss their answers to the following 11 questions (in sequence):

1. Over the course of your career, how frequently would you estimate that you were called upon to participate in the assessment of an older adult's mental capacity? Briefly describe the nature of your participation (your role on the team).

2. When team members are discussing a particular case (as during "rounds") is the possible *legal* outcome of the assessment in question ever discussed?

3. Do you understand the decision to admit a person to a care facility to have any *legal* aspects (is this, in any way, a legal question)?

4. What in your opinion is the purpose, or objective, of appointing a committee for an older adult, or for a younger person? Do you understand these purposes to be different in any way, and if so how?

5. Please explain your understanding of the role of health professionals in the determination of mental capacity for the purpose of appointing a committee.

6. Please explain your understanding of the court's role in the determination of mental capacity for the purpose of appointing a committee.
7. What is your understanding of the concept of "mental capacity"? Please explain what you understand that term to mean generally, and as it relates to older adults.
8. Can you describe a case example (in which, to your knowledge, the appointment of a committee for an older adult was being considered) in which you found mental capacity to be a difficult or problematic concept to apply? Can you describe a case example (in which, to your knowledge, the appointment of a committee for an older adult was being considered) in which you found mental capacity to be a straightforward and useful concept to apply?
9. What is your understanding of the concept of "vulnerability"? Please explain what you understand that term to mean generally, and as it relates to older adults.
10. Did you ever consider the vulnerability of an older adult when assessing that person in a case in which, to your knowledge, the appointment of a committee was being considered?

If the answer is yes, please describe (as applicable):

- a) a case example in which you found vulnerability to be a difficult or problematic concept to apply
 - b) a case example in which you found vulnerability to be a straightforward and useful concept to apply
11. In what circumstances (if ever) would you base your assessment of an older adult on your perception of that person's vulnerability rather than his or her mental capacity (in a case where the appointment of a committee was, to your knowledge, being considered)?

Interviews were recorded and transcribed. The two data sets were then analysed by the researcher using the method of applied thematic analysis described below.

5.6 Research structure and design: limitations and validity

This research study was designed in accordance with Dewey's three phases of pragmatic inquiry. This includes an extensive conceptual and theoretical examination in addition to the empirical research phase described in this Chapter. As explained in Chapter 3, the use of this methodology (developed in the early part of the 20th century) in relation to law as it "organises" a practice carried out by both legal and non-legal actors is a significant contribution made by this research study.

One limitation in the research design was the restriction of participants to the members in Sets A and B. The reasons for that restriction are set out earlier in this Chapter. Participation by guardians, persons subject to guardians, lawyers, participants in the statutory guardianship process and also family doctors would have provided useful information. Widening the scope of the second phase to include these participants would have significantly expanded the project, however; in some cases, additional practical difficulties existed (such as the Public Guardian and Trustee declining to participate in the study). Bearing in mind the specific objective of pragmatic inquiry- testing ideas for the purpose of changing the field of practice- these limitations did not frustrate the usefulness of the data in terms of testing and developing the phase 1 findings set out in Chapter 4. Given the tripartite nature of pragmatic inquiry, significantly expanding the scope of the empirical phase would not have been feasible.

The second phase of pragmatic inquiry involves qualitative research and, accordingly, I have incorporated qualitative method (applied thematic analysis, described below) within this phase. In a similar way, I have sought to incorporate qualitative strategies for ensuring the validity or trustworthiness of research findings. As described below, I have tried to balance/reconcile these strategies with the methodological structure of this research study. The validity criteria and strategies discussed below must be understood in the context of this larger structure. These criteria/strategies were developed in relation to qualitative research studies; the qualitative research carried out in this study is one of three intersecting parts, each building on and intersecting with the other within the framework of pragmatic inquiry.

Lincoln and Guba have set out four criteria for evaluating validity: credibility; transferability; dependability; and confirmability.¹⁸ To be credible, research findings must be believably connected to reality. Strategies for establishing credibility include triangulation, member checking, and prolonged engagement in the field.¹⁹ Triangulation refers to the collection of data from multiple sources (interviews, focus groups, ethnographic observation, literature review, etc.) as a strategy for developing but also for supporting research findings. Chapters 2 and 4 contain literature reviews that provide context for the findings discussed in Chapter 6 in a way that assists with the credibility of those findings. The theoretical examination (set out in Chapter 4) of the concepts explored at the empirical phase provides another kind and source of triangulation that is consistent with the methodology of pragmatic inquiry. Focus groups would not have been an effective means of gathering the kind of information I was interested in, but it would have been effective for me to pursue obtaining documentary information (court filings, for example) to augment or supplement my findings. Given the focus of my inquiry however- the way in which the concepts of vulnerability and mental capacity are understood and used by actors involved in adult guardianship- open-ended interviews were the most effective method for gathering the information I needed to answer my research questions. My engagement in the field has been extensive, but could have been added to through court observations and seeking research ethics approval for observation of health team “rounds.”

Member checking is a step that I could have usefully integrated into my research design without significantly (and possibly unfeasibly) expanding the scope of phase two. Member checking, “taking data and interpretations back to the participants in the study so that they can confirm the credibility of the information and narrative account,”²⁰ could have been carried out as part of the third stage of pragmatic inquiry (“Judgment”) set out in Chapter 7. Member checking in this phase would have involved returning to participants in Group A and Group B with the adult guardianship model developed and set out in Chapter 7; collecting their thoughts and feedback about that model in a final open ended interview; and including those observations in the

¹⁸ Y.S. Lincoln & E.G. Guba. *Naturalistic inquiry: The paradigm revolution*. (London: Sage, 1985) at 290.

¹⁹ *Ibid.*

²⁰ Y.S. Lincoln & E.G. Guba. *Naturalistic inquiry: The paradigm revolution*. (London: Sage, 1985) at 127.

judgment phase. Integrating member checking within my research design would have strengthened the validity of the research findings.

Transferability refers to establishing that the research findings are not specific or particular to the research participants but have a more general applicability. Lincoln and Guba describe “thick description” (a rich and detailed account of the interview experience) as a key transferability strategy; by situating information in cultural and social context thick description enables the reader to draw her own conclusions about generability.²¹ The discussion of research findings set out in Chapter 6 draws on this technique, providing sufficient detail to convey the very distinct “voices” of the participants and the feel of the interview process. Providing those voices contextualises the research findings, maintaining a connection to participants’ personalities, attitudes and emotions. In accordance with Lincoln and Guba’s third criteria of dependability, I had my supervisory committee members examine the appropriateness of the research design and tracked and documented all stages of the data analysis.

The last criteria, confirmability, means “confirming” that the empirical research findings are based on the information provided by the participants rather than the researcher’s own biases. In this part I have sought to explain the reasons for making the research decisions that I made in structuring this phase of the research. In the following part of this Chapter, I explain my choice of the research method of applied thematic analysis. In other parts of this research study (Chapter 1 and 3), I have explained my selection of pragmatic inquiry methodology (providing the overarching structure of this research); at the conclusion of Chapter 3, I situate that choice in the interdisciplinary nature of adult guardianship and my own knowledge-background as a legal academic with interests in adult guardianship and health law but also private law.

5.7 Research method: applied thematic analysis as a method of pragmatic inquiry

As described in Chapter 3, a research methodology is a theory about the nature and purpose of the research exercise, providing the conceptual framework for a particular research study. The research method chosen should generate the kind of information or knowledge that will best achieve this purpose. The researcher’s choice of both methodology and method is rooted in the epistemology, or theory of knowledge (“the nature of knowledge and its justification”)²²

²¹ *Ibid.*, at 316.

²² Thomas A Schwandt, *Dictionary of Qualitative Inquiry*, 2d ed (Thousand Oaks: Sage, 2001) 71.

underlying the research study and the objectives or purpose of that study: what does the researcher want to know? Is her objective to deepen understanding about a phenomenon, or to examine and suggest a solution to a particular problem?

The ultimate objective of pragmatic inquiry, the methodology used in this research, is the re-organisation and transformation of problematic situations: this is not possible without understanding how the organizing idea of that situation works (through its implementation by actors in the field) in practice. Knowledge of how ideas or theories are implemented in practice informs and deepens understanding of a situation in a way that is essential to its successful reconstruction on a different theoretical basis. The coherence and workability of any alternative basis must also be examined with reference to its implementation in the field by the actors working in the field of practice: if the vulnerability theory described at the conclusion of Chapter 4 cannot be coherently and consistently implemented in the field of practice it is not valid. As described below, the research method of applied thematic analysis (as defined below) is consistent with these objectives.

5.7.1 Research method: applied thematic analysis

The interview data collected through the open ended interviews carried out in this research phase was analyzed using the qualitative method of applied thematic analysis. Thematic analysis generally refers to a method of analyzing data that “mov[es] beyond counting words and phrases to focus on identifying and describing both implicit and explicit ideas within the data, that is themes.”²³ *Applied* thematic analysis (as opposed to “pure” forms of data analysis “oriented towards furthering existing knowledge for the sake of curiosity and knowledge itself”)²⁴ is carried out for the “common end purpose of solving practical problems.”²⁵ Applied thematic analysis is therefore different in terms of both purpose and nature from grounded theory, in which the researcher approaches the data without objective (i.e. something she wants to know, or a theory she wants to test) for the purpose of “construct[ing] theories that are “grounded” [or arise from] in the data itself.”²⁶ In this way, applied thematic analysis is consistent with the

²³ Greg Guest, Kathleen M MacQueen & Emily E Namey, *Applied Thematic Analysis* (Los Angeles: Sage, 2012) at 10.

²⁴ “Grounded theory” is an example of this kind of approach. See Kathy Charmaz, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (Thousand Oaks: Sage, 2006) at 2.

²⁵ *Ibid* at 11.

²⁶ *Ibid*.

objectives of pragmatic inquiry: to examine and resolve specific problems arising in a particular environment or “situation.”

Guest, MacQueen and Namey have defined applied thematic analysis as “referring to the identification of themes in relation to a specific theory, objective, or hypothesis related to a particular problem with the goal of resolving that problem” (as opposed to a more open analysis in which theory and objectives arise through the analysis of the data).²⁷ The authors describe applied thematic analysis using the metaphor of a composite fighting style developed by the great martial artist Bruce Lee, which he called “Jeet Kune Do:”

I have not invented a “new style”, composite, modified or otherwise that is set within a distinct form as apart from “this” method or “that” method. On the contrary, I hope to free my followers from clinging to styles, matters, or molds.²⁸

Lee saw Jeet Kune Do as an “emancipatory” approach that would allow practitioners to choose from a wide range of techniques and employ the most appropriate one for a given objective.

Guest, MacQueen and Namey describe good data analysis as, similar to Jeet Kune Do, “combine[ing] appropriate elements and epistemologies from across traditions and epistemological perspective.”²⁹ The objective is the starting place: what is your purpose? Methodology and method are chosen in terms of their suitability or usefulness and a means of achieving that purpose.

In accordance with the spirit of Jeet Kune Do, the epistemology of pragmatic philosophy and Dewey’s methodology of pragmatic inquiry were selected for this research study because of their usefulness as a way of understanding and responding to legal problems, with the objective of resolving those problems through legal change or reform. Applied thematic analysis is used in this research study as a means of implementing pragmatic inquiry in empirical research, generating the kind of information that will help to achieve this objective. Neither method nor

²⁷ See, Barney Glaser & Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (New York: Aldine de Gruyter, 1967).

²⁸ Guest, MacQueen & Namey, *supra* note 23 at 3, quoting Bruce Lee, “Liberate Yourself From Classical Karate”, *Black Belt* 9:9 (1971) at 24.

²⁹ Guest, MacQueen & Namey, *ibid.* at 3.

methodology used in this study is a traditional form of legal research; their use in this context is itself an example of Jeet Kune Do.

5.7.2 Identifying themes

Themes are repetitive high-level patterns of information and meaning that emerge through a close reading of the data in connection with the questions framing the research and the objective of the research study. Themes are identified through thematic analysis, a process which creates a deep familiarity with and understanding of the data. The first step in that process is referred to as “coding.” Coding refers to the identification of recurring phrases (explicit) or ideas (implicit) through an iterative process in which the identification of initial codes informs subsequent reading of the data (revealing in turn new ideas in the data and new ways of thinking about and understanding previously identified codes).³⁰ The coding process develops a familiarity and an intimacy with the data that makes it possible for the researcher to identify emerging themes.³¹ Emerging themes are then reviewed in relation to each other and in relation to the theory and questions underlying the research, creating another level of understanding about the situation under consideration and, higher level, more general themes.³² The purpose of identifying these high level themes is to address the questions underlying this research, and to develop meaning and understanding both about the research problem and about the proposed resolution to that problem set out at the conclusion of Chapter 4: a coherent theory of vulnerability rooted in legal principle.

The identification of themes in the data was carried out using both an inductive and a deductive approach. Deductive research aims to test a theory against/in relation to the data; research that is inductive in nature, in contrast, is concerned with the generation of new theory emerging from the data. Guest, MacQueen and Namey use the term “explanatory analysis” to refer to an research approach that incorporates both aspects: where the analysis is driven by the objective of explaining certain phenomena or concepts with reference to a particular theory, but the “data is

³⁰ Coding is in this way a method of deep reading, rather than the mere identification of recurring words in the data

³¹ The research questions are necessarily related to the themes, as the information provided by participants is shaped, to a significant extent, by those questions.

³² Virginia Braun & Victoria Clarke Victoria Clarke, “Using Thematic Analysis in Psychology” (2006) 3:2 *Qualitative Research in Psychology* 73 at 83.

sufficiently rich to inform [that] theory.”³³ This approach aligns perfectly with the pragmatic inquiry objective. Applied thematic analysis, incorporating this deductive/inductive “explanatory” approach, is also apposite to the objectives of reform-oriented legal research more generally: to identify and understand problems, as they are informed by a particular theory (i.e. the applicable law), and to resolve those problems through the development of new law.

In order to convey the nature of the themes identified in Chapter 6, details and quotations from the interviews are provided to convey the richness and nuance of meaning contained in the data, and the strong voices of the participants (which I think adds to meaning). The themes emerged both through explicit statements of research participants and through ideas or meaning implicit in those statements, arising through the researcher’s careful reading of the data and the identification of underlying or implicit recurring ideas. In this way, identification of a theme happens through the interaction of the researcher (her knowledge and theoretical standpoint) with the participant data.

The following chapter (Chapter 6) sets out the themes identified in the data for each set, followed by an initial integration of these themes into higher-level thematic statements.

³³ *Ibid.* The authors describe explanatory analysis as “an increasingly important approach within applied qualitative research” at 39.

Chapter 6. Pragmatic Inquiry Phase 2: Empirical Inquiry m

The first two parts of this Chapter set out the themes identified in the interview data for Set A and B, respectively, using the method of applied thematic analysis (as described in Chapter 5). These themes are integrated within the over-arching or higher level themes discussed in the final part of this Chapter. Themes are illustrated with quotations from the data, providing a depth and richness of meaning through the voices of the participants (the kind of “thick description” described in Chapter 5).

6.1 Set A themes: retired judges

As described in Chapter 5, semi-structured interviews were carried out with 7 retired judges of the BC Supreme Court. The table below identifies each participant in terms of their experience:

Table 3: Set A Participants (Supreme Court Judges)

Judge 1	Judge 2	Judge 3	Judge 4	Judge 5	Judge 6	Judge 7
12 years experience (BCSC)	22 years experience (BCSC)	20 years experience (BCSC and BCCA)	34 years experience (BC Provincial Court and BCSC)	11 years experience (BCSC)	28 years experience (BCSC and BCCA)	31 years experience (BCSC and BCCA)

1. Apparent low occurrence of judicial decision-making about mental capacity in the context of court appointed guardianship/committeeship proceedings

Participants were asked to estimate the number of times they would have considered the mental capacity of an adult in a case concerning the appointment of a committee (*Patients Property Act*). The responses received indicated that this issue arose infrequently and that, in any event, these cases would have been unlikely to leave either a written or a mental/memory trace:

“I would guess that it was probably less than a dozen times... A smattering... with very few exceptions, cases to me were like bathtubs- you filled the tub up with water, you dealt

with them, and then when you dealt with them you pulled the plug and the water drained out!... I don't think I ever had occasion to write reasons on any of these cases... often the family would be in the courtroom... And I always thought it was preferable to try and talk to them about the result... than write to them about the result I was going to impose.”

“We would sit in Chambers probably every couple of months, at least, and then you went through... it's just a wide spectrum of cases... and you deal with them expeditiously... and somewhere in the mix I'm sure I must have dealt with cases where people were not capable for one reason or another but I can't recall any specific cases where there was a problem... I don't recall writing any decisions about it, and yet they must have come up. They had to.”

“Only one that I recall... for much of my career I was on the Court of Appeal [would not have heard any]... in trial court, when you're on the bench once you've finished with a case it's really out of your mind... I tend not to remember cases and I think that's rather common.”

“I know I did do some *Patients Property Act* applications but they're done in Chambers and there's no record of them so I have no idea how many of those I did but not a lot. I did more in practice...”

“If they weren't difficult they would have been settled. When cases are obvious they make an application and [everyone agrees]... and I wouldn't even remember it.”

I did not anticipate this finding, which has two important implications. On the one hand, this lack of experience and/or recollection of the process makes the information Set A provided about that process relatively thin. The fact that all Set A respondents made this same point suggests that their lack of familiarity with/recollection of the guardianship process was not specific to the individuals who participated in this research process, however. This consistency is relevant to the validity of the research findings, indicating there is not a significant number of judges out there with more to say about court appointed guardianship who were not represented in this study. The judges who did participate in this study had served on the bench for substantial periods of time (as indicated in the chart) and judges in British Columbia are generalists, hearing cases of all kinds. It would therefore be unlikely that these particular individuals had, unusually, missed

guardianship cases over the course of their long careers (with those cases being heard by other judges who did not participate in the study).

The Set A lack of familiarity with /recollection of the guardianship process means that it would have been useful to include experienced lawyers working in the area (wills and estates) in my research design. I anticipate that they would have been able to provide me with more details about the process, about their dealings with individuals and families, and about their experience in gathering evidence relating to mental capacity. However, the Set A findings on this point are extremely important in and of themselves. These findings indicate that court appointed guardianship in British Columbia is a marginal process, relatively little used and carried out on a *pro forma* basis in all but a very few cases where guardianship is contested (cases generally involving family member conflict). The responses received from the Set B participants also indicate that court appointed guardianship is a marginal response. The Set B participants identified a much greater familiarity with statutory guardianship, perhaps reflecting their own role within the health authority (whereas family doctors may be more familiar with private guardianship applications), although the legislation provides that statutory guardianship should be considered only a last resort (where no other response, including court appointed guardianship, is available). That relative disuse could indicate that court appointed guardianship is “withering away” as an anachronism that few people are interested in pursuing. Or, it could indicate that the current model of court appointed guardianship is problematic in ways that limit its practical usefulness. It is also significant that some of the Set A participants described guardianship processes as unmemorable to the extent that, even if they had participated in them, they would not have recalled anything about them (even in a general or overall sense). This finding indicates something about the nature of court appointed guardianship, where carried out.

Set A participants did have a significant amount to say about their understanding of the concepts under examination in this phase: mental capacity and vulnerability. These responses were useful and important to the further development of those concepts in this study, despite the limitations posed by participants’ lack of familiarity/recollection and the relatively small sample size (although, as explained in Chapter 5, that sample size is adequate for saturation in a qualitative research study involving culturally homogenous professional participants).

2. The importance of family and family context at all stages of the guardianship process (bringing applications/managing the consequences of incapacity)

Family relationships were mentioned by participants as crucial at all stages of the guardianship process. Family members were most likely to bring guardianship applications. Participants mentioned family disagreement as a focus of contested (and therefore memorable) guardianship applications; at the same time, the guardianship “remedy” depended on a workable resolution of family conflict.

“I do recall one particular case... where there was a competition between I think a daughter and a niece over who should be the committee for this older adult... there was a big fight and one of the problems was that the person who was probably the most objective was a relative who was living some distance away and not that close to the older adult or the rest of the family... But she was further away and this was going to be a difficult committee... .. it can be quite onerous, particularly if it’s not just the financial but there are elements of quality of care involved in it to.”

“Had one case of father in his 80s... family doctor knew father quite well and psychiatrist was called in to give a second opinion..., father adamant there is nothing wrong with him. Father did have some limitations in his affairs but real situation was daughters didn’t trust father to make the right will as they saw it... concerned he had other relatives he favoured over them for his property...”

“It’s easy to get involved in fights in families... They all involve ongoing relationships gone sour and the relationships get into person’s personalities... [as a judge] you develop an ability to stand back from it and say the only way I can be of help these people is to fashion a remedy that will help them out of their mess that they can live with.”

“...you also have to take [the family] into account even as a judge because if the family’s not supportive... they have to be ultimately there to support the person... you’ve got to be balanced.. you can’t get the family up in arms because the person needs their family... but most of the time you do this as lawyers not as judges and you get them all together and you work it out... the judge goes along with it because you feed him or her the right information.”

3. The role of the court: managing the lack of capacity

Asked to describe their understanding of the role of the court in determining mental capacity (specifically, in a *Patients Property Act* application), respondents noted the role of the court as the objective “final decider” on the adequacy of evidence of incapacity and in the rare cases where evidence was contested (rather than *evaluating* the person’s capacity).

“The court’s role... is to listen and try to absorb the evidence... to consider as dispassionately as possible where that evidence seems to lead...”

Respondents also described the judges’ role in terms of managing the consequences of the incapacity finding (i.e. appointment of a committee, identity of the committee, and the nature of the committeeeship).

“Someone has to assess the overall picture and the judge has been given that responsibility in our system... we have to make a decision about what restrictions to put on any committeeeship or whether they need a personal committee as well as property... you don’t want to hand total control over a person... who is perfectly capable of making a decision as to who they want to have as a friend for example.”

“I can’t recall the issue being so much ... of whether the committee should be appointed as who was going to best safeguard the interests of the party... in a sense mental capacity was not so much an issue as was the framework around which the lack of capacity was going to be managed.”

“It’s a huge power [committeeeship]... if you’re going to give them that the court’s role is to pick the appropriate person and given them the appropriate power.”

4. The importance of evidence in relation to mental capacity (mental capacity is as easy or hard to apply as the evidence presented)

Respondents generally defined the question of whether mental capacity was a difficult or an easy concept to apply in terms of the quality of evidence submitted (as opposed to any difficulty associated with the concept itself); mental capacity was as easy or difficulty as the evidence made it. Some expressed frustration at the calibre of evidence provided:

“You get more forceful with the lawyers about the kind of evidence you need which they’re not providing... a lot of people do this work that have no experience in it... they go to two doctors get their certificates saying this person is mentally incapable.. I say what powers do you want him [the committee] to have they say everything... I say is there nothing he can do for himself? They say they don’t know, they didn’t ask the doctor, the doctors maybe don’t know they just know he can’t pass the test they give him whatever it is.”

“The biggest problem always is to figure out where the best evidence is to be found in trying to assess the extent to which that person requires the intervention of the court and the protection of the court.”

“In many ways its analogous to making a custody decision because you don’t see the child, and in these cases you would rarely see the person whose capacity is in issue... So it’s hard to be sure that you have- as a judge- all of the relevant evidence... the stakes are so high for the person that I think any judge would be enormously apprehensive about the decision they make.”

On the other hand, one respondent indicated that the question of the individual’s mental capacity and need for guardianship was obvious in most cases (making mental capacity an easy concept to apply), providing the following account:

“In fact is usually fairly easy and obvious the only thing that isn’t obvious is whether there should be restrictions in the committeehip [depends largely on nature of estate]- by the time they get to making an application it’s pretty obvious that these are people that are way beyond the point where they can run anything including their health decisions and even personal care decisions... these are people in a really bad state when I see them... the older ones are mostly ones with dementia and its progressed to the point where... people today let them look after themselves for quite a long time with help.”

5. The role of the court: safeguarding the interests of the individual

The idea of protecting or safeguarding the interests of the person was another theme relating to the role of the court and the purpose of guardianship generally. For some participants, this idea of safeguarding has two aspects: protecting/safeguarding the person’s interests from others

(including family members) who would “prey” on him/her and safeguarding the person’s interest in privacy, dignity, and family support (taking care to craft orders in a way that would respect those interests).

“The court’s role... [is] to make the order which is going to least invade the privacy and personal rights of the patient while providing the necessary degree of protection... And I think the Court’s view is to try to respect the person’s rights and dignity and to only deprive them when it appears to be... certainly a lot more likely than not to be in their best interests.”

“I think in this area it [the role of the court] is really respect for the individual but also recognition that there is a huge need to protect individuals against predators, many of whom are very close to the patient, often warring siblings.”

“That’s what you are concerned about in contested cases- the vulnerabilities and also their strengths so you don’t take those strengths away... people have come to rely upon them [their strengths] so if you take those away.... You don’t want to take people’s identity away unless it’s gone already.”

Others discussed safeguarding solely in terms of protection, from predatory abusers or more generally.

“There are all kinds of patients [across the age spectrum] who are very gullible when they are mentally infirm, and there are all kinds of predators out there who are prepared to take advantage of them, and indeed do. So it strikes me again that the purpose of the committee is to protect the economic, financial, physical and emotional interests of the individual, hopefully through a transition process where ultimately health care and treatment will permit them to resume the conduct of their own affairs.”

“My job was the protection of the patient personally and their estate for their own sake and interests so they can be properly looked after and preserve their estate for their child or spouse or anyone else.”

“Primarily the concern was either the alleged abuse or prevention of abuse of the patient with sometimes justified claims being brought against the committee, and in other cases...

just an internal war between... the committee and those who thought they should have been or worrying about the fact that committee wasn't acting in mother or father's best interests... [alleged abuse was] mostly financial... thinking back in it I had a couple of instances of allegations of physical or emotional mistreatment but essentially most... were financial."

6. Doctors and medical evidence: neutral medical evidence assisting the court

Participants were most voluble in their responses to being asked about the role of medical actors in the guardianship process (participants in Set B, in contrast, had comparatively little to say about the role of the court). Participants emphasised the importance of medical actors understanding their role in terms of *assisting* the judicial decision maker by giving her or him the kind of information required to make a sound decision: a "neutral" and "purely medical assessment" about what the person "can and cannot do". The comments below support the analysis of the mental capacity construct in Chapter 4: that the evaluative nature of mental capacity assessment is not visible to legal "users," who expect and rely on medical actors to provide evidence of mental capacity as a neutral and objective bio-fact.

"Having unbiased opinion is a pretty necessary part of the process, and this is where the assistance of health professionals is really the safest route to follow, or at least the safest foundation on which a determination should be made as to whether the person is in need of protection of some sort; who should provide for it; who should pay for it; and where should it be done?"

"I recognize that they try hard, and the assessment of mental capacity is difficult, and I'm not sure how one engages in the scientific assessment of mental capacity- it's not my job- but I thought, quite frankly, that on many occasions the medical input was thin... I think they could do a much better job."

One participant was harshly critical of the medical evidence provided in guardianship applications as mere opinion, provided as a matter of course and without factual basis.

"[T]he child or a couple of siblings who want mum to be declared incapable for any reason... go to their family doctor who really knows very little about capacity and he just swears one of these affidavits saying 'In my view not capable. And they get another doctor

who knows almost nothing and he does exactly the same thing. And there they go off to court to get an order for a committee based on these statutorily required two affidavits.... They are just nonsense, they're meaningless, they're inadequate, they're inappropriate... These doctors may consider that to be their opinion, but if there are no facts underlying the opinion, it isn't worth a damn.”

Others criticised physicians for stepping outside of their roles as providers of neutral medical evidence:

“They shouldn't be advocates. They should be helping the court to understand what is going on. They should let the parties and the lawyers sort out ...the social context and relationships between the individuals, and there should be purely a medical assessment of whether there is capacity or not.”

“As an expert your duty is to assist the court. You're meant to be neutral. You absolutely have to be neutral... the purpose of reports and evidence is to assist the courts, not to make the determination themselves. And there are, unfortunately...doctors who think that capacity or capability is a medical determination, when in fact it is not. It is a legal determination to be made by the court. With the assistance, obviously.”

“I guess it would be unfair to the medical profession... to say that I don't think they do a very good job. But, in this area, I don't think they do a very good job... I recognise that the task that they have is a difficult one, but... they have tended to become an advocate either for the claimant or against the claimant or for someone who has an interest in the estate, and I have often thought that the reports... were not as objective as they might have been, or thorough as they might have been”

[regarding variability in medical evidence] “Oh there's a huge difference... you can get an medical opinion that this man is incapable of managing his affairs but that's a decision for the court not a question for the doctor... the doctors should be telling me what he can and cannot do... where he is on what spectrum of management... that's always the problem with expert opinion they think.. you should be following them... that's not the way the system of law works ... the good one are really good...but then there are the others... you

think they're doing what they're told... what they see as in the best interest of the family often..."

7. The knowledgeable family doctor v. the objective expert

The distinction between general practitioners and experts was mentioned by several respondents (this was not the subject of a question), sufficient that it emerged as distinct theme. Several respondents mentioned general practitioners (or family doctors) as well suited to give evidence of mental capacity because of their familiarity with the patient; one response mentioned the sometimes artificial environment in which expert assessments were carried out. Another respondent, however, noted the benefit of a specialist's greater objectivity towards her patient. Underlying the preference for the general practitioner is a traditional, and (increasingly uncommon) idea of a family doctor as being in a long term relationship with her or his patient (who she/he would see on a regular basis). The unwillingness of many physicians to provide mental capacity assessments (described by Set B participants but not members of Set A) indicates this idea is becoming disconnected from reality for many people.

[recalling a "bad baby" case] "At the end of the day, the only medical evidence that I really found convincing in that case... was that provided by a family practitioner who on some scales would be regarded as low-end of the feed chain... and his evidence was absolutely excellent... it wasn't facile."

"The family doctor is rarely an expert in issues of capacity, but that person has seen the patient- their patient- for one year, two years, five years, ten years, and that spectrum is hugely useful for the trier of fact. If an expert is appointed... that person has far more experience and expertise in dealing with issues of capacity but it is generally kind of a one off... And so I think the court has to look at what other factors were at play at the time of the interview.... Whether the person is comfortable or not."

"The family doctor would be the starting point... if he or she has had significant experience with the person who is the subject of the inquiry, that is the obvious place to start. I guess you'd turn to other people in the health system or social health system. whoever has had dealings with the person, I guess."

On the other hand, one participant described family doctors as less objective, more inclined to take on an advocacy role for their patients:

“My impression is that family doctors tend to be supportive of their patients and therefore don’t question whether what they’re being told is accurate whereas specialists tend to be more removed and have a more detached focus when answering questions about capacity... not to say all specialist are producing opinions [that are] reasonable... the problem with expert witnesses is they tend to be hired guns... over many years the PGT office has had some problems... .to get competent people to give opinions and I think a lot of that is a question of money.”

8. What is mental capacity: reasonable and rational decision-making in the circumstances (i.e. capacity to do what? making appropriate decisions and looking after yourself)

Participants were asked about their understanding of the concepts of vulnerability and mental capacity, their experiences in working with those concepts, and their understanding about the relationship or intersection between them. When asked about their understanding of vulnerability, several participants discussed mental capacity (as one aspect of vulnerability); participants did not refer to vulnerability when asked to define mental capacity. Participants generally defined mental capacity in terms of an ability to make rational and appropriate decisions (“within a range of reasonableness”) in the circumstances.

“[Mental capacity] is really... to try to determine whether or not the patient can make reasonable and rational decisions ... [emphasis on] rational because the patient’s concept of reasonableness might not conform to my concept.”

“One is looking for evidence... whether the patient is or is not able by a rational process to make a decision that he or she perceives to be in their best interests... a result which can be regarded as reasonable within a range of reasonableness ...”

“The judge is the person who sets out the parameters of reasonableness and you can’t help but be affected by some of your own perceptions as to how the world turns in setting that range.... a rational decision-making process is what everyone tries to do... you think about things and you consider the factors that are relevant, objective and subjective. And if you do that you are going to come up with a decision that is in the range of reasonableness.

And we're not all going to agree about what the decision should be- it doesn't matter. Is it one a rational person thinking about their context could reach?"

"The difficulty of course is that there is a spectrum and the issue of capacity usually arises in the context of some specific circumstances and the question typically is whether the capacity is there to deal with those circumstances."

"None of us are mentally capable of doing everything so it starts with that... I don't see mental capacity as having a definition I see it as capacity to do what... this covers the whole area of the law... we have parents who are incapable of raising children they just don't have what it takes and yet they are raising children... then somebody with Alzheimer's who can't do a thing for themselves and are eventually like babies... There's no definition it's just can this person do things and at some point you have to say yes, no, make categories. I refuse to accept a definition except that, can this person make that decision or group of decisions... you have to tailor it to people..."

"The ability of a person to look after himself or herself. It's that simple, I think."

9. Vulnerability as the inability to safeguard one's-self: Mental capacity as an aspect of (multi-faceted and factual) vulnerability

Asked to define vulnerability, respondents described a broad concept, even a universal aspect of the human condition, related to the ability to protect one's self and one's interests.

"The inability, which could result from any number of reasons to protect one's self and to act in one's self interest as opposed to being, if you like told what their self-interests are or led to believe that their self-interest").

"[P]eople can be left open and vulnerable by virtue of harbouring some sense of guilt about how they've... treated other people in the past."

"Anything that prevents one from making that rational decision that falls within the range of reasonableness! And that to me, in a broad context, is what vulnerability is."

"I think everyone has vulnerabilities for sure... its some area where you don't have the capacity or don't have the interest to develop the capacity... you should know from when you're very young you should be conscious of your vulnerabilities because that's what

other people will prey on who want to take advantage of you, for one thing, it's where you will always need help or resources..."

"If you have all the evidence brought before you... It's pretty easy to see they are vulnerable! The question is: how are you going to minimise their vulnerability and prevent someone from taking advantage of it."

Mental capacity was also identified as one aspect of an individual's vulnerability or, conversely, strength: "It is impossible to separate them, really, because vulnerability is so often the by-product of diminished capacity, an obvious sort of by-product. So you know the connection is pretty obvious to me."

"I think vulnerability is a bigger concept and mental capacity is one part of that, a subsection if you will of vulnerability, or strength if you are strong mentally ..."

"[Vulnerability is] When it becomes obvious that the community has to intervene in somebody's behalf because of their limited capacity or vulnerability, if you prefer, there it is. Somebody for whom there has to be intervention, whether it be committee-ship or protection or whatever."

"Vulnerability [is] the danger that someone of deteriorating capacity has to face, deal with, or at least live with, as capacity diminishes. Obviously that person's vulnerability requires some, eventually, intervention on his or her behalf. .. I suppose its establishing vulnerability that really brings into play the whole committee-ship process."

"In this kind of work categories are helpful, they help you to organise your thinking but you've got to be sufficiently flexible in your thinking to see the person because the person is real... [some people are] especially vulnerable because of a need for affection that makes them prey, but that's part of the human condition... its part of who they are [their personalities]... I know there are vulnerable persons like that but I'd hate to take away their decision-making powers I'd want some protection for them... build in the protection and punish those who take advantage of them [workers in nursing homes for example]... including lawyers.... That's where the vulnerable should be supported instead of taking their powers away from them."

10. Special application of vulnerability in relation to old age: exploitation (assets + family)

Respondents recognised that the concept of vulnerability has a special meaning/significance in relation to old age without being *specific* to old age (the parallel question regarding mental capacity and old age, in contrast, drew a more mixed response with some respondents describing mental capacity as a more generic concept). The special vulnerability arising in old age was associated with exploitation by others.

[in response to a question about whether he had ever considered the vulnerability of an older adult in a case involving appointment of a committee] “Oh, I think I have to say always... I saw many instances where bank account were emptied... the pretense was the funds were being used to support the patient but... [predominantly benefitted] the committee at the expense of the patient... There were instances where the committee had deprived the patient of their living accommodations... the moneys would have been used on a miserly basis to support the patient and yeah, I would have to say that in every case vulnerability was a huge issues.”

Where [vulnerability] comes up, I think, quite frequently with respect to older adults is when they need care and they have assets and the family members who are responsible are going to inherit what is left of these assets and there’s a certain financial tension between providing quality care at expense and depleting the estate, and I think this comes up a lot. It’s a real problem... there probably should be more oversight for these situations than there is.”

[Asked if vulnerability has any special application older people] “Sure it does. I think that older people, my impression is that older people often become fearful and they are afraid of how they will be cared for and for that reason they are singularly vulnerable to relatives taking advantage of them in terms of property, money and what kinds of provision of care they’re going to have... abuse of elders is generally family members and friends and so a declining mental capacity, mental capacity makes them more vulnerable to that...there are all these people going around trying to sell them things and our consumer protection legislation doesn’t do much about that.”

Several responses describe vulnerability as a universal quality waxing and waning, and taking different forms, over the life course.

“it [vulnerability] probably applies generally, but it comes up much more often with older adults. I mean, most families don’t get into these situations with family members who are not older adults. I mean, there’s some families who have disabled children, for example, but they’re not as common as the situations involving older adults. And, of course, you know the cost of care for older adults can be pretty steep, care facilities, private care facilities....”

“Yeah they are more vulnerable.... One certainly thinks of people getting more vulnerable as they age but at the same time, some people age 19 are more vulnerable than other people at age 90.”

“I’m more vulnerable now in certain things than when I was 20 but there are some things in which I was more vulnerable at 20 than now... you can’t getting away from treating people as individuals... I can’t accept that anything applies to everyone generally... if rules are too flexible you can’t trust the legal and medical professions that’s a problem... but if they’re too rigid you forget the person’s family context and the social context of that person’s community... it’s very difficult... [for judges who have no training or experience with cases involving emotions] it’s very hard for them, they want a box, to say, “what’s the rule here”? You need structures more than rules.”

11. Mental capacity in relation to old age: concept is generic, context is not

Respondents generally supported treating the definition of mental capacity as “generic” (“applying to the entire population, regardless of age”) while recognising that people were statistically more likely to lose capacity in old age. Respondents also recognised that the needs arising from impaired capacity will likely be different: “what is besetting an older person will typically be different from what is besetting a younger person in terms of... need”

“[Yes] to this extent that inevitably older adults have declining capacity and the question is when this capacity declines to the point where somebody has to intervene in their interest. So in that sense, yeah, it’s special cases.”

“With older adults it’s not necessarily brain damage [as with younger persons] but some kind of deterioration... in mental functioning.”

12. Summation

The Set A participants indicated a lack of familiarity with/recollection of adult guardianship cases that was unexpected, indicating that guardianship is a relatively marginal response and that the evaluation of mental capacity in guardianship cases is carried out on a *pro forma* basis. The judges had a lot to say (despite their stated lack of familiarity/recollection) about the importance of neutral/objective of medical evidence in guardianship cases, emphasizing their reliance on that evidence in their own decision-making process. The judges were generally critical of the evidence provided by physicians. A tension emerged within the responses related to medical evidence between the importance of familiarity with the individual and the importance of objectivity (requiring an arm’s length stance). Familiarity could lead to advocacy and non-neutral evidence. On the other hand, the evidence of a geriatric psychiatrist who had seen the person only one time for the purpose of carrying out cognitive testing may be less valuable than the evidence of a family doctor with the opportunity to see changes in thinking performance and behavior over a longer period of time.

Set A participants also emphasized the role of families in the process, as the instigators of the guardianship process, the persons asking to be appointed as guardians, and the providers of evidence. Set A participants also indicated that only dysfunctional families would need guardianship; functional families would be able to sort things out between themselves, although participants did not provide detail about how functional families would do this without the authority that guardianship provides (unless a decision-maker had been appointed through an advance planning instrument before capacity became impaired). The failure to appoint a power of attorney or representative is not necessarily an indicator of dysfunction. Set A participants also noted the importance of family evidence about the person’s day to day functioning, although that evidence is not required and would not be provided in non-contested cases. Financial exploitation, most often carried out by family members, was mentioned by Set A participants as a major reason for the instigation of the guardianship process.

The judge participants in Set A described vulnerability as a broad and universal concept; everyone was vulnerable in one way or another (one judge noting that each of us must identify

our own vulnerability and find a strategy to cushion its impact on our lives). Mental capacity, defined as reasonable decision-making within a broad range of reasonableness and the ability to put thought into action, was described as one aspect of vulnerability for some individuals.

Where vulnerability included impaired mental capacity, guardianship provided one response.

The judges saw the court's role in these situations as safeguarding the individual's material and personal interests, including his or her rights to dignity and autonomy.

6.2 Set B themes: health professionals

As explained in Chapter 5, the health professionals interviewed were less homogenous than the legal actors in terms of professional role.

The Set B participants are summarised by profession in the table below:

Table 4: Set B Participants (Health Professionals)

MH1	MH1	MH1	MH2	MH2	MH2
Geriatric Psychiatrist	Neuropsychologist	Clinical Social Worker	Occupational Therapist Case Manager	Family and Social Support Mental Health Practitioner	Case Manager

MH3	MH 3	MH3	MH3	Mh4
Occupational Therapist	Case Manager	Clinical Supervisor	Occupational Therapist	Geriatric Psychiatrist

I have not included information about years of experience (as I did for the judges) because this question is more complicated in this context; some participants would have been working generally in this field for the majority of their careers but perhaps changed titled and position during that period, or worked in the area of (for example) social work for their entire careers but with older adults for only a portion of that time. It is clearest and most representative to say that all of the health professionals interviewed had many years of experience working in the older adult mental health field generally.

Some of the themes identified below track the themes identified in the previous section. Very similar questions were asked of each Set, and some overlap was anticipated. Despite the similar

nature of the questions asked, however, there also a considerable difference in terms of the emphases in the answers provided as well as content. The participants in Set B were also notably more talkative and expansive in their answers; many seemed to enjoy the process of thinking about familiar tasks and words from a different perspective, and articulating those thoughts.

1. Involvement in court appointed guardianship/committeeship proceedings rare and limited to assets + family conflict

Older adult mental health teams are a first or early stage responder group in relation to concerns about older adults arising in both community and hospital settings. These teams play a key role in deciding what next steps should be taken in response to those concerns. Next steps are not limited to legal involvement or processes; some participants suggested that legal involvement was considered only as a last resort. Unlike the Set A participants, therefore, the team members in Set B contextualised guardianship as one of a range of potential legal and non-legal processes.

Court appointed committeeship, of all potential legal responses in this context, emerged as the least likely to be considered and only in cases involving significant assets and family conflict; cases involving assets but non-conflicted families tended to be resolved within the family using advanced planning instruments (powers of attorney and representation agreements) with no legal involvement required beyond drawing up the document (problems with this solution where the person was not capable of creating an advance planning document were not mentioned).

Statutory guardianship was more common than court appointed guardianship as a means of safeguarding funds in cases where the issue could not be resolved by family- because there were none, or because they were unsuitable. Some responses suggested that family members interested in pursuing committeeship would be unlikely to involve health teams in the process.

“If they don’t have a power of attorney we go to the PGT [re statutory guardianship]... It [court appointed guardianship] is sort of the last straw and usually there has to be someone who can do it, like a family member or someone involved... and that’s a huge responsibility and again its very legal.... It’s a tool that could be easily abused and I think it’s a complicated tool and expensive and... not really a useful tool, from a practical standpoint....”

“Not too many of our patients end up having a committee appointment. It seems like it’s a fairly unusual thing to do. ...I mean if you’ve got at least one functional child who has a good relationship with that person, most of the time it stays at POA level.... A patient can be very very ill but if you have a family that can work together around them, it tends to stay at a POA level... because the committee, you know costs money.”

“My experience of committees is actually very infrequent, if not rare, really... but my understanding is a committee would be pursued if we needed an air-tight guardian... and those situations are usually if there is a family that is not in agreement with one another and/or perhaps if there is a large estate... or there are potentially abuse and neglect issues involved.... a lot of our patients understand that it has to go through a lawyers and cost 3 or 4 thousand dollars and a lot of our patients, even if we suggest it, they don’t want to spend the money, they don’t have it.”

“Most people are [capable of giving a power of attorney or representation agreement]... about 90%... For those that are not, we would probably request the PGT [statutory guardianship] or if there is not a lot of money the Bloom Group or St James.” [referring to a not-for-profit organization providing financial management services for low-income persons in the lower mainland, previously called the St. James Society now called the Bloom Group].

“It’s kind of a last resort.”

“It’s pretty uncommon to be honest because it costs money and people don’t want to pay money to have that done.”

“The majority of cases get resolved informally, I would think.”

“It comes up rarely. Usually it’s with people that have a lot of assets... and there’s conflict among [the family].. [describing a case] it was all about keeping peace in the family.”

“When people have assets there’s often more resources in terms of family too... seems to go hand in hand with whatever adulthood they had or whatever... when they’re lots of assets there is usually family and it doesn’t go to that.”

One participant responded to the question about committeeship in terms of ethical/legal (rather than practical) implications:

“The right to freedom; the right to personal choice... who decides these are taken away? Committee is taking that all away. Committee of person is taking the person’s basic human rights away... if you can get a judge to agree with you, but do you have that right? I don’t think it’s constitutional.”

2. The role of the court: accepting/rejecting medical assessments and deciding who will have authority over the person (a “bigger role” beyond the determination of mental capacity in determining how incapacity will be managed)

Set B participants understood the court’s role in determining mental capacity (specifically, in a case involving the *Patients Property Act*) in fairly mechanistic terms: accepting or rejecting medical evidence and deciding who was most suitable to be appointed as committee. Like the Set A participants, Set B respondents did not understand judges as *evaluating* capacity.

“I would imagine they base it on medical assessments, hopefully more than one [laughs]... you probably need the law to participate in choosing someone to represent that person... I think their bigger role would be where do we go from here?”

“The court’s role is to interpret the medical opinions, put it in their own legalese and make a determination of what is then the outcome... if it’s accepted that someone isn’t capable then to me the court is in the position to determine who then has authority over this person.”

“I think the court has to... look at who is applying to be committee, to determine whether they would be a reasonable committee... my job is just whether or not the person I’m assessing is capable or not. And the judge has a bigger job to do.”

Set B participants also questioned how judges made their decisions; unlike the judges they did not identify the quality of medical opinion as a problem in this respect, but queried the way in which evidence was evaluated and used by judges.

“It [the medical opinion of capacity] is just an opinion... if three other doctors come along and say “No you guys were full of crap the day you did your... you know, Fine! It’s just

an opinion... I would love to get inside the heads of judges to figure out how they determine who's the best person when there's so much dispute.”

“It [capacity] is a legal decision... what we [health professionals] need to be able to do is... to educate the judge so he or she has the information they need to make the decision. And it really falls to us.... To try to give the judges what they need.... I know I might be in the minority on that....”

“I imagine there's somebody sitting there and they look at all the evidence and then they stamp it Yes or No.”

“I've often wondered what the court is doing. The court will take affidavits and to me sometimes it really is blind in terms of when you get two family members fighting over who's going to be committee-over a pot of money... how they [the court] make a judgment call without doing anything more than looking at what's before them in terms of the papers... in fairness it would be nice to see a system where the courts could do more to pull in the health care professionals who really know these people.”

“I'm sure judges must have a hard time....they're basically going to make a decision on the evidence in front of them and the problem is the evidence in front of them... that being said, it's still very easy to get committeeship if you have a good lawyer because I've seen it happen a couple of times. So you know it's an area that going to explode”

3. Mental capacity as reason in relation to function: the “ability to basically engage with the world thoughtfully and rationally” on a consistent basis

Participants were asked about their understanding of the concepts of vulnerability and mental capacity and their experiences in working with those concepts, and about their understanding of the relationship between these concepts. Several minor themes emerged from the answers to these questions, constructing a multi-faceted understanding of mental capacity (alone and in connection with vulnerability). These themes are set out below, together with individual quotes (illustrating and embedding themes in the voices of the participants, consistent with a “thick description” approach) The answers provided by individual participants frequently combined the minor themes identified below; the majority of participants identified multiple aspects of

mental capacity, providing long and thoughtful answers when asked to describe their understanding of the concept.

Several participants emphasised the relationship between rational/reasonable thinking together with the ability to consistently implement and actualise those thoughts in their actions as comprising mental capacity:

“It sounds so easy but when you have to put it into words! [laughs] Mental capacity... I mean it’s a broad term isn’t it?.. So just broadly mental capacity is: do they have the ability to take in information, synthesize it, manipulate it and work through rational solutions and have insight and awareness related to that information and relate it to their own self and strengths and deficits... but not just that, but that they can actually do the tasks at hand. Because there are different capacities related to different tasks.”

Invited to comment further on the meaning of “rationality” and “reasonableness” in this context, participants discussed those concepts with reference to a “general population” baseline (a social rather than medical measure):

“Ultimately it’s a measure of their decision-making against the general population, even your own, to say is that reasonable? Is that what a reasonable person would do?”

“Can you do the bare minimum to function in society without being red flagged somewhere: there’s some problem.”

One participant described mental capacity in terms of continuity:

“Is someone continuing to make decisions in a way that is consistent with how they’ve always made decisions in their lifetime? ... [or] Have they changed course into a whole different way of being that draws attention to themselves.”

I know a lot of people who, if you did a functional MRI, their brain functioning seems to be working well [but they can’t manage, make bad decisions]... is this a life-long pattern or something that’s happened since they got the diagnosis of dementia?”

Most participants referred to cognitive function when defining mental capacity- the brain’s ability to carry out the processes of decision-making. As illustrated by the quotes below, individual answers describing mental capacity in terms of cognitive function also referenced

other aspects of mental capacity including assessing risks and keeping yourself safe, (mental capacity as a multi-faceted idea):

“The overarching idea is, is someone able to learn and retain and understand and appreciate material well enough so they can make decisions for themselves, keep themselves safe and relatively content.”

“[Mental capacity means] your ability to have insight, judgement, memory, knowledge: all the parts of cognition... and capacity to assess the risks and to make a reasoned decision about the risk you’re running. And the fallout-consequences- of things you do or don’t do.”

“It means they are able to appreciate the question being put forth... and whether they can come to a decision that is consistent and capable of being replicated... and they can follow through on it.”

“It is a way of identifying how well a person’s brain works and, as a result, the way their brain works influences the decisions they make. ... “Do they have cognition to follow through on an action in the community whether it’s going to the bank or driving a car or whatever?”

“Can they learn? Can they understand? Can they appreciate? It’s cruel to put that person in a situation where they are trying to do something, make decisions, that they can’t do. And then they have to live with the serious consequences of those decisions. Because they can still feel the fear and confusion and the distress even if they can’t remember why.”

Other participants described mental capacity primarily in terms of the person’s ability to function in the community: what can a person do? Can a person function safely (either with or without supports)?

“I see it as an assessment of someone’s function. And we do that everyday probably... I mean I’m looking at the function and asking “are they going to be okay living here? Are they going to be ok? If we just leave them in this situation? And then the actual capacity part is “Do I need to do something formal about the situation? Do I need to apply to the PGT? Do I need to tell a family member? Go off and talk to a lawyer?”

“... I had a client who was able to answer questions wonderfully she had all the answers but when I asked that person to perform getting them to do things like a task and stuff. there are no norms associated with the test I could see she had struggles... she had too much information coming at her... her ability to answer questions is not indicative of her capacity”

4. Mental capacity as the ability to recognise and respond to risk (“competency becomes a factor when risk becomes intolerable”)

Several participants mentioned “risk” as an integral aspect of their definition of mental capacity, i.e. being mentally capable includes being able to appreciate and respond to risk as one aspect of the ability to engage with the world thoughtfully and rationally on a consistent basis. Risk was also discussed in relation to vulnerability (risk as a factor creating vulnerability or vulnerability as risk). Risk, as described in the quotes given below, has several aspects: risk to self; risk to others in the community; the ability to understand and appreciate the risk associated with your decisions and actions:

“It [mental capacity] is a misnomer... it comes down to functionality and what is the risk factor. In other words, from society’s standpoint... what kind of risk are you putting yourself or others in when it comes to competency?”

“[Mental capacity means] to have a sense that the person understands the consequences of their actions..., are they understanding the risk?... it all gets a bit blurry if there are questions about mood... if they are persons who are very volatile... Is it his depression or is it him?”

[Mental capacity means] “How are they cognitively? What’s [the risk level]? Have we done everything we can? Are they able to make this decision? Do they have insight? Our job is to keep people safe and at home in their own homes for as long as they’re safe there.”

“There’s lot of seniors living in what we would classify as extreme risk with some safety built in... as much as they’re accepting and...we can afford to put in and as much as the family can put in... competency becomes a factor when risk becomes intolerable.”

“I guess it’s about risk...and the risk factors could be mental capacity, but it could also be physical capacity, or it could be access to resources, or it could be being socially isolated, it could be being without finances or without social supports... you’re vulnerable when you’re kind of lacking these internal or external resources to take care of yourself safely”

“You send them to hospital that day because there’s too much risk... especially aggression or changes of behaviour... if there’s grandchildren or great-grandchildren in the house”

5. Mental capacity and vulnerability: two sides of the equation (“vulnerability is being incapable in a context you can’t handle”)

The inter-relationship between these concepts was a major theme emerging from participants’ answers to questions about both mental capacity and vulnerability. Participants descriptions of that inter-relationship were consistent with the responses received from Set A participants (the conceptualisation of vulnerability as an inability to safeguard one’s self and interests, arising through the intersection of social, relationship and physiological factors). Vulnerability is the broader concept, of which mental capacity is one element or part:

“Vulnerability is more about someone taking advantage of someone... [lack of] mental capacity makes that person more vulnerable to being taken advantage of.”

“I’ve never separated out those concepts [vulnerability and mental capacity] before this interview... its two sides of the equation, two factors in the equation... they seem to hold equal weight when we do an assessment so I don’t separate it.”

“I see it as our brains, if they’re functioning, we’re wired to look for threats in our environment... you flag things in your environment... perhaps I see it as very biological that way, that a failure or some inability to do that makes us mentally incapable because our brain is not doing that job and then we’re vulnerable to whatever is lurking... I see it as an equation of your mental capacity plus what’s out there, that’s vulnerability.”

“Part of our [evaluation] is they may be incapable but are they vulnerable? If they have a very loving family that seems to be very well resourced and educated and know what the community can offer and not offer and navigate the health care system for them, transport them to appointments, they may be incapable but they are not necessarily vulnerable

right?...I guess that makes you wonder if they're really incapable if they are willing to let their families or loved ones make the decisions for them... by definition are they incapable?... is incapability just contextual? I would say they are incapable if left on their own... but in the context of a strong support and social network, they are safe and not vulnerable... if you are incapable, vulnerability is being incapable in a context that you can't handle."

"I always think of them [mental capacity and vulnerability] together... its teasing out [the questions] things that you always see together."

"I don't see them [vulnerability and mental capacity] as different. I would hope that it would actually be on function [with vulnerability and mental capacity being two aspects of functioning]... When we say vulnerability I see that as subjective, more emotional."

"I see vulnerability as a factor arising from incapacity... I really see vulnerability as something that is coming out of capacity more than I think that split you're proposing... I wouldn't say that somebody who has a bad family and doesn't have someone to take care of them but who is capable is necessarily more vulnerable than somebody who has a good family and isn't capable themselves..."

6. Assessment as a continuum: evaluation and assessment

An important theme emerging from the Set B data was the nature of mental capacity assessment, from the standpoint of the Set B participants, as an ongoing continuum throughout the process of engagement with an individual: the initial identification of a problem requiring involvement and response; the identification of the most appropriate response to that problem (including but not limited to legal actions); and the steps taken for the purpose of achieving that response (which could include a formal assessment of capacity if and as required). Participants generally used the word "assessment" to refer to activity at all points on this continuum. In the excerpts below, I use the word assessment to indicate when a formal assessment is being discussed, and the word evaluation to indicate that assessment at an earlier stage is being referred to.

Responses emphasised the importance at all stages (evaluation + assessment) of obtaining adequate evidence (and some of the challenges in doing so).

a) initial evaluation: capacity “crisis” where risk no longer/cannot be contained by context

“If someone is going into crisis or someone’s been propped up by a family member or a spouse... and something happens [to that person], the client’s disability... becomes a crisis because they’ve been taken care of by someone else... in other words we’re brought in because there is no spouse and the family is trying to cope”

“Where social support networks are falling apart because they can’t cope with changes in behaviour or there’s been a shift in a person’s level of functioning and its all just falling apart”

“We often get calls from neighbours going how can you let someone live like this blah blah blah? It’s a balance between what I think is reasonably expected in society in terms of cleanliness and sometimes it’s how you view risk. Over the years I’ve practiced my standards have become broader and broader and broader [laughs]... its experience [and] less of an emotional first response... so long as we can make your environment reasonably safe and clean, and your bills are paid, and you’re not going to be evicted hey I’m fine”

b) evaluation before the (formal) mental capacity assessment: holistic evaluation of self in context

[evaluation] “On every occasion that you’re interacting with an older adult you’re assessing that [mental capacity]”

[evaluation] “The assessment starts from the moment you pull up and look at the house, right?... it’s a wreck or it looks good or there’s stuff piled up to the ceiling or whatever.. you ask them “can you tell me what your life is like here and tell me what your typical day is. Are there any problems, any concerns?”

[evaluation] “Whenever you’re dealing with a client or patient, depending on where you’re working, requires evaluation [of mental and physical status/health]... Mental health is directly affected by physical and vice versa. So I would say daily that I do that.’

c) “formal” mental capacity assessment: enabling a “path of response”

“The formal assessment is about his capacity for finance and person... we need to maneuver through an assessment in a way that doesn’t cause further risk and harm to the person and disrupt whatever social support is in place.”

“[Assessment] is part of the treatment plan... to develop a plan to help them... maintain an independent way in the community... part of that may be assessing their ability to participate in creating the plan... [mental capacity] is one aspect.”

“By the time it gets to that point [mental capacity assessment for legal purposes] there is usually a very clear preponderance of evidence... when it reaches that point, it is almost always a situation where either there are identified villains who are engaged in some kind of financial shenanigans or very often the patient themselves because of their illness is making some unwise choices.”

“We do think what does it mean if we go through this process [formal mental capacity assessment]? Is it going to be the family that will take over? The PGT never wants to be committee of person so we tend to not to go down that path.”

Formal mental capacity assessments were identified as difficult, and time consuming and, therefore, to be avoided if possible.

“To deem someone incompetent of person is almost impossible.... it’s never easy and its very time consuming and long, and even the psychiatrists don’t like to do it very quickly and easily.”

“We always have difficulty around getting incapability assessments or... even a diagnosis of dementia... because the GP may not want to do it. They may not have a GP. They go to the hospital... they come back. We’re so grateful to [the specialist assessment unit at VGH] because they help us with that....”

“It’s our biggest conundrum now that we can’t legally admit a person against their will, but ... deeming them incompetent is very difficult. Psychiatrists won’t do it.... It’s an ethical and legal quagmire but it comes down to safety... that’s why competency isn’t really the issue it’s a safety issue”

d) obtaining evidence: crucial and challenging

Participants were not specifically asked to comment on issues and challenges relating to obtaining evidence during mental capacity evaluation/assessment. This was a subject raised by the majority of Set B participants themselves, indicating that obtaining evidence is a significant issue. Problems included the quality and reliability of evidence (obtained through cognitive testing or through “collateral” information):

“That’s the Pandora’s box no-one wants to open because it’s very complex and its very volatile because... take our standardised Mini Mental test. I could give it to you this morning and this afternoon and you’d get a different score, as a completely together adult. You do that with someone who’s sundowning and someone who has got dementia and the numbers can be across the board... so what rulers do psychiatrists use you know? They have a battery of tests... [that] can be inconclusive.”

“It’s mostly around a sense of confidence or lack of confidence in their family, in the information the family gives or the ability of the family to understand or appreciate the problems or deficits the patient has... Sometimes out of good intentions because they don’t want mum to be put in a home... perhaps the heart of it is the emotional entanglement and expectations that they have... and here you feel as a clinician you’re carrying the needle to pop the balloon and do you pop it or not? And how slowly do you let the air out? Sometimes it’s your obligation [in cases of significant risk as in children in the home]”

“I want to see what you [the client] can do. And I’ve had sons and daughters over me giving me answers where I’ve had to say “I understand that you want to help mum and that’s great but I really need to know what she knows... You know, can you please just be quiet.”

A psychiatrist described the importance of information going to “everyday” function and social context:

“If I [a psychiatrist] do it by myself, just a psychiatrist doing it, you’re working- I feel- you’re working with one hand tied behind your back [referring to the importance of input from other social workers and others]”

Participants also described difficulties in obtaining evidence (often intertwined with problems of quality and reliability):

At the end of the day its finding that credible source and then putting the credible sources together... otherwise how can you make an informed decision or assessment?"

"Sometimes it can be even the fact that someone doesn't want to be assessed... just the mere ability to have the opportunity to determine if someone is competent or not."

"If you're a family doctor... and you don't have the time to do that kind of assessment and you really don't know what you're supposed to be looking for and you don't have the benefit of family- being able to speak with family- and having them come in and spend hours with you then yeah, it can be difficult."

7. Mental capacity on the spectrum: black, white, and grey

After providing their definition of mental capacity, participants were asked to comment on whether they found mental capacity a difficult or an easy concept to work with. The responses indicated that sometimes it was, sometimes it wasn't depending on the presentation of black and white or various "shades of grey"- a spectrum of mental capacity. Dementia, family/relationship context, and concerns about financial exploitation were all mentioned as relevant to the question of whether the mental capacity question in a particular case was black and white or a shade of grey.

a) black and white (advanced dementia and exploitation)

"Black and white" mental capacity questions were described as those involving advanced dementia; exploitation; and a global/general inability to cope with the activities of daily living in the community (these "black and white" areas parallel the gaps in the supported decision-making paradigm identified in Chapter 1):

"If you're working with people who are more demented and already in nursing homes then it might tend to be easier [to assess mental capacity]..."

"A widowed man moving in with an 18 year old homeless girl on the Downtown Eastside who is moving in all her friends and they're beating him and selling his stuff to buy drugs, you know, it's pretty clear."

“The guy with the bedbugs. He has no short term working memory at all [diagnosed with dementia]... doesn’t know he has \$20,000 in the bank, wasn’t sure where he banked. It was so obvious he was completely incapable of managing his finances in any way to benefit himself. He was wearing old pants tied up with rope it was just a no brainer. It was like, you’re incapable. We did the assessment. I did a functional... boom it’s gone. There’s no question we did the right thing because he ended up being able to live cleanly in the place and going to this day program, right?”

“It’s easy when it’s a persistent problem such as profound dementia. They’re not going to recover from that.”

“Working with an elderly mom who, a daughter was using, was living with her, taking loads of her money, taking her to the doctor to get medications and then using them... the building manager was worried about mom since daughter moved in... all of a sudden [mom] is on daughter’s schedule and not going out at all and getting more and more confused... we did functional and cognitive assessments... the bank manager called us and thousands of dollars were missing... it turned out to be obvious she didn’t have the capacity to manage her finances at all... she was making decisions to have daughter manage it for her because they were so co-dependent... they still live together but her funds are cared for... ”

“When they’re not able to, like, everything from shopping and hygiene and cooking and cleaning and leaving stovetops, like that. If it’s all areas that their activities of daily living are affected, then it’s pretty clear. That’s pretty easy.”

“You’re not going to be appointing a committee unless the person is pretty vulnerable... if it is getting to a committee it’s horrible! I mean every bad... it is those clear black and white no grey cases, where bad things happened, are continuing to happen and worse things are on the immediate horizon.”

b) shades of grey (early dementia, reliance on family collateral evidence, fluctuation and inconsistency)

Participants also described more ambiguous mental capacity situations in terms of early stage dementia (including “shifting sands”):

“We administer standardised measures of cognition. So really, what I am doing is diagnosing dementia. What kind of dementia and how has it progressed?”

“When you have fluctuating conditions... that make people incapable then that’s really challenging.”

“If it’s a milder level[of dementia] but you have family members expressing concern... then it can be a bit more challenging because sometimes in some aspects they are and in others aspects they aren’t. And it’s really teasing it out, and can take a long time.”

“There are definitely more complicated ones because possibly their dementia has not progressed so far as the black and white ones, so it’s not as clear. And there’s probably a subtle evaluation of what does the estate size look like too. What are the decisions that need to be made and where are the conflicts in the decisions?”

Two participants noted distinctions where early stage dementia was identified as arising from different sources:

“Sometimes [someone’s] physically quite well but they start to dement, its frontal first or judgement, but in every other way they seem normal or as before... they are actually very vulnerable because their judgment and reasoning is extremely poor. But because there’s no obvious physical change that’s when it gets unclear. Because you know something is wrong you know from the behaviour that something is not the way it should... In [a case of] very early dementia and there’s not an obvious physical issue or addiction sometimes that’s hard to tease out and I get kind of frustrated it’s not clear, right?”

[describing different kinds of dementias] “They all end up in the same place but there are differences.... Different cognitive skills might be deteriorated quicker [in some than others]...Alzheimer’s it’s going to be global deterioration.... fronto-temporal its more your executive skills, so planning, organization. So these people might appear normal but make off the rail decisions. And those are quite complex. You might have someone with more vascular-based dementia where they have- it fluctuates. Where they can look very bad one day and the fairly reasonable another... and where do you do the cross-section?”

Participants also described the importance of family context in the identification and further evaluation of “shades of grey” situations. Families were described as the primary source of evidence (raising initial concerns for further evaluation and possibly assessment) where mental capacity problems were not “black and white.” The collateral evidence provided by family members at this stage was both essential and difficult in terms of reliability:

“I think the harder part is when the families disagree with the patient... it doesn’t mean that [the patient] is incapable it just means they are making life decisions that the family may not agree with... if they come up with a rationale that’s consistent... they haven’t gone fully incapable, so most of them [family] are uncomfortable in those situations.”

“... what I find hard is when they’re only intermittently making poor decisions and this doesn’t follow a pattern, it doesn’t seem to be getting worse and the information you get is very vague... a lot of elderly are left at home while the sons or daughters they live with are working and once they left a pot on... or they don’t speak English so you can’t really access what is going on in their mind. Or their level of education was never that high so their level of functioning was never that high to being with... you can’t really tell if there’s a change.”

One participant referred specifically to hoarding behavior in relation to the “grey zone”:

“In cases where people are hoarding there’s a real difficulty there... we know there’s some executive functioning there... there’s anxiety and trauma... it’s a harder one to assess, the mental capacity.”

Another participant identified the grey zone as, specifically, a situation in which the potential for exploitation was especially high (resonating with the high-jacking of mere choices described in Chapters 1 and 4):

“It’s that grey area of people... who may be considered technically capable just either because they’ve never been assessed... or because it’s sort of bad, but not that bad, or they’re so variable from day to day they’re vulnerable to exploitation but still on this side of being considered capable... People target that all the time.”

8. Using the law in response to vulnerability (including impaired mental capacity) and risk: law as one tool in the box

This theme emerged through responses to questions about how participants understood their role in relation to the law and how they understood the law to be relevant to their work. These responses indicated that participants understood law as providing a set of tools to be selected and used (or not used) to achieve a particular response. Participants did not indicate that they considered their actions to be controlled by the law (that the law compelled one response rather than another) although the law was seen more generally as setting the parameters for what could and could not be done:

“Legal is always an issue [sic]. It’s just like anything else you have to think of when you’re assessing someone.... Everything is legal... we have certain things we can and cannot do and family members think we can go I and take mum away because she’s not doing very well and sometimes they’re very shocked- especially culturally- that... actually we can’t.... so we are advocates for the rights of our clients.”

“We’re always aware that legislation impacts our work and how we need to manoeuvre within each of those [statutes relevant in this area].”

Unlike the judges in Set A, whose role involved considering only the application before them (a request for committeeship for example), the health teams considered all legislative options together with non-legal options before deciding which “path” to pursue. Depending on the circumstances, one tool might be more useful than another.

“It becomes a legal issue when a person is a harm to themselves or others, doesn’t have the capacity... and doesn’t have the insight or compliance to go... the whole question is are the legal tools that we have, are they the right tools?... there’s got to be some plan, who’s going to take care of them?”

[for the appointment of a committee] “They have to be clearly incapable. There’s always avenues to deal with someone who’s vulnerable. You just click in a different direction.... We’ll ask the PGT for an investigation [of financial abuse] rather than an assessment [of mental capacity for the purposes of statutory guardianship], for example.... And they’ll

work their system so they don't have to do anything legally...they'd rather work with the family and see what they need and do it differently.”

“It [legal response] depends on family and who else is involved.”

Several participants identified legal mechanisms as undesirable *per se* (a goal being to avoid having to use them): difficult to use, time consuming, expensive

“Home health might say “let's get Mental Health in here and declare them incapable of person and we'll put them in a nursing home and that's it; that'll be the end of it. But that's not how we think... we would get involved with a view to how can we best support this person in the community, the least intrusive most effective support... sometimes they look at a legal solution as the only solution cause it seems quick and dirty [laughs] But it's not really. It's more complicated. And then there's often a cost associated with these things as well.”

“If someone raises the flag or... for instance comes from a legal background, the family, or if someone's applied for a panel review, then unfortunately the focus becomes legal... I generally approach it from a safety and independence, quality of life... it's important to do because otherwise if you look at it legally always trying to cover your bases as opposed to helping the person.”

“Even if they're living in squalor the first question is “Can we leave them safely here?”...is there an informal way we can do it without using the hammer of the legal Acts?”

“I guess most people think the law is the last resort where things have become so contentious and so to avoid contention and no longer pass the buck.”

Legal responses were discussed by participants in relation to contextual factors (concern about abuse/exploitation; “squalor”) in addition to concerns about mental capacity (prior to formal assessment). Potential legal responses to be considered included guardianship (court appointed and statutory guardianship), advance planning where possible (powers of attorney and

representation agreement), and care facility admission (the *Mental Health Act* is, currently, the tool used most often for this purpose in British Columbia).¹

“We have a nice, healthy, functional family, with someone who has, unfortunately, mild cognitive impairment, it might be something we’re talking about, very briefly.... Get thee to a notary and get it [power of attorney] taken care of... Where we tend to talk about it more is where it’s messier. There are concerns about one or more children taking advantage of the situation, or there is longstanding family conflict where the patient can’t easily identify who they want to be power of attorney. That is when we tend to talk more about what the legal system might do... In an ideal world no one ever actually has to say the words “lawyer” “judge” you know?”

“When I work in the community [as opposed to a hospital setting], we do outreach and home visits, often in that situation Adult Guardianship [Part 3] comes up... if there is no one around or the patient’s illness has put them, in a sense, in a place where they’re more vulnerable, then that’s where the legal issues more come up.”

Guardianship and advance planning were discussed primarily in terms of “managing the money”:

“If you’ve got cognitive impairment and they’re hopelessly drinking, much as you hate to often the only way to stabilize the situation is to get control of the money and get the money under PGT [through statutory guardianship] and then we can dole it out so they’re not so out of control... you have to be careful because very often the family may be no help in this and may in fact have their own agenda. Even the good families quote unquote... the family’s agenda is to get them into residential care so they can sell the house.”

“You go out and see someone who’s really quite... like who’s living in squalor and not functioning and who looks really unwell. I’m already thinking who manages the money? How’s it being managed and is there anyone else who can manage it so we can get hold of some money and have something to work with to help this situation?”

¹ The care facility admission provisions of the *Health Care Consent and Care Facility Act* have not been proclaimed.

One participant recounted at some length the story of one client for whom “managing the money” allowed him to remain in his home (avoiding eviction or, possibly, hospitalisation or placement in a care facility).

“I had one guy in a seniors housing ... completely demented and no short term memory whatever... his place was squalor he was covered in bedbugs... “Oh they’re no problem” [he said]... If we want to do something with this and keep you in your home we need to have access to your money... so I referred to the PGT [statutory guardianship]... so arranged a big clean up, threw things out, bought him new clothes... got him to Adult Day Program... he’s still living there he’s 97.”

Several participants referred specifically to the *Adult Guardianship Act (Part 3)*, applying to abuse and neglect, and the *Mental Health Act* (as a mechanism for admitting a person to a care facility without consent) in relation to one another and in terms of their relative (perceived) effectiveness and difficulty to “use,” suggesting that these legal tools provide alternative responses to the same kinds of situations. Both statutes can be used for this purpose (there is no care facility admission legislation in force in British Columbia). The comments below illustrate participants’ approach to the question of which tool would be the most appropriate and effective in a particular situation, and why, and are included for this purpose (and not as the researcher’s endorsement of the approaches discussed).

[re AGA (Part 3)] “You’re getting the person’s agreement to go along with you in this plan. Nothing to stop them from getting home and saying “[expletive] you. I don’t want the plan” [laughs] So it does inform how I look at situations absolutely [and the participant’s interest in using the AGA (Part 3) tool].”

“They are using it [AGA Part 3] more and more which is interesting to watch because up til now I would have thought that it was going to be a laughable experience to try to do that, but they’re making it work. Because our view point is why would I use AGA Part 3 if I can use the *Mental Health Act* right? It’s got a lot more strength, but yet the AGA Part 3 is being respected when it’s being used.”

“We [the team of which this respondent was a part] have access to using doctors to get people moving through the system with the MHA but.... Other groups of people working

with seniors they don't have access to that *per se*... The GP may not want to get involved in signing pink. The person may be known to no one... they might have tried... Mental Health Emergency Services and failed maybe because someone wasn't certifiable in the moment.... And yet still have this person terribly at risk at home. So I think this has pushed them into using the AGA Part 3.... Someone's vulnerable but they are not certifiable what can we do about this? So they may be doing it now to have a way to deal with these people.... I've seen it used to get people into hospital but not as follow up... We tend to try to use moral persuasion and the MHA to get things where things need to go. You know? Or good old paternalism, right? Let's just make it happen, right? At least that's my view."

"That's why people end up going [to care facilities]... under the *Mental Health Act*... because it's the easiest one to get triggered. Although some psychiatrists will not use it... they have very different opinions about it.

"I think the MHA when we use it is satisfactory because it does honour that people still have rights and they need to be reviewed and they need to be reminded of those rights and there is a process... there's a lot of controversy... but what else have we got for vulnerable adults who can't speak for themselves and may not have anybody else?"

Several participants emphasised the importance of involuntary care facility admission (and the availability of legal mechanisms for that purpose) as an option for some (not all)- a necessary last resort:

"I don't believe anymore that care facilities are the answer to everyone's... cause I worked in one and I've sent lots of people to one... and I've done all sorts of things. And what I see now is that if you can stay in your own home in any way I think that should be supported... there's an evolution of individuals who do the work."

"[The MHA] is mostly what we're using now [to admit a person to a care facility]... unless there is a family member or someone willing to take over as substitute decision-maker. But I have found that puts them in a difficult situation as well so I've swung back to using the MHA rather than pushing for a substitute decision-maker... so in that sense the legal implications are concerned."

“You need some mechanism to make sure that residential care placement takes place... If you’ve got an abusive family out they go [from hospital] in days... the hospital has a real lack of awareness about what goes on in the community.”

9. Abuse and exploitation: the special nature of the (older) parent/adult) child dynamic

Responses to several questions included references to concerns about family abuse and exploitation, particularly in relation to the parent/adult child relationship. Comments relating to this theme were made in response to several questions during the interview process.

“Adult guardianship [Part 3] made a huge impact, the legislation made a huge impact... previously... we would go to the door and say “I’m here to talk can I help you?”... and abusive sons or whatever would tell you to get lost... it’s [now] much more like child protection... From a societal level it’s a good thing... often in the perspective of the clients they don’t necessarily perceive it as a good thing because they’re afraid of the alternatives... people get almost like a Stockholm syndrome... it’s the child they’re trying to protect. Its mother-child... good mothers will do anything to protect their child... [old women] have a whole different value set... their self-image is based in being a good mother.. the most frustrating part is the grey area around incapability you know?”

“[re the dysfunctional child, usually son] Mum has looked after them their whole lives, mum’s now 80 she needs the caregiving, they can’t rise to the occasion so they become abusive.... It’s like you have two victims... They [the dysfunctional child] can hardly look after themselves... if we can help him in some way we will but we’ve got to focus on who’s the client.”

“Financial abuse of elders is extremely prevalent in our society.”

“I’ve seen a lot of financial abuse... often the person doesn’t have the cognitive capacity to make that decision. But it’s complicated because most of the time... it’s not a stranger knocking on the door and taking their money its usually family... sometimes even the person with dementia understands enough to know the daughter or son... isn’t well or isn’t making decisions in their best interest, but they’re trying to support them in their own way... so they’re sort of, in their mind, allowing it to happen because they don’t want to see something bad happen to their loved one... we’ve seen lots of that where it’s a delicate

process... People often get mad [the family members] and either stop or go away... that kinds of thing... they know someone's sort of watching and that's how it ends [when the team becomes involved].”

“Sometimes it goes to a place where it's just convincing her to have all the bills [paid by automatic deposit] “You know your son's not well and we're worried about him. And it would just be safer for both of you... You're choosing to do that.” Because you know they don't want them buying drugs with the money either, or whatever.”

10. Purpose of guardianship: safeguarding the individual's interests and the “social responsibility to look out for people who can't look out for themselves”

Both sets of participants were asked to comment on a broad question regarding the social purpose of guardianship- why have law relating to guardianship at all (any kind of law)? Why not let the chips lie where they fall? Set A responses were directed to the role of the court in guardianship, and some of those responses are set out under the Set A theme relating the role of the court in safeguarding the individual's interests. Set B responses to this question (while not articulated in terms of the role of the court) were broadly similar in terms of content: safeguarding assets; protecting the safety of people who cannot look after themselves; a broad social responsibility towards people who cannot look out for their own interests (personal and financial); protecting the person's interests by providing mechanisms through which their dignity can be protected, and their preferences enabled.

“It's critical to have that in place because some people are not in a position to be able to make decisions for themselves and they need some help... we do this to protect vulnerable individuals basically.”

“To protect the individual and their assets and certainly with committee of person to protect them from exploitation and sometimes from themselves.”

“Looking after people that can't look after themselves basically... legally it hinges on safety.”

“The situation has already kind of gone awry at that point, where you have a conflicted family or no family, you have somebody who is potentially at risk, and you've got a lot of

assets..... I think the goal of appointing a committee really is to protect the patient and their assets.”

“So that the health care system and legal system isn’t personally involved in making personal decisions for somebody or decisions in someone’s best interests... our social responsibility to look out for people who can’t look out for themselves and... our ethics around that... to help people around us who can’t help themselves.”

“[Without guardianship] it would be impossible to be able to do some of the things that we need to do for people. I’m thinking of one guy who is completely aphasic... he couldn’t do anything. Without a committee what would you do? Knowing their preferences, managing their affairs, keeping them safe? I have another woman... very brain-injured... and in a relationship with someone who is very challenging on his own. She has the potential to have a lot of money. What would you do if you didn’t have someone who could manage that stuff for her? ... that is the whole purpose of it... she would be extremely vulnerable without a committee.”

“Protection. What other objective is there? I mean, protection and to ensure that the person’s wishes, preferences and values continue to be communicated. That maintains the dignity of individuality, I suggest.”

11. Mental capacity, vulnerability and guardianship in old age: “paternalism” pro and con

Several Set B participants mentioned paternalism in relation to the question of whether mental capacity, vulnerability and guardianship had any special meaning or application with relation to persons in old age (paternalism was not mentioned by Set A participants). These participants were self-aware that paternalism affected the approach of older adult mental health teams generally (as opposed to practice with other population groups). Paternalism was discussed in terms of ageism (a negative), but also in terms of a willingness to become involved for the purpose of helping the person to stay at home (as opposed to a “hands off” approach until things declined to the point where care facility admittance became the only option) and helping the person to “live the life they lead in a better way.”

“[Re older people] we question it more. But there’s a lot of younger people that probably are not capable but we don’t ask because on the surface level they seem to be making

decisions fairly reasonably... perhaps its ageism... or perhaps it's an instinctual paternalism that we're trying to look after someone that's older... and we want to question if they're safe, if they can make decisions. I guess its two sides of the same coin really."

"I think we hold older adults to a higher standard... we act more we intervene more. Somehow we feel more protective... more paternalistic. I know I think I do. I'm okay with being paternalistic if I'm able to keep someone in a familiar environment... people are more concerned cause partly it's an emotional response."

"In my neighbourhood get a lot of midlife adults with chronic mental illness... they've been followed around by a [mental health team] with a very hands off approach. And I get them and I'm just horrified actually by how they've been living, by how little interventions have been done that could actually assist them to live better where they're living... live the life they lead in a better way."

"With older adults I think we're far more paternalistic in saying "I don't think someone should live like this. What options are there? Or is it appropriate? I do think with older adults we look at it differently [asked why this might be] "it's the ageing, it's the frailty... I know we look at older people as less able to be self-directed.... And I think there's a bias in society that if you're physically frail and perhaps a bit mentally frail that somehow we need to step in and do something about it."

"When you get really old and you're more frail and more suggestible it's much easier... just to suggest to people and do things than when... someone is 50... People just tell me to get lost... and when you're younger you feel less vulnerable I guess, and you feel more strongly that you are going to live the way you want to live."

"[Describing the situation of someone who aged into the older adult team] the adult team had let him live like this and go in and out of hospital and I said... if you look at the AGA Part 3 you could say this is self-neglect...you could look at it "well that's how he's choosing to live"... or you could say he can't get out of that situation...[we were able to make an arrangement with him regarding money held in trust] so we didn't go near a court but we were able to have an arrangement with the trust. Now meals are being paid for,

he's going to day hospital... things are looking up... we have a good relationship... he's got nursing. Still likes to drink beer and smoke pot but that's fine."

12. Mental capacity in relation to old age: concept is generic, context is not

Referring specifically to mental capacity, participants (similar to the Set A participants) described mental capacity as a concept of general application, but one whose manifestation and impact on the individual was informed by nature of old age.

"The issues are different, the goal is the same [quality of life], so therefore it's a different age and needs would be different, right?... someone who's worked, earned an income, got a house, got assets, the financial aspect is certainly more... with a senior it may relate more to palliative issues too... so all of these things... so its dependent on life stage."

"Yes I think so... there's aspects of ageing such as sensory changes that make people more vulnerable... a senior whose frail and has a lot of medical problems and doesn't get fluid for two das its different than if I don't have fluid for two days."

"When you hit older adult stage there are probably... you're at risk to develop greater risk, you know, increased health risk, increased cognitive risk, and just from living longer."

"At least with seniors, generally, they've had a long period where they're capable... the younger mentally ill are a whole different kettle of fish in terms of how you come at them. Ditto with the younger disabled clients."

One participant noted a difference in the ability to resist capacity assessment:

"Probably... older people get more managed because they don't have the energy or capacity to actually fight back as much as adults."

Another described difference in terms of the kind and quality of evidence on which to base an assessment:

"You have the additional benefit of someone having lived a longer life so you know what their decision-making has been in general. You've got collateral sources to draw from... you're still assessing for insight, judgement, executive planning, the whole bit... But you've got more evidence you can gather, more ways to get evidence."

One participant noted the significance of the relatively “short term” nature of substitute decision making or care facility admission (as consequences of mental capacity assessment).

“I think culturally and socially we are more accepting of an older adult having it done because they are at the end of their lives and it’s not a long term thing.”

13. Vulnerability and risk in social and relationship context: “cause you see the whole person, right?”

Two themes emerged through responses dealing with the subject of vulnerability. The first (Theme 5, “Mental capacity and vulnerability: two sides of the equation (“vulnerability is being incapable in a context you can’t handle”)”) dealt with the relationship between vulnerability and mental capacity. The second theme, described below, concerned the relationship between vulnerability, risk, and social/relationship context, in particular, the family.

“Yup its always there- risk or vulnerability- for everything. Cause you see the whole person, right? Who cares if someone’s depressed. But if they’re depressed and that means they’re not eating and drinking and they weigh 80 pounds that’s different than if they’re depressed and they have a husband who cooks for them and children who take them out. So it’s always part of that discussion.”

“To me it [vulnerability] means an individual isn’t able to navigate through a stressor or a decision... through changes and upcoming changes in their environment or social milieu or context. So there’s change happening and they’re not able to navigate or negotiate and get the information needed to make a rational decision... because their brain is just not working as well as it used to.”

“Her vulnerability is blanketed by supports [the person living with her] but if she was by herself she would be like a 2 year old on a freeway...”

“You’ve got to look at the environment and context. I had a client who was really quite demented but the amazing thing was she stayed in the neighbourhood and was able to take the bus and get around... her strength was that she was able to talk to people and was friendly... so people want to help... so that was a strength and that allowed her to function.”

“Vulnerability is so tied with medical or mental frailty... some medical or psychiatric problem... the [family situations] go along fine for years until there’s some physical or mental decline in the adult and that’s when things fall apart... [the situation] doesn’t work because she [mother] starts to dement... I guess she used to be able to hold her own with her son, right? She was kind of in charge, she’s not in charge anymore.”

“It’s not internal to us so much as the context that we’re in can create or alleviate or exacerbate vulnerabilities.”

“In reality vulnerability plays a huge role in terms of what we do... I am always looking at vulnerability as well because they might be capable or not capable, but maybe they can still live where they are. But if they are vulnerable, we have to address the vulnerability issue first, and protect them. And maybe it means more resources in the house, or moving [i.e. reducing vulnerability through context change].”

Family and material context were described as a potential source of risk and vulnerability, while potentially absorbing or reducing what would otherwise be sources of vulnerability and risk:

“It [vulnerability] depends on life stage... maybe they have that house... maybe their spouse died and they’re not used to dealing with finances.”

“I’ve dealt with people who have just horrible families... take advantage of them right? That’s also a piece [of vulnerability]... over the years dysfunctional relationships with your child have been either... people have families where there’s poor boundaries, or no boundaries and you’ve got an adult that’s financially dependent on the parent or has been dependent and now the parent is no longer able to look out for whatever interests they had.”

“I’ve had cases where... you go in there and the adult son comes thundering up from living in the basement: that’s always a bad sign... you know he’s probably not able to look out, care for himself... or big extended families where they need the money right?... and they don’t consider that person’s individual needs... they’ve brought them over to care for the children and they take all their money that’s just part of what the family unit does: it’s for everybody. We consider that financial abuse.”

“[Vulnerability is] a very very broad concept that you can apply in a lot of circumstances... the family dynamic piece... we’re human beings and when we have a dementia we are still very emotionally vulnerable... somebody who is meeting one of our emotional needs...we’re willing to hurt ourselves to keep it, a lot of times.”

“It usually comes to financial... I am thinking more of my younger population where they are often very vulnerable with people taking money from them... [you ask] is this now abuse because she’s brain injured and can’t respond the way she used to?”

[Describing the case of a woman being exploited by her daughter] “She did want some help to get this daughter out who was causing her a lot of grief but she couldn’t do it herself...you could say well, if you’re capable and choosing to do this that’s your choice. So is she more vulnerable? It’s a difficult situation. I don’t have a good answer.”

“Just look at what’s happened to real estate values and the vulnerability for many people in this neighbourhood... that makes them very vulnerable to exploitation and financial abuse and all sorts of things and they don’t know or want to use the capital to make their lives better.”

“The thing that’s different with older adults is you’ll have someone who was the leader of the family you know? This successful business person who had been a successful parent and now can’t do that anymore. So it gets a bit complicated.”

14. Summation

Set B participants described a very deep knowledge of the processes associated with mental capacity assessment, situations involving dementia in old age where guardianship provides one potential response, and a range of legal and non-legal responses to those situations (and their own role in decision-making about “which way to click”). Among these options, court appointed guardianship was (in the experience of Set B) rarely sought. Some participants suggested that their lack of involvement in court appointed guardianship could be a function of the health teams’ role, primarily serving lower income clients (many without family doctors). Others suggested that the expense of the process for clients, combined with its relatively cumbersome nature, was responsible for its disuse. It is likely that both of these factors contribute to Set B’s low level of involvement in court appointed guardianship. These results are consistent with the

Set A responses (judges), however, supporting the conclusion that court appointed guardianship is simply little used.

Set B participants described at great length their approaches to the evaluation of mental capacity at all stages of their involvement with the client. Evaluation at these initial stages would be carried out primarily through observation, and the decision about next steps (which might include a formal capacity assessment involving cognitive testing) would be made on that basis. Set B participants defined the concept of mental capacity in terms similar to Set A. One participant used the phrase “reason in relation to function” to describe mental capacity, incorporating both qualitatively reasonable thinking processes and the ability to “follow through” or put those thought processes into action. This was the approach to defining mental capacity generally expressed by Set B participants. Set B participants, like Set A participants, described the concept of mental capacity as playing out in particular ways in the context of dementia in old age. As a disorder of thinking processes, dementia necessarily impacts mental capacity, initially in ways that are variable and ambiguous or “grey” but eventually in ways that are comprehensive and “black and white.” Impaired mental capacity may- but need not, in every case- be a source of vulnerability.

Like the Set A participants, Set B participants described vulnerability as a broad concept manifesting in different ways for different individuals. Impaired mental capacity (as defined and discussed by the participants) could be one aspect of vulnerability and, where that was the case, one of several legal responses discussed by Set B could provide the most appropriate response (although Set B participants preferred to avoid the law if they could). Impaired capacity was not equivalent to vulnerability, and where the consequences of impaired mental capacity were managed by the conditions of that person’s social, material and relationship contexts the person’s impaired mental capacity would not be a source of vulnerability. Conversely, the consequences of impaired mental capacity could be exacerbated by the conditions of a person’s context (where the person was embedded in an exploitative relationship, for example). Vulnerability was described by one Set B participant as “being incapable in a context you can’t handle.” Like the Set A participants, Set B participants noted exploitation arising from the interaction between the “incapable” self and his or her relationship context as a major concern (and one where legal response could be useful by enabling “management of the money”).

Set B participants generally described the overall purpose of their role as responding to heightened vulnerability, described by some participants in terms of risk. Legal response of any kind (which was cumbersome, time consuming and expensive for the system) would be justified only on the basis of risk to the self or to others. The term “risk” is used here in a way that is analogous to the concept of heightened vulnerability (understanding vulnerability as the universal exposure to physical and socially-caused harm).² Everyone is at some risk to the extent that everyone is vulnerable; social response of any kind (including legal and non-legal responses) will be justified only where that risk/vulnerability is heightened, making the question of how high that risk needs to be (and how to measure it) an important one.

Several Set B responses indicated the importance of recognising client autonomy; one participant expressed her role as helping the client to live as he wanted, but in a way that was safer and more comfortable. Participants described neighbours and family members being disappointed that they could not simply “solve the problem” by putting the person in a care facility. One participant, with many years’ experience working in older adult mental health, described how her emotional responses, initially overwhelming, had changed over time. She now found situations acceptable that formerly would have been unacceptable to her, and interventions that she once would have considered warranted in a particular case (trying to have a person committed to a care facility) she would now find an unwarranted interference with autonomy and would never pursue.

Some participants frankly acknowledged that what they referred to as “paternalism” sometimes influenced their practice, to “get things done,” and that paternalism generally influenced practice with older adults to a greater extent (in comparison with health teams working with younger adults living with mental illnesses). Interestingly, some individual Set B participants spoke about the importance of autonomy and, in other parts of the interview, mentioned “paternalism” in this sense.

The word “paternalism” evokes a disregard for an individual’s rights, with decision-making about the person carried out on the sole basis of what the professional thinks is sensible or best (without consideration at all of what that person herself wants or whether the person is capable

² As explained in Chapter 4 and, *infra*, in Chapter 7.

making decisions about it). I am not convinced that the Set B participants who used the word paternalism meant it in this way, especially on a holistic reading of their individual interviews. On the other hand, “paternalism” is a loaded word in this context and participants must have been aware of this when using it. The use of paternalism by the Set B participants (not used by any Set A participant to describe any aspect of their practice) seems to describe a willingness, in this context, to give more weight to the client’s physical and emotional well-being and safety when balanced against the right to self-determination (a balancing exercise carried out differently in other contexts). It would be extremely useful to follow up with mental health team members serving a range of client groups to examine their understanding of paternalism as a concept (similar to the ways in which the concepts of mental capacity and vulnerability were examined in this research), and the ways in which team members understand paternalism to inform their practice or not.

6.3 Overarching themes

6.3.1 Overarching themes: Set A

Integrating the themes identified in the preceding part, the following overarching themes emerged from the Set A data:

1. Meaning of vulnerability as a broad concept; guardianship as one response to a specific quality of vulnerability that includes impaired mental capacity, for the purpose of safeguarding person’s interests

Vulnerability is a broad concept, arising in multiple ways; everyone is vulnerable in some way, at some point in time. The law of guardianship (committeeship in British Columbia) is concerned with a particular kind or quality of vulnerability caused by impaired mental capacity (as described in theme 2, below). Guardianship is sought where the individual is vulnerable in this sense and where the individual is unable to safeguard her interests without legal intervention: her thinking problems cannot be treated and her interests cannot be safeguarded by her family.

2. Meaning of mental capacity as the demonstrated ability to engage in rational thinking processes, the outcomes of which fall within a range of reasonableness (including the ability to look after one’s self); importance of neutral medical evidence about rational decision-making, medical/family evidence about what the person can do

Mental capacity means the demonstrated ability to engage in thinking processes (including remembering, judging, comprehending) in a way that can be recognised as reasonable in the broadest sense- an expansive and flexible “range of reasonableness” that provides for individual eccentricities and differences. Judges are the final arbiters of this, but must rely on evidence provided by others including “neutral” and reliable medical evidence about the person’s ability to engage in thinking processes. Collateral evidence from family members (and possibly others) is also relevant to this question. Questions about how impaired capacity should be managed- who should be committee and the scope of their powers- are within the purview of the court.

3. Limited use of court appointed guardianship indicates limited scope of usefulness for the guardianship tool

Court appointed guardianship appears to be infrequently used (bearing in mind that non-contested applications seem to leave little trace in the minds of decision-makers; non-written judgments disappear). Whereas marginal health team involvement/awareness about guardianship could be explained in terms of their role in these processes (i.e. people seeking committeeship will tend to use private lawyers and GPs), judges must be involved in court appointed guardianship, and the apparent lack of familiarity with guardianship on the part of the Set A participants was a surprise. Respondents reported that they might well have heard but not remembered guardianship applications as they would have been quickly dispatched factual decisions regarding the adequacy of evidence and the best management plan moving forwards. (leaving no written trail). Contested applications would involve family conflict over control of assets.

4. The purpose and function of court appointed guardianship: safeguarding interests (protection from exploitation and safeguarding autonomy, dignity and rights)

On the basis of the Set A responses, the most significant purpose of court appointed guardianship is to set up arrangements for managing an individual’ impaired mental capacity (as one aspect of

a broader concept of vulnerability) in a way that safeguards her interests. Safeguarding interests has two distinct aspects: preventing exploitation by others, and protecting the individual's rights and dignity (as a restraint on family members who might seek to control the individual's life and assets).

6.3.2 Overarching themes: Set B

Integrating the themes identified in the previous section, the following overarching themes emerge from the Set B data:

1. Meaning of vulnerability as a broad concept: being vulnerable is being incapable in a context you can't handle

Vulnerability arises through the interaction of the self with one's total life context in a way that is harmful to the person or that makes her unable to safeguard her own interests. That context has numerous aspects including living environment and the tasks of daily living that the individual is responsible for; relationship and family context (including harmful and exploitative relationships); and the help and assistance available to the individual. The self also has multiple aspects, of which mental capacity (as defined in theme 2, below) is one. Diminished capacity is only problematic (requiring public response of some kind) to the extent that it interacts with context to create vulnerability. Exploitative relationships arising out of parent/adult child (especially mother/child) dynamics are a significant source of contextual vulnerability in the context of dementia in old age. Each of these contextual vulnerability factors can be changed (using different legal and non-legal tools) in ways that absorb or reduce vulnerability (and therefore risk, as described below).

2. Meaning of mental capacity: rational thinking and following through (functional capacity)

Mental capacity refers to a person's demonstrated ability to engage in the processes of thinking: remembering, judging, comprehending: the enactment of thinking processes in a way that is reasonable or rational. Mental capacity is impaired or diminished where a person's performance of thinking processes is inadequate for the purposes of coping with her life context, in a way that creates an unacceptable level of vulnerability (or risk). Thinking problems of this kind indicate a

problem in brain functioning or cognition, information that is useful in terms of choosing the right response (can medical treatment reduce vulnerability? controlling addiction? is the prognosis for long term decline, as with dementia?)

In some situations the mental capacity question is very obvious- black and white- as where a person cannot care for herself in any way (a complete failure to cope creating very high risk to self and/or others). Advanced dementia causes this kind of coping failure. In other situations the question is grey, as in early stage dementia. These are the hard cases and it is useful to ascertain whether this is a change or consistent with the way in which the person has always functioned. Grey mental capacity questions require more extensive evidence and different *kinds* of evidence (with several respondents telling stories about the problem of family evidence in the grey zone- families have close knowledge of everyday coping, but are often unreliable narrators).

3. Response to vulnerability as the overarching role/responsibility of health team members: capacity assessment/legal response one aspect of that role

The over-arching task of team members was described as responding to the needs of older adults experiencing intense vulnerability where mental capacity (the performance of thinking processes) was one element or aspect of that vulnerability. Carrying out this task requires an evaluation of vulnerability and identification of its sources. Responding to vulnerability means ameliorating the sources of vulnerability (in both self and context) and readjusting or recalibrating the intersection between them. Vulnerability can be reduced through a focus on the self (medical treatment or addressing addiction, for example) and/or through context change (“managing the money,” disrupting exploitative relationships and/or providing housing or home support). Where the source of vulnerability relating to mental capacity is extreme and cannot be ameliorated, as in advanced dementia, care facility admission may be the only feasible option (the most extreme form of context change). It is always a question of the relationship between context and self.

4. Law as a tool for reducing vulnerability through context change

Many tools are available for responding to vulnerability including (but not limited to) legal tools. Legal tools (unlike medical tools such as treatment) work primarily by changing context- disrupting exploitative relationships, arranging home support, financial management,

improvements to living conditions- thereby minimising the impact of diminished mental capacity (as defined above) by diminishing vulnerability.³ Enhancement or strengthening of a person's mental capacity might not be possible in the case of dementia (as a chronic and progressive syndrome), but changing the person's material or relationship context can reduce the negative impact of mental capacity problems on the individual's life. The story told by one participant of an elderly man with extremely advanced dementia living in squalor in seniors' housing illustrates this point: by providing housekeeping, money management, and social support the impact of the client's impaired mental capacity was significantly reduced (although his mental capacity remained severely impaired). Without those contextual changes, the client would have lost his home (becoming homeless or being admitted to a hospital or care facility). Legal tools of different kinds, including but not limited to both statutory and court appointed guardianship, effect context change in different ways (as different tools in a "box" of legal and non/legal responses).

5. Court appointed guardianship as a marginally useful legal tool: the significance of money and family

Respondents described court appointed guardianship as one of several potential tools for context change. Court appointed guardianship will be the most useful tool in a limited number of situations. If the individual has a family member who is sufficiently close and supportive to be suitable for appointment as a committee (committees are almost always family members), it means that the individual is less likely to be vulnerable and, therefore, less likely to be in need of a committee. An exception arises (and a space for committee) where family members are in conflict and at least one family member would be a suitable committee. Conflicts of this kind generally involve significant assets and concerns about exploitation. Another situation in which court appointed guardianship provides a useful response arises where the person is in an exploitative relationship with a non-family interloper- the "new best friend." In this case, committee enables the family to break up that relationship and/or manage and control the person's assets. This limited scope of utility, together with the expense involved, explains the infrequent use of court appointed guardianship compared to other legal and non-legal tools

³ The *Mental Health Act* and advance planning instruments enabling health care (the *Representation Agreement Act* in BC, for example) also enable change through treatment (a self as opposed to contextual focus).

although changes in the broader social context (increasing wealth generated by the steep rise in property values together with other factors) may see an increase in its utility and use moving forwards.

6.4 Conclusions

The over-arching themes from Sets A and B showed a strong congruence between participants' understandings of the two major concepts examined in this research inquiry: mental capacity and vulnerability. That congruence, together with points of difference, is discussed below.

Mental capacity was described by participants in both Sets in primarily non-medical terms as the reasonable and rational performance of thinking processes, "performance" for this purpose including both conceptualisation (reason) and the ability to put thought into action (function). For Set A, this theme is expressed as "meaning of mental capacity as the demonstrated ability to engage in rational thinking processes, the outcomes of which fall within a range of reasonableness (including the ability to look after one's self)." Judges identified themselves as the final decision-maker about the individual's mental capacity, while noting their reliance on medical evidence in exercising that role. Set A participants also referred to the usefulness of evidence provided by family members about the person's functional capacity (i.e. the ability to put reason into function), although that evidence is not required and would generally not be provided in non-contested guardianship cases.

The definition of mental capacity provided by participants in Set B can be summarised as "rational thinking and following through." One Set B respondent described this idea as "reason in relation to function." Set B participants also described the importance of evidence to the evaluation of mental capacity, and the challenges associated with gathering that evidence. Set B participants described assembling evidence from a broad range of sources: medical evidence of diagnosis and prognosis; cognitive testing; functional assessment (carried out by health team members); and evidence of both cognitive thinking processes and day to day functioning provided by family members. Each source of evidence presented its own challenges. Where the person was not hospitalised, medical evidence might not be available (and hard to get). Family evidence, while important, had to be evaluated carefully; family members might present information for the purpose of casting an older family member in the best light (i.e. as non-impaired) or, conversely, family members could over-state difficulties in the hopes that

professionals would take care of the “problem” (putting the wheels in motion to admit the person to a care facility). Cognitive testing tools were described by some participants as generating inconsistent results, and in themselves not enough to found an accurate assessment. Set B participants generally considered their own functional assessments, carried out at all stages of involvement with a client (rather than a discrete assessment session), to provide the most reliable form of evidence, while noting the importance of assembling evidence from numerous sources. This option would be available to mental health team members (the Set B participants), but not to family physicians for whom these steps would be unusual and practically difficult, and neither expected or required.

Both Sets described vulnerability as a broad concept which could arise in a number of ways, involving various factors. Unreasonable or irrational thinking processes could be one aspect of vulnerability at the individual level, although a person’s vulnerability could arise through other circumstances. A person could be vulnerable because of their emotional relationships, or because of guilt about past behaviour (as described by one Set A participant), for example. Vulnerability on the individual level could arise through the interaction of all of these factors, or others.

Set A respondents described vulnerability as a universal concept (everyone is vulnerable in some way), with certain distinctive vulnerabilities arising in the context of dementia in old age because of changes in thinking processes, increasing physical frailty and dependence, and the risk of exploitation associated with family roles and dynamics and the accumulation of assets. Most Set A respondents described guardianship as a response to a particular quality of vulnerability, where the person’s mental capacity was impaired and where the person was unable to protect her or his own interests (impaired mental capacity being one aspect of the broader vulnerability to which guardianship responds), as opposed to vulnerability *per se*. If a person’s interests were protected in some other way, guardianship would not be necessary, i.e. the person would not be vulnerable in a way that required appointment of a guardian to reduce vulnerability or prevent its exacerbation (through the loss of assets, for example). One Set A participant described the vulnerability of an older parent whose children were trying to use the law to control their father, in a way that would decrease the father’s autonomy and dignity. This participant described her own role in the case as protecting the father’s autonomy interests from the daughters’ attempt to

use guardianship in this way, suggesting that the law can itself can be a source of vulnerability and that legal decision-makers must be on guard for this possibility.

Set B participants also described vulnerability as a broad and universal concept, and one that manifested on the individual level in different ways requiring different responses. Some Set B participants explicitly described vulnerability in terms of the relationship or intersection between the individual and that person's context, with one Set B participant describing vulnerability in the context of dementia in old age as "being incapable in a context you can't handle." "Context" for this purpose includes both intimate relationship contexts and social and material contexts (housing, assistance with care including housekeeping, access to health and social programs e.g.). Set B participants described their own over-arching role and responsibility in terms of reducing vulnerability; legal responses of different kinds provided one set of tools that could be used for this purpose, with their usefulness depending on the circumstances in each case. Set B participants discussed a range of legal responses (care facility admission under the *Mental Health Act*, statutory guardianship, *Adult Guardianship Act (Part 3)*, court appointed guardianship) and non-legal responses (providing housing, housekeeping, access to an adult day centre) that could be used to reduce vulnerability by creating contextual change.

Participants in both Sets provided substantial information about the concepts of vulnerability and mental capacity, but had much less to say about court appointed guardianship itself. This is not an outcome I would have anticipated when designing this research study. The Set A participants described a general inability to recollect their participation in guardianship cases (although one participant noted that he must have done so on many occasions over the course of his lengthy career), which seems to indicate that the great majority of guardianship cases are carried out in a *pro forma* manner and determined by the medical evidence provided. There is no reason to think otherwise.

Set A respondents also indicated that guardianship would become necessary only where the family was dysfunctional in some way and therefore incapable of working out problems associated with their family member between themselves. On the other hand, appointment of a guardian required at least one functional family member. The kinds of situations in which a guardian application would be brought therefore tended to involve disputes between family members over control of the person (as where child A sought to be appointed guardian to break

up an exploitative relationship between her parent and child B). Set B participants described court appointed guardianship as an option that was very unlikely to be considered, suggesting that the major reason for this dis-use was cost; Set B responses indicated that this dis-use probably reflected their client base, who tended to be low income. This finding indicates that empirical research carried out with family doctors, despite the challenges noted in Chapter 5, would be useful.

Chapter 7. Judgment and Conclusions: Rethinking the Adult Guardianship Response

7.1. Introduction

This research study has been carried out using the methodology of pragmatic inquiry developed by the American philosopher John Dewey (as discussed in Chapter 3). Underlying pragmatic inquiry is a particular understanding of the relationship between practice and ideas, in which fields of practice (such as adult guardianship) are “organized” by foundational ideas or theories. Organizing ideas of this kind provide a necessary basis for co-ordinated action, and a field of practice (involving multiple actors working together) could not function unless it was organized in this way. For this reason, according to Dewey, successful organization of a field requires that actors in the field, generally, believe in the validity or “truth” of the organizing idea. No field of practice exists in isolation and the ongoing viability of its organization also depends on compatibility or fit with the wider contexts in which it is situated. In relation to adult guardianship, this means that the field of practice must be organized in a way that is consistent with legal principles more broadly.

Dewey used the term “situation” to refer to a field of practice as that field is organized by a particular idea.¹ As discussed in Chapters 2 and 4 of this study, the field of adult guardianship is currently organized by the mental capacity construct. The term medico-legal guardianship, as used in this study, refers to the current adult guardianship situation (i.e. the practice of adult guardianship as organized by the mental capacity construct). That situation is currently a site of conflict (as discussed in Chapters 2 and 4), and some have argued that the problems associated with medico-legal guardianship require the abolition of adult guardianship altogether. This argument has been most fully developed in relation to persons with developmental disabilities, as discussed in Chapters 1 and 2. Specific problems arising in the context of dementia in old age are discussed in Chapter 4 of this study, and developed further through the empirical research discussed in Chapter 6.

¹ See discussion, Chapter 3.

The problems in medico-legal guardianship are not inevitably attributable to the mental capacity construct. Many problems arising within a situation can be significantly ameliorated by reforms *within* that situation (through funding and/or additional training, for example, or the development of new tools) without challenging its ideational premise. One purpose of pragmatic inquiry is to distinguish between problems that can be addressed through these kinds of reforms and problems that can be resolved only through a transformation of the situation (requiring its ideational re-organization). The failure of multiple attempts at reform to resolve persistent and intractable problems within a situation is evidence that a situation has become problematic in this second way. Direct criticism of the organizing idea itself, casting doubt on its validity or truth, provides further evidence about the nature of persistent problems within the situation. The trajectory of the adult guardianship reform movement described in Chapter 2 and the “search for the perfect capacimeter” discussed in Chapter 4 suggest that continuing reform within the medico-legal guardianship situation will not resolve the problems which have brought adult guardianship to the brink of extinction. Within legal discourse, moreover, mental capacity in the guardianship context has been directly criticised as a source of discrimination on the basis of disability, violating fundamental legal principles of equality. That critique has informed the Committee on the Rights of Persons with Disabilities’ (United Nations Human Rights Office of the High Commissioner) interpretation of the *Convention on the Rights of Persons With Disabilities* as fundamentally incompatible with medico-legal guardianship.² These problems cannot be resolved through reforms to modes of assessment, or other kinds of incremental change carried out within the current adult guardianship situation (i.e. medico-legal guardianship).

Dewey’s ideas about situations, organizing ideas, and transformative change v. incremental reform resemble Kuhn’s theory of “paradigms” and paradigm shifts in several key respects.³ The connection is important, as the language of the paradigm shift is used in the current discourse around adult guardianship to refer to the disappearance of mental capacity as a legally meaningful concept and, with it, adult guardianship. Despite conceptual similarities, however, Kuhn’s theory is descriptive rather than methodological. Kuhn’s purpose was to

² See note 10, *infra*, and the discussion of the Convention on the Rights of Persons with Disabilities in Chapter 2.

³ Thomas Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 1962). Kuhn’s theory of paradigms and “paradigm revolutions” is also discussed in Chapter 1.

describe the way in which scientific knowledge is generated through the internal dynamics of scientific practice (stretches of incremental “normal science” and periodic paradigm shifts). The language of paradigm shifts in adult guardianship discourse, similarly, is used to describe the anticipated disappearance of adult guardianship (the supported decision-making paradigm discussed in Chapter 2). Dewey’s methodology of pragmatic inquiry, in contrast, provides a systematic approach to the proactive examination of situations, the assessment of problems and doubt within them, and the construction of potential alternatives if warranted. The alternative organizing idea constructed through this process would, in turn, provide the basis for modified structures and practices (transforming the situation). For Dewey, as for his fellow pragmatist William James, the ultimate success of both ideational and practical changes depends on their ability to fit together with current modes of understanding and practice (without being identical to them); “we will count a new idea as true”, James wrote, “if we can use it to assimilate a new experience to our old beliefs without disturbing them too much.”⁴

The first phase of the pragmatic inquiry carried out in this research was a theoretical examination of the situation under consideration (the field of practice as organised by a particular idea or theory), including the identification of problems arising within the field and the relationship of those problems to the organizing idea. This first phase was set out in Chapter 4, which examined the mental capacity construct (as the organizing idea of medico-legal guardianship) and identified a number of specific problems arising in the context of dementia in old age. Vulnerability, as a potential alternative organizing idea, was also examined during this phase. The second phase of pragmatic inquiry examined these ideas- mental capacity and vulnerability- through an applied thematic analysis of open ended interviews carried out with actors involved in different aspects of the adult guardianship field of practice. Chapter 5 described the way in which the empirical research design and method was selected, and crafted, to be consistent with the structure and objectives of pragmatic inquiry (as the methodology used in this study). Chapter 5 also identified and discussed the limitations of the research design in terms of participation and the kind of information provided. Chapter 6 set out the themes identified through the empirical research, as illustrated and given depth through the voices of the interview

⁴ William James, *Pragmatism* (Cambridge: Harvard University Press, 1975) at 36, quoted in Margaret Radin, “The Pragmatist and the Feminist” (1990) 63 (6) S Cal L Rev 1699 at 1709 at 1709.

participants. Both phases focused on adult guardianship in the context of dementia in old age as the context in which guardianship is especially likely to be used, now and in the future.

This Chapter sets out the third and final phase of pragmatic inquiry: judgment. The judgment phase comprises the researcher's conclusion, based upon and warranted by phases one and two, about the relative validity of mental capacity and vulnerability as organizing ideas in the field of adult guardianship,⁵ with reference to the research questions posed in Chapter 1 (restated below):

- To what extent is the mental capacity construct coherent as the “organizing idea” (in the pragmatist sense) of adult guardianship generally and, in particular, in the context of dementia in old age?
- To what extent is the mental capacity construct capable of consistent implementation by medical and legal actors involved in the processes of guardianship? What special issues (if any) arise in the context of dementia in old age? What specific problems or difficulties are created by inconsistent implementation?
- Can vulnerability provide a more coherent and workable “organizing idea” (in terms of both theoretical coherence and consistent implementation) in the field of adult guardianship, especially in relation to dementia in old age? What would a coherent/workable theory of vulnerability in this context look like?

The ultimate objective of Dewey's methodology was to transform situations- not just talk about them. The true validity or “success” of a new organizing theory or idea could therefore only be tested in action: by “accomplishing this work.” As Dewey explained:

If ideas, conceptions, notions, theories, systems are instrumental to an active reorganization of the given environment, to a removal of some specific trouble and

⁵ Dewey defined judgment as an “assertion” about the relative “validity” of one theory as preferable to another in terms of re-organizing the situation in a way that “replace[s] doubtful situations by situations that [are] non-problematic.” *Pragmatism and Inquiry: Selected Essays* (Oxford: Oxford University Press, 2013) at 288.

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, eliminate defects, if they increase confusion, uncertainty and evil when they are acted upon, then are they truly false. Confirmation, corroboration, verification lie in works, consequences. By their fruits ye shall know them.⁶

The kind of “testing” described by Dewey in this passage would require implementation of a new vulnerability-based adult guardianship model (on a pilot basis or otherwise), and is beyond the scope of this research study. The judgment phase set out in this Chapter therefore concludes with a preliminary framework for a vulnerability-based guardianship model, answering the final research question: What would a coherent/workable theory of vulnerability in this context look like? Development of this model for the purposes of piloting/implementation would require additional empirical research and analysis (as described, *infra*). This research would involve the two participant sets interviewed in phase two of this research study, persons who have been involved in the guardianship application and statutory guardianship processes (in a personal rather than professional capacity), lawyers working in this area, and professionals involved in the statutory guardianship process (including, hopefully, the Public Guardian and Trustee).

7.2 Phase 3: Judgment.

This section synthesises the findings from the first two research phases to answer the research questions re-stated above and, on that basis, to make a judgment about the relative validity of mental capacity and vulnerability as organizing ideas in the field of adult guardianship.

7.2.1 Medico-legal guardianship and the mental capacity construct

Chapter 4 of this research study examined the theoretical construct of mental capacity in medico-legal guardianship, focusing on the context of dementia in old age. This medico-legal idea of mental capacity is synonymous with cognitive decision-making ability, i.e. the brain’s ability to carry out the decision-making process. Decision-making, for this purpose, involves the following cognitive steps: understanding the matter in question, including potential consequences of choosing one way rather than another; weighing alternatives and deliberately choosing between

⁶ John Dewey, *Reconstruction in Philosophy* (Boston: Beacon Press, 1948) at 156. This passage is also cited in Chapter 3 at page 58.

them; and adopting the chosen alternative as one's own decision. The nature of cognitive decision-making means that this process is specific to certain kinds of decisions; a person may be capable of decision-making where the matter in question and consequences of choosing are simple (in terms of the comprehension, memory and judgment skills involved) but not where the matter is more complex and, therefore, more demanding.

The cognitive process of decision-making cannot be seen or directly ascertained through the equivalent of a blood test or brain scan and the issue of assessment and evidence (as discussed in Chapter 4) has been the subject of ongoing critique and reform from the mid-1970s to the present. Evidence of cognitive decision-making can come from a number of sources: cognitive testing (the Mini Mental Status Exam, for example); diagnosis of a disease or disorder affecting brain function, providing an explanation for impaired decision-making; observation of behaviour; and assessment of a person's performance of the "functions" of day-to-day life or activities of daily living. The latter form of assessment is sometimes referred to as "functional assessment," in which functional impairment (a consistent failure to eat, e.g.), understood in connection with other sources of evidence, provides evidence of impaired cognitive decision-making (that the functional impairment is the result of problems in brain function rather than a *decision* not to eat).⁷ A person may also be capable of making decisions (in terms of brain function) but not implementing them. Where this is the case, capability can be enabled through the necessary support.⁸

The belief that mental capacity can be objectively and scientifically measured (through cognitive and/or functional assessment) to produce "neutral" evidence is integral to the mental capacity construct and the justifiability of medico-legal guardianship in terms of autonomy (as discussed in Chapters 1 and 4). The empirical research set out in Chapter 6 describes how legal decision-makers in the guardianship process (Set A) expect and rely on this kind of neutral evidence, and expect it to be provided by medical actors. The Set A participants had more to say about this than

⁷ Cognitive testing and functional assessment are most likely to be carried out where mental health teams or geriatric psychiatrists are involved in the assessment process, less likely where medical evidence is provided by general practitioners ("family doctors").

⁸ As discussed in Chapter 2, "The supported decision-making paradigm and the Convention on the Rights of Persons with Disabilities".

any other question, acknowledging the difficulty of the physician's task but critical (in some cases strongly) about the product. The nature of evidence in the mental capacity assessment means that scientific objectivity (analogous to a blood test or cell on a slide) cannot be achieved, however. Chapter 4 describes how the legal imperative to produce definitive neutral evidence of mental capacity has spurred a search for the chimera of a "perfect capacimeter"⁹ within the medical and allied health professions,¹⁰ including the alternative capacity assessment models discussed in the latter part of Chapter 4.¹¹ Within legal discourse, disillusion with the mental capacity "bio-fact" has led to its rejection altogether as a legally meaningful idea by General Comment #1 (interpreting the *Convention on the Rights of Persons With Disabilities*): "not, as is commonly presented, an objective, scientific and naturally occurring phenomenon" but "contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity."¹² Even if mental capacity were capable of objective proof, linking autonomy-impairing legal consequences (such as guardianship) to the disability of impaired mental capacity is discriminatory and antithetical to fundamental principles of equality and liberty.¹³

During the empirical phase of this research study (the second phase of pragmatic inquiry) participants were asked to define mental capacity, generally and in the context of dementia in old age, and asked whether they found the concept easy or hard to use. Both sets defined mental

⁹ Marshall B Kapp & Douglas Mossman, "Measuring Decisional Capacity: Cautions on the Construction of a 'Capacimeter'" (1996) 2:1 Psychol Pub Pol'y & L 73. ("[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" at 79).

¹⁰ Professionals working within the health system (social workers e.g.) who are not physicians or nurses.

¹¹ At the conclusion of Chapter 4 I suggest that these alternative models are less coherent as theories of mental capacity than vulnerability.

¹² See, CRPD, *General Comment No. 1 (2014)*, 11th Sess, adopted 11 April 2014, UN Doc C/GC/1, online: <<https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>> [CRPD, *General Comment No. 1*]. The *General Comment* provides an "authoritative, if not binding interpretation"; See Wayne Martin et al, "Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?" (2015) Report Submitted to the UK Ministry of Justice, online: <<http://repository.essex.ac.uk/13624/1/EAP-Position-Paper-FINAL-copy.pdf>> Most commentary has adopted the interpretative approach set out in comment No. 1; See, Eilionoir Flynn & Anna Arstein-Kerslake, "Legislating Personhood: Realising The Right to Support In Exercising Legal Capacity" (2014) 10:1 Intl J L in Context 81. The General Comment and responses to it are discussed in Chapter 2.

¹³ See, Leslie Salzman, "Rethinking Guardianship (Again): Substituted Decision-Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act" (2010) 81:1 U Colo L Rev 157.

capacity primarily in terms of the reasonableness or rationality of the person's decision-making behaviour (including decision-content and decision-implementation, i.e. reasonable decisions put into practice). Set A participants defined mental capacity in terms of rationality, decision-making within a "range of reasonableness", and the functional ability to ability to carry out reasonable decisions. Several Set B participants referred to mental capacity using similarly non-medical language, describing mental capacity as "reason in relation to function: the "ability to basically engage with the world thoughtfully and rationally" on a consistent basis" (theme 3); and "the ability to recognise and respond to risk ("competency becomes a factor when risk becomes intolerable") (theme 4). A minority of Set B respondents explicitly described the concept of mental capacity in terms of cognitive capacity or the brain's ability to carry out thinking processes (the biomedical mental capacity model), although the *assessment* of mental capacity (as opposed to the abstract concept of mental capacity) was defined in terms of demonstrated reasonableness or rationality in thought processes and "follow through" (i.e. functioning in day-to-day life).

7.2.2 Mental capacity in the context of dementia in old age

Special problems and difficulties arise in the context of dementia old age (the *loss* of mental capacity in old age for the first time, without an external brain-injury causing event such a car accident, is generally attributed to dementia).¹⁴ Dementia is not equivalent to impaired cognitive decision-making ability and a person diagnosed with dementia may nevertheless be cognitively capable of making certain kinds of decisions. A decreasing ability to make decisions is *part of* dementia, however, as a syndrome of irreversible and progressive decline in thinking processes. Changes in thinking processes will necessarily impact decision-making and a diagnosis of dementia will always be relevant to the assessment of mental capacity. Furthermore, the mental capacity assessment and the dementia diagnosis rely on similar kinds of evidence: cognitive and functional testing, and medical evidence, where available, of underlying cause (Alzheimer's disease or stroke, for example).¹⁵ Both mental capacity assessment and dementia diagnosis are

¹⁴ These problems are discussed in detail in Chapter 4, 4.4.1 "Mental capacity, adult guardianship, and dementia in old age".

¹⁵ Evidence of underlying disorder is not essential to the dementia diagnosis and the cause of dementia is more likely to remain theoretical.

processes of “evaluative judgment based on correlations between neuro-pathology and symptoms and signs”, distinguishing the pathological” from “normal aging” without a “hard scientific boundary between disease and normality.”¹⁶

Factors relating to social context are also relevant to evaluation of the “symptoms and signs” of dementia and the assessment of mental capacity in the old. Pervasive social attitudes towards the difference of aging and the aging body make it more likely that symptoms and signs of “normal aging” (as different from the non-old norm) will be read as pathological. At the same time, the physiological experience of aging generally tends to increase the frequency with which older persons are examined and evaluated by medical professionals (increasing the likelihood that dementia will be “found”). The heavy stigma associated with the diagnosis of dementia further impacts the assessment of dementia and of mental capacity in the old, in similar ways. The Set B participants described some family members as anxious to put their parents in the “best light,” and participants in assessment may perform (in a theatrical sense) in a way that is not indicative of day to day performance (highlighting for some Set B participants the importance of in-home functional assessment). On the other hand, some family members were described as over-stating the signs and symptoms of dementia, depending on the outcome they sought.¹⁷ These factors will not be magically dissolved by the shift to a vulnerability based guardianship practice, but I suggest that the problems they create are exacerbated by the pretence of scientific objectivity in medico-legal guardianship.¹⁸

The often fluid nature of early to moderate stage dementia, within an overall arc of decline, further complicates both the assessment of dementia and the assessment of impaired mental capacity *caused* by dementia. As dementia progresses, the person will experience increasingly intense needs for care and assistance (a decline in the ability to function independently) together with a decreasing ability to recognise and comprehend those needs. The early stages of dementia, in contrast, are often characterised by distortions in judgment and emotion at a time when the

¹⁶ “Lines can be drawn, but their exact location is a matter of evaluative judgment based on correlations between neuro-pathology and symptoms and signs. But which symptoms and signs? How much forgetfulness is pathological? What counts as normal aging?” Julian Hughes, Stephen Louw & Steven R. Sabat, eds., *Dementia: Mind, Meaning and the Person* (Oxford: Oxford University Press, 2005).

¹⁷ See the discussion of stigma in Chapter 4 at page 104.

¹⁸ See discussion, M.I. Hall (2012) 58(1) “Mental Capacity in the (Civil) Law McGill Law Journal 1.

individual retains the ability to effect or carry out mere choices (as opposed to genuine decisions) about significant discrete matters such as selling a house or making a gift. During this period, the performance of thinking processes can vary dramatically, a “grey zone” period of shifting sands during which the person can present as capable long enough to effect a discrete transaction (especially where lawyers’ and notaries’ attention to a client’s mental capacity is cursory).¹⁹

These distinctive aspects of dementia give rise to two distinctive problems: how to provide care and support where need (arising from an inability to carry out the activities of daily living) cannot be perceived or comprehended, and how to respond to the manipulation and exploitation of mere choices in the earlier stages of dementia. Both problems raise questions of fairness (is it fair to hold individual to consequences of her mere choice that are *contra* her own interests) and public policy (discouraging exploitation, and the “humane development of the law”).²⁰

Empirical research participants described the assessment of mental capacity in the “grey zone” of early to moderate dementia as difficult (consistent with the theoretical examination in Chapter 4). One Set A participant discussed the significance of brain damage evidence in brain injury/negligence cases, and the absence of equivalent evidence in guardianship cases involving dementia in old age. In the absence of this kind of evidence, changes in behaviour, judgment and the performance of thinking processes (changes in relation to one’s former younger self) were described as an important source of evidence, especially where connected with physical change or disease diagnosis. On the other hand, mental capacity was described as easy or obvious in “black and white” cases involving advanced dementia. Set A participants indicated that guardianship applications tended to involve “black and white” cases of this kind (although Set A participants were still critical of the medical evidence they were provided with).

The absence of “hard lines” meant that family perspectives, ageist attitudes and paternalism (as described by several Set B participants) also appear to play a significant role in the assessment of mental capacity in the context of dementia in old age (with the exception of black and white cases of advanced dementia). Concerns about exploitation were also mentioned by participants in both Sets as a relevant factor in the determination of mental capacity; the extent to which an older person was considered unable to protect herself and/or her assets appears to be treated as

¹⁹ See Lise Barry “He wore street clothes, not pyjamas: common mistakes of lawyers’ assessment of legal capacity for vulnerable older clients” (2018) 21(1) Legal Ethics 3.

²⁰ *In Re F*, [1991] UKHL 1, [1990] AC 1 at 19 per Lord Goff.

important evidence of impaired decision-making ability. Asked to define the purpose of guardianship (why have guardianship at all? what's it for?) participants in both Sets referred to the need to safeguard the individual's assets and person, including preservation of the individual's dignity and freedom from fear and suffering.

7.2.3 Summary and conclusions: mental capacity

Summary

The persistent problems in medico-legal guardianship are deeply intertwined with the mental capacity construct at its conceptual core. The mental capacity construct within adult guardianship²¹ has been a site of controversy and dissatisfaction for decades (despite the successive waves of reform described in Chapter 2). That dissatisfaction has now culminated in calls for the abolition of mental capacity as a legally meaningful concept.²² Special difficulties arise in the context of dementia in old age, in which questions of mental capacity (cognitive decision-making ability) and the diagnosis of dementia are intertwined. Problems with cognitive decision-making ability are one aspect of the broader phenomenon of dementia. Late stage dementia involves a comprehensive breakdown in decision-making ability, in terms of both thought process and function (carrying out thought processes in the activities of daily living); the mental capacity question in this context is obvious, “black and white.” In early-moderate stage dementia, however (“shades of grey”), the mental capacity question is more difficult and more ambiguous. Exploitation is a particular concern at this stage, informing the mental capacity determination for participants in Set A and Set B.

One outcome of the problematic nature of mental capacity (except in black and white cases of advanced dementia) that became evident through the empirical research in phase 2 is an increasing reluctance on the part of physicians to become involved in the capacity assessment process. I suggest that this reluctance reflects the impossibility of the task: to produce neutral and scientifically objective evidence of cognitive decision-making ability (as expected by legal decision-makers) in a situation where evidence is necessarily evaluative, a question of “lines

²¹ As discussed in Chapter 4, mental capacity has been more successful in the context of agreements, transactions, and bequests and (albeit to a lesser extent) health care consent.

²² The impact of its abolition on those areas of the law where it appears to work without significant problems, discussed in Chapter 4, is a larger topic to be considered in future research.

drawn” (the back and white cases are relatively easy because the lines are easy to draw). Set A participants’ criticism of physicians’ failure to provide the kinds of neutral evidence they needed is indicative of this problem. The medico-legal guardianship process requires physician participation, and cannot function without it, and this is an important finding. If physicians are opting out of medico-legal guardianship, it will not remain a viable response. Further research with physicians on this point would be helpful.

Participants in Set B generally described the relative disuse of court-appointed guardianship, ascribing this marginality to the expense of the process (bearing in mind that higher-income individuals would have been less likely to see mental health teams and more likely to see family doctors and/or geriatric psychiatrists in connection with court appointed guardianship applications). Set A participants also described little recollection of dealing with guardianship cases, although a large part of this they ascribed to their unmemorable (and apparently *pro-forma*) nature, which would have left no mental trace, “like water running out of a bath-tub” in the words of one Set A participant. Finally, participants’ description of mental capacity in terms of reasonableness and rationality (when asked to define mental capacity) refers to non-biomedical or scientific measures. These concepts are more legal in nature, and “reasonableness” is a long established objective test in law (legal objectivity being different from scientific objectivity). Set A descriptions of mental capacity in these terms were in tension with their comments regarding the significance of neutral medical evidence and criticism of physicians who stepped outside of this scope to “advocate” for their patients, or to include non-medical information in their evidence relating to capacity.

Set A participants described their own role as one of final decision-maker about the individual’s mental capacity and the arrangements necessary for managing impaired capacity (selection of the guardian and the scope of guardian authority). On the issue of mental capacity, however, guardianship legislation in British Columbia requires only the provision of medical evidence and it is difficult to know another basis on which a judge could make a determination of whether the person’s decision-making fell within the “range of reasonableness.” Additional affidavits may be provided as collateral evidence of a person’s impaired capacity (generally describing the person’s functioning in the community) and/or the suitability of one potential guardian over another- but these are the exception rather than the rule, and generally involve competitions

between would-be guardians or applications where guardianship is sought by an adult child to disrupt a purportedly exploitative relationship (where the suspected exploiter resists guardianship).²³ Set B participants described more a direct and explicit assessment of the reasonableness of decision-making at all stages of assessment (including formal assessment processes and informal assessment, as described in Chapter 6).

Conclusions

In conclusion, and responding to the research questions re-stated at the beginning of this Chapter:

- The mental capacity construct, as the organizing idea of medico-legal guardianship, is a source of persistent and recurring problems within adult guardianship, giving rise to particular problems in the context of dementia in old age. The evaluation of mental capacity is less problematic in relation to advanced dementia (involving comprehensive impairment that includes impaired decision-making). The discrimination-based critique of the mental capacity construct in legal discourse (discussed in Chapter 4) is equally applicable in this context, however.
- The neutral scientific/objective assessment of mental capacity cannot be consistently enacted by medical actors involved in the guardianship process, despite the legal imperative (and expectation) that they do so; legal actors depend on this kind of medical evidence (hence their insistence on it/disappointment at not receiving it). Furthermore, when asked to define mental capacity participants in both Sets did so with reference to primarily non-medical concepts. This disconnect creates incoherence, in-consistent implementation, and makes it more likely that hidden contextual factors (social ageism, the stigma associated with dementia, and enhanced scrutiny of the aging body) will influence capacity assessment and guardianship outcomes.

As noted in previous chapters and above, the problems associated with mental capacity in the guardianship context have led some commentators to call for the abolition of adult guardianship

²³ Guardianship terminates a power of attorney and may terminate a representation agreement. Guardianship may therefore be sought in cases of suspected power of attorney or representation abuse.

altogether.²⁴ Their conclusion begs the question- is there anything about guardianship (i.e. a guardianship continuum that includes supported, assisted, and substitute decision making) that makes it worth reconstructing, and saving?

The question of whether guardianship is worth saving ultimately comes down to a question about the validity, and justifiability, of substitute decision-making. Substitute decision-making itself has two aspects: the ability to make a decision on behalf of another person, where that individual cannot effect any kind of choice (the person in a coma e.g.); and the ability to over-rule a person's mere choices on an ongoing basis. The second aspect is the more problematic in terms of autonomy and (with the partial exception of advance planning and temporary substitute decision-making in health care consent legislation)²⁵ it is the unique or special power that guardianship confers.²⁶ The question of whether one person should ever have the authority to over-rule the mere choices of another is, at its core, a question of principle and judgment. One reason for the mental capacity construct's persistence is its re-conceptualisation of this question as a scientific matter that can be answered on the basis of scientific evidence (apparently removing the need for judgment). That re-conceptualisation has ultimately been unsuccessful, giving rise to the current doubts about the justifiability of adult guardianship.

On the basis of fundamental legal principles of fairness and principles of public policy, I propose that a valid role for guardianship (including the potential appointment of a substitute decision-maker) remains in relation to the following situations (where no substitute decision maker has been appointed through an advance planning instrument, or where an advance planning relationship has become unworkable because of exploitation or otherwise):

- to provide care and support where a high level of need (arising from an inability to carry out the activities of daily living)²⁷ cannot be perceived or comprehended by the individual affected; and

²⁴ See also, Nina A Kohn, Jeremy A Blumenthal & Amy T Campbell, "Supported Decision-Making: A Viable Alternative to Guardianship" (2013) 117:4 Penn St L Rev 1111 at 1113, 1117-120; Kristin Booth Glen, "Changing Paradigms: Mental Capacity, Legal Capacity Guardianship, and Beyond" (2012) 44:1 Colum HRLR 93

²⁵ Powers or attorney and representation agreements confer a similar authority, although the fact that the decision-maker has been chosen by the donor theoretically limits the autonomy impairment these instruments confer.

²⁶ Health care may be provided through health care consent legislation; care facility admission may be provided for through (currently) the *Mental Health Act* in British Columbia.

²⁷ Including management of finances.

- to disrupt the manipulation and exploitation of *mere* choices by others (as that term is used in this study to described choices that are distorted by the individual's impaired thinking processes, as described in Step 1 of the model set out in the following section).

Substitute decision-making in both contexts is justified of the basis of fairness. Both problems require an evaluation of the person's performance of thinking processes, and both problems have particular relevance to the context of dementia in old age.

On the basis of the analysis in this part, I conclude that medico-legal guardianship is unsustainable. If, as I suggest, adult guardianship has a continuing role to play, it must be re-organized. The following section assesses (for the purpose of judgment) the concept of vulnerability as the theoretical basis for that re-organisation.

7.2.4 Vulnerability: theoretical framework and preliminary model

Adult guardianship (in particular, the guardian's authority to over-rule mere choice) entails a significant degree of interference with autonomy. For this reason, guardianship requires a clear boundary and basis for appointment. The apparent ability of the mental capacity construct to provide that boundary has accounted for its survival to date, despite increasing doubts about its validity. Maybe nobody really believes in its truth anymore, but without mental capacity the fear is either that guardianship would have to disappear (the gist of General Comment No. 1) or that guardianship would become *ad hoc* and unprincipled, based on prejudice and value-judgment. Indeed, the mental capacity construct in adult guardianship first emerged as a hoped-for corrective to bias and the paternalism of the *parens patriae* guardianship model (as discussed in Chapter 2).

The following sections consider whether vulnerability can provide an alternative boundary and basis for adult guardianship that is principled, capable of consistent implementation, and justifiable in terms of legal principle (building on and further developing the theoretical and empirical examination in phases 1 and 2).

7.2.4.1 Vulnerability: the theoretical framework

The word “vulnerability” has multiple meanings. In this study, “vulnerability” refers to the exposure to harm experienced by every person as a consequence of her or his physical embodiment and embeddedness in social and relationship context (as opposed to the “vulnerable populations” identification of vulnerability in opposition to an *invulnerable* norm).²⁸ This baseline vulnerability is universal, but each individual’s vulnerability manifests in different ways depending on the individual’s physiological self, her social, material and relationship contexts, and the relationship between context and self.

Vulnerability may be increased by changes in the self and context throughout the life-course; vulnerabilities may also be absorbed, or resisted, by changes to the contexts in which the person is situated and/or through strengthening of the self. The baby, for example, is potentially highly vulnerable. Where the baby’s vulnerability is absorbed by a responsive and supportive (relationship, social and material) context, however, the baby’s vulnerability is significantly diminished to the extent that she or he is only marginally more vulnerable than most adults, and less vulnerable than some. Conversely, vulnerability can be significantly increased by contextual factors (poverty, social stigma, or abusive or oppressive relationship context, for example). Public responses to vulnerability must also take into account the potential for that response to *increase* vulnerability in unintended ways. Catriona Mackenzie, Wendy Rogers & Susan Dodd refer to this source of vulnerability as “pathogenic”, “where the response intended to ameliorate vulnerability has the paradoxical effect of exacerbating existing vulnerabilities or generating new ones.”²⁹ The critique of medico-legal guardianship associated with the discourse around supported decision-making and the CRPD has emphasized these kinds of pathogenic consequences for persons with developmental disabilities.

Recognising a universal baseline of vulnerability does not equate to demanding its elimination; vulnerability can never be eliminated altogether and that is not the goal (although some universal

²⁸ These different definitions of vulnerability are examined in Chapter 4.

²⁹ Catriona Mackenzie, Wendy Rogers & Susan Dodd “Introduction: What is Vulnerability and Why Does it Matter for Moral Theory?” in C. Mackenzie, W. Rogers & S. Dodd, eds. *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford, UK: Oxford University Press, 2014) at 9.

social programs may be understood as lowering baseline vulnerability in a general sense). Social response to *heightened* vulnerability may be justified where that response works to recalibrate the relationship between context and self in a way that reduces vulnerability (without creating pathogenic consequences). The kind of response needed will depend on the nature and source of heightened vulnerability in a particular case. In the case of the baby described above, for example, no response is required (although the baby is objectively a member of a “vulnerable population”). Where a baby’s material context cannot absorb her vulnerability, providing the baby’s family with housing and benefits will change her context in a way that reduces vulnerability (although the baby’s physiological self remains unchanged). Where a baby’s vulnerability is otherwise absorbed by her context but a medical condition (for which treatment is available) creates heightened vulnerability, reducing that baby’s vulnerability requires treatment. In this example, the baby’s vulnerability is reduced through strengthening her physiological self- her context remains the same. These simple examples show that heightened vulnerability arises in many different ways; that there are many different responses to that vulnerability; and that the most appropriate response in the circumstances depends on the nature of that vulnerability and its source.

Thinking about these responses in terms of vulnerability may seem pointless- don’t we do these things anyway (treat the sick baby, provide benefits to the baby’s parent/s?) What difference, if any, does it make to theorise the purpose of treatment or the provision of benefits in terms of reducing vulnerability through a recalibration of the relationship between context and self? These questions can only be answered in relation to a particular field of practice, by examining the way in which that field is currently organized (by an idea or theoretical framework), by imagining what an alternative organization would look like, and by assessing the differences between the two. This approach is consistent with pragmatic inquiry methodology. In the field of adult guardianship this means asking: if adult guardianship was conceptualised as a response to vulnerability rather than a response to impaired decision-making ability, what kinds of structures and practices would result from, and operationalise, that re-conceptualisation? Would they work differently, in a way that produces coherent, consistent and beneficial outcomes, for the persons involved? Would a vulnerability-based guardianship model and practice be compatible or fit with the wider contexts of practice and principle in which it is situated?

The framework for a vulnerability-based guardianship model set out in the following section addresses the final research questions re-stated at the beginning of this Chapter:

- Can vulnerability provide a more coherent and workable “organizing idea” (in terms of both theoretical coherence and potential for consistent implementation) for adult guardianship, especially in relation to dementia in old age? What would a coherent/workable theory of vulnerability in this context look like?

These questions must be answered together: it is not possible to assess the potential success (on Dewey’s terms) of a vulnerability-based guardianship model without examining, in some detail, what that model would actually look like and entail, including the ways in which it would be different from and similar to the current adult guardianship situation “organized” by the mental capacity construct.³⁰ This model builds on the discussion in Chapter 4, including the alternative mental capacity models discussed in that Chapter as *de facto* theories of vulnerability (articulated in terms of mental capacity to fit the current legislative frame), and the discussion of empirical research set out in Chapter 6. A detailed plan for the implementation of this preliminary model on a pilot basis or otherwise (remaking adult guardianship) is beyond the scope of this study, requiring further empirical research and analysis (as discussed in the following part).

7.2.4.2 Adult guardianship as a response to vulnerability: framework for a preliminary model

The adult guardianship model set out below provides one response to a particular kind and quality of heightened vulnerability, and not to a generic “vulnerability” *per se*. Research participants in both sets, when asked to define mental capacity and vulnerability, referred to vulnerability as the broader concept of which mental capacity was sometimes a part (although one could also be vulnerable for other reasons, and having impaired mental capacity did not necessarily mean that one was vulnerable). This quality of vulnerability, and the relationship between vulnerability and mental capacity, was captured in one Set B participant’s definition of vulnerability: “vulnerability is being incapable in a context you can’t handle.”

³⁰ The organisation of adult guardianship by the mental capacity construct is discussed extensively in Chapters 2 and 4.

The objective of the guardianship process set out in this part is to determine whether a person is vulnerable, and whether her performance of thinking processes (as discussed below) is one aspect of that vulnerability. Where this quality of vulnerability is established, guardianship may—but may not—provide an appropriate response. Treatment, or the development of decision-making capability through supported decision-making, may be the more appropriate approach to reducing vulnerability in a particular situation, for example. Step 3 in the preliminary model set out below provides for a consideration of the most appropriate response to vulnerability in a particular situation. Guardianship is especially likely to be appropriate in the context of dementia for the reasons described in the preceding part of this Chapter, although guardianship will not always be the most appropriate response in this context as in others. Guardianship will not be an appropriate response where a person’s vulnerability arises from sources that do not include the performance of thinking processes.

The following section outlines four steps in a preliminary vulnerability-based guardianship model. Those four steps provide a framework for further development and, following that development, implementation.

Step 1: Evaluation of an individual’s performance of thinking processes in relation to his or her management of finances and/or person (including both “reason” and “function”) using a reasonableness-based measure (likelihood or risk, gravity of risk, and understanding/adoption of risk), , together with a consideration of relevant diagnosis and prognosis.

Step 1 resembles the two stage capacity assessment process provided for in British Columbia’s statutory guardianship legislation (*Adult Guardianship Act* 2.1)³¹, although the introduction of a *measure* (reasonableness) for the evaluation of thinking processes at Step 1 is distinct.

³¹ Also described in Chapters 2 and 5.

Adult Guardianship Act 2.1,³² which came into force in December 2014 and took statutory guardianship outside of the *Patients Property Act*,³³ explicitly introduced a functional aspect into a two stage assessment of decision-making ability.³⁴ Stage one of that process, carried out by a physician, provides for a medical examination that includes all diagnoses and prognoses relevant to the person’s inability to manage his or her financial affairs. Stage two provides for evaluation of a person’s ability to understand the nature and extent of her finances and property, his or her functional management of finances and property and understanding of the actions required to do so, and the person’s understanding of the risks associated with taking one course of action over another. This second stage evaluation can be carried out by a non-physician “qualified health provider” (as described *infra*, and in Chapters 2 and 5).

The “performance of thinking processes” referred to at Step 1 is both conceptual and functional in nature (“reason” and “function”). In this respect, Step 1 resembles the assessment of “understanding” and “function” at the second stage of the statutory guardianship assessment process and, as with that process, the Step 1 assessment could be carried out by a physician or by a qualified health care provider. Evidence collected at this stage would include observations/interviews, collateral information, cognitive testing, and clinical observations. The forms and templates used in the statutory guardianship capacity assessment process provide a useful starting point for further development of this Step³⁵ (modified to reflect the reasonableness measure described below.)

Step 1 departs from the statutory guardianship approach by explicitly identifying a measure for evaluating the individual’s performance of thinking processes. The statutory guardianship approach, consistent with the medico-legal guardianship model, refers only to whether a person

³² *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, Part 2.1

³³ *Patients Property Act*, RSBC 1996, c 349.

³⁴ Functional assessment is not provided for in the legislation applying to the court appointed guardianship process; functional assessment may (but need not) provide a basis for a physician’s finding of mental capacity under that legislation, and is more or less likely to do so depending on whether a family physician, mental health team, or psychiatrist is involved.

³⁵ See Appendix E, Public Guardian and Trustee of British Columbia and the Ministry of Health of British Columbia, *A Guide to the Certificate of Incapability Process Under the Adult Guardianship Act*(2016) <http://www.trustee.bc.ca/reports-and-publications/Documents/A%20Guide%20to%20the%20Certificate%20of%20Incapacity%20Process%20under%20the%20Adult%20Guardianship%20Act.pdf>

can understand, appreciate and manage (i.e. whether or not a person is cognitively capable of carrying out these conceptual and functional processes). Including a measure at this Step responds to the findings at phases 1 and 2 of this research study. Those findings support the conclusion that thinking processes (including the ability to translate thought into action) can be ascertained only through a qualitative evaluation of the individual's performance of thinking processes. X's evaluation of whether Ms. Y "can" understand is, in reality, an evaluation of the quality of understanding demonstrated by Ms. Y through her responses to questions and/or score on a Mini Mental Status Exam, for example. Similarly, X's evaluation of whether Ms. Y "can" carry out the functions of self-management is an evaluation of whether or not Ms. Y's management is acceptable with reference to some measure. The measure used by X in this context may be exacting, or permissive; either approach would appear on its face to result from the same assessment process, although the outcome would be very different. The failure to explicitly provide for a measure creates a meaning vacuum in which evaluators (whether legal or medical) apply their own measures on a covert and unregulated basis. Without an express requirement and clear definition, A's understanding of "reasonable" performance may be very different from B's, for example, while C might apply a different measure altogether (perhaps one in which older persons are held to higher standards). Perhaps D's measure of Ms. Y's capability depends on the resources available to him, or his willingness to expend effort in order to secure them.

The adoption of reasonableness as the measure used at this Step reflects the findings at the empirical phase of this research study (in which both participants sets defined mental capacity primarily in relation to the reasonableness and/or rationality of performance) and the use of reasonableness in law as a test of *legal* objectivity in cases where scientific objectivity is not possible (mental capacity being one such case). This distinctively legal idea of reasonableness is associated with risk, involving a balancing of the likelihood of harm created by problems in the performance of thinking processes and the gravity of that harm (should it materialise).³⁶ If a person's problems in the performance of thinking processes are not associated with risk in this way, the Step 1 requirement will not be met and the inquiry will not proceed to Step 2.

³⁶ This is the legal approach to the objective standard of reasonableness.

Note that risk is relevant at Step 1 as it relates to the reasonableness (or not) of the person's performance of thinking processes, i.e. whether that performance is itself a *source* of risk in a way that makes it unreasonable. If a person understands risk and affirmatively undertakes it, risk is the consequence of that decision (and not the person's performance of thinking processes); the decision not to eat is different from an inability to perceive the significance of eating and/or to carry out the tasks associated with eating, for example. This aspect of the relationship between risk and the evaluation of reasonableness means that the assessment of a person's understanding and adoption of risk must be part of the Step 1 evaluation. Assessment of a person's understanding of risk at the second stage of the statutory guardianship capacity assessment process provides for a similar (but not identical) inquiry, and it would be useful to carry out empirical research with qualified health care providers to examine in detail how understanding of risk is evaluated at that stage (i.e. providers' implementation of the forms and templates referred to, *supra*, in footnote 35). Obtaining detailed information from older adult mental health teams about the approaches and tools used in their own risk assessment processes,³⁷ together with surveying risk assessment tools used in other contexts, would also assist in further development of this Step.

The significance of diagnosis and prognosis at this stage resembles the first stage in the statutory guardianship process, but is different in important respects.. Within the statutory guardianship model, diagnosis and prognosis are considered as part of the mental capacity assessment. Diagnosis and prognosis are considered at Step 1 of a vulnerability-based model because of their relevance to the question of what response to the impaired performance of thinking processes will be appropriate (and not to the question of whether or not that performance falls outside the measure of reasonableness). Diagnosis and prognosis indicate whether treatment is available to strengthen performance, and whether the person's performance of thinking processes is expected to remain stable, to decline, or to improve. All of these factors are essential to the issue of appropriate response. The appointment of a guardian as a substitute decision-maker will be considered only where the individual's performance of thinking processes is evaluated as outside the reasonableness measure, and where diagnosis/prognosis suggests that the impairment of thinking processes is chronic and/or declining and cannot be ameliorated.

³⁷ Several Set B participants referred to the significance of risk assessment in relation to mental capacity.

Where a person's performance of thinking processes falls outside the measure of reasonableness at this Step, he or she is *potentially* vulnerable. The next Step involves an assessment of the individual's social, relationship and material contexts in connection with the evaluation of thinking processes carried out in Step 1 for the purposes of evaluating vulnerability. Where vulnerability is not established at the second step, guardianship will not be justified.

Step 2: Evaluation of vulnerability arising from the interaction between the impaired self and social/relationship/material context.

Step 2 involves the evaluation of vulnerability, taking into account the relationship between the individual (including evaluation of the performance of thinking processes at Step 1) and the social, material, and relationship contexts in which the individual is situated. The potential vulnerability established through the inquiry carried out at Step 1 may be absorbed, or exacerbated, by those contexts. If absorbed, the person is not vulnerable and the inquiry stops. If not absorbed, or exacerbated, the person is vulnerable for the purposes of Step 2. Step 3 considers the most appropriate response to that vulnerability; the evidence gathered in relation to thinking processes (at Step 1) and context (at Step 2) will inform decision-making at Step 3. The potential for pathogenic vulnerability must also be taken into account and weighed at this step.

Conceptualising adult guardianship as a response to heightened vulnerability, rather than impaired decision-making ability, makes the evidence-based evaluation of these contextual factors an essential factor in the adult guardianship process. This is a significant difference from the current court appointment process. Minimal contextual information is currently provided by the "Affidavit of Kindred and Fortune" (including the names and addresses of persons related to the individual and a statement of the individual's property, income, debts and liabilities) that person's initiating a guardianship application, must provide.³⁸ That information is considered by the Public Guardian and Trustee, who then provides an opinion as to whether any limits on the scope of the guardian's authority (generally relating to finances) should be imposed, and the degree of ongoing oversight by the Public Guardian and Trustee required. No additional

³⁸ The person initiating a guardianship application virtually always does so for the purpose of being appointed as guardian him or her-self.

evidence relating to context is required in the court appointment process although (as discussed in Chapter 6) additional affidavit evidence relating to relationship and material context may be provided in contested cases (as where family member A contends that guardianship is unnecessary because of the care he provides and family member B contends that guardianship is necessary precisely to protect the person from A's "care"). With these limited exceptions, evidence is limited to the medical affidavits provided by physicians (which Set A respondents clearly indicated should include neutral medical information only). Somewhat paradoxically, respondents in Set A also indicated that evidence of abusive and/or exploitative relationship context provided in contested cases was an important factor in their decision-making about *whether* a guardian was needed (in addition to the question of who that guardian should be).

One Set B respondent described her mystification about how judges make decisions in guardianship cases given the paucity of evidence provided:

“I’ve often wondered what the court is doing. The court will take affidavits and to me sometimes it really is blind in terms of when you get two family members fighting over who’s going to be committee-over a pot of money... how they [the court] make a judgment call without doing anything more than looking at what’s before them in terms of the papers... in fairness it would be nice to see a system where the courts could do more to pull in the health care professionals who really know these people”.

Describing their own decision-making process around whether to pursue a formal capacity assessment for the purpose of “triggering” a legal response under the *Adult Guardianship Act (Part 3)*, statutory guardianship, or the *Mental Health Act*, Set B respondents described the significance of contextual factors in terms of whether to proceed and the particular response sought (care facility admission or money management, for example).³⁹

The statutory guardianship process provides for a partial consideration of contextual factors (albeit obliquely) by requiring a consideration of existing and available private arrangements and

³⁹ The court appointed guardianship process, in contrast, is “triggered” by the private individual bringing the application.

options⁴⁰ before the Public Guardian and Trustee can be appointed as guardian of finance, even where impaired decision-making ability has been established. The reason is practical: as a public service,⁴¹ statutory guardianship is a last resort for persons *without* a supportive social and relationship context but with money that, if managed, can be used to improve the individual's living conditions and security (i.e. her material context).⁴² Control of finances is also an effective tool for the disruption of exploitative relationship contexts.

Contextual factors relevant to evaluation at this Step would include: information about the person's living situation (where, with whom, and on what basis i.e. ownership, rental, etc.); a financial and property "snapshot" (information currently included in the Affidavit of Kindred and Fortune); information about current systems in place for financial management and home/personal care (formal or informal); information about any services (health or otherwise) being provided to the person; information from family members (or other persons similarly situated) regarding their availability and willingness to provide care and support; information regarding any complaints regarding financial abuse made to the Public Guardian and Trustee. The question of who would collect and provide this information requires further examination. The applicant is one option. This may be a role more appropriately carried out by the Public Guardian and Trustee (requiring increased financing of that office). Development of a template (a form and checklist) for the collection of this information, including the level of detail required, is also beyond the scope of this research study. Creation of a template is not essential to assessing the usefulness of collecting contextual information to the objective of reducing vulnerability, however. This is in fact the kind of information that is collected by mental health teams (the Set B participants) in the course of working with clients, with the exact scope and nature of evidence in each case depending on the client's individual situation. Developing this step would involve further consultation with the phase B participants about the procedures used to collect this kind of contextual evidence (including any templates used). Consultation with judges and lawyers will also be important to assess practical issues and identify additional

⁴⁰ Including court appointed guardianship and advance planning instruments (powers of attorney, and representation agreements).

⁴¹ Although the Public Guardian and Trustee reimburses itself for its management services from the individual's estate.

⁴² The not-for-profit Bloom Group, referred to by one Set B participant in Chapter 6, provides money management services for low income persons (a service currently available in the Lower Mainland of British Columbia only).

information which would be useful at this stage. Consultation with the Public Guardian and Trustee on this point would also be useful.

The problems of social ageism, paternalism and the medicalization of the aging self will of course not magically disappear by shifting the guardianship focus to vulnerability rather than decision-making ability. These attitudes will, unfortunately, continue to impact the assessment of vulnerability, risk, and the performance of thinking processes, just as they currently impact the assessment of “decision-making ability” (i.e. mental capacity). The vulnerability lens has the potential to lessen the impact of these factors, however, by removing the sole focus on the self and requiring a consideration of the self in relation to context. It is not just the older person who is the subject of scrutiny and judgment but, equally, the contexts of her life and the way those contexts can be changed to reduce vulnerability. The model set out here also requires a consideration of pathogenic outcomes as part of the decision-making process about guardianship and other forms of legal and non-legal response. Not perfect, but better.

Step 3: Consideration by an inter-disciplinary guardianship tribunal of whether guardianship is the most effective tool, under the circumstances, for recalibrating the relationship between self and context in a way that reduces the vulnerability established at Step 2. Alternative tools considered at this step include non-legal tools such as home supports or medical treatment (as indicated by Step 1), legal alternatives to guardianship (in British Columbia, *Adult Guardianship Act Part 3*), advance planning instruments, or care facility admission using (at this time, the *Mental Health Act*)⁴³

Step 3, following the evaluation of vulnerability provided for through steps 1 and 2, requires structural in addition to legislative change. The approach set out in Step 3 resembles the statutory guardianship scheme, which requires a consideration of alternate private responses before proceeding with statutory guardianship, but without positioning guardianship (statutory or court appointed) as a “last resort” and taking into account both the contextual and personal evidence provided at the first two steps.

⁴³ The care facility admissions sections of the *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, are expected to be brought into force in 2018.

The process described in the 4 step guardianship model set out here could be initiated in a number of ways: as an application for court appointed guardianship; through the statutory guardianship process; as an application for care facility admission (currently carried out pursuant to the *Mental Health Act*); or as an application pursuant to Part 3 of the *Adult Guardianship Act* (British Columbia's adult abuse and neglect legislation). However initiated, vulnerability (at the level of real risk) would need to be established through steps 1 and 2. Step 3 would then require a consideration of both legal and non-legal responses to that vulnerability (including appointment of a publicly accountable substitute decision-maker), and a determination of which response would be the most appropriate in the circumstances. That determination would be based on the information collected through steps 1 and 2, and would most appropriately be carried out by an interdisciplinary tribunal (including representation from law, medicine and social work). The potential creation of "pathogenic vulnerability" arising from different responses would also be considered at this stage.

Further development of a tribunal model is beyond the scope of this research study, and would require additional empirical research, a survey of guardianship tribunals (past and present) in Australian jurisdictions, together with an economic analysis and administrative feasibility study. Potential time delays caused by gathering additional information would also need to be assessed.⁴⁴ A good place to start would be through an assessment of the statutory guardianship process which came into force in 2014, a considerably more complicated process than its predecessor, and one which resembles the model set out above in several respects. Has the new statutory guardianship scheme been a source of significant delays? What lessons can be learned there? The experience of the Australian tribunals will also be significant on this point, and will need to be examined. Terry Carney has referred to Australian guardianship tribunals as "cheap, accessible and user friendly, leading to large numbers of applications," an observation which suggests that the marginality of court appointed guardianship is a function of the current process, and not a more fundamental irrelevance of guardianship itself. Carney notes that the tribunal model may have had the effect of making guardianship model *too* accessible, without

⁴⁴ The Public Guardian and Trustee is empowered to control assets for the purposes of investigating financial abuse and provisions of the *Adult Guardianship Part 3* allows health authorities to investigate and provide services in case of abuse and neglect without court order.

“systematic filters” providing for other, less autonomy-intrusive responses (Step 3 of the vulnerability-based model set out in this part would provide for a “filter” by requiring consideration of alternative responses).⁴⁵ An economic analysis would also need to consider the economic implications, if any, of a vulnerability-based guardianship model for the health care system more broadly. Further research may establish that guardianship tribunals are not feasible (although the existence of guardianship tribunals in Australia suggests that they are a workable model). If so, more modest reforms to legislation applying to court appointed guardianship (incorporating steps 1, 2 and 4) may be achievable.

Step 4: If guardianship provides the most appropriate response, who is best suited to be guardian? What supports will they need to effectively carry out this task?

The consideration of who is best suited to be a guardian is an important part of existing court appointed guardianship processes (as described in Chapters 2, 4 and 6). The personal and contextual evidence required by steps 1 and 2 would provide the basis for that consideration in a vulnerability-based guardianship model in both contested and uncontested guardianship cases.⁴⁶ The second consideration at this step (supports needed to effectively carry out the guardianship task) is not part of the current model, beyond the question of whether guardianship should be restricted or subject to over-sight from the Public Guardian and Trustee (if over-sight can be considered a minimal form of support). I suggest that the question of support is essential to the success of guardianship as a mechanism for reducing vulnerability. Despite the historical origins of guardianship in public responsibility, our society has agreed that the functions of guardianship should be downloaded to private individuals wherever possible (through advance planning, court appointed guardianship, or other private arrangements). That understanding is codified in the statutory guardianship legislation discussed above (creating statutory guardianship as the option of last resort). Fairness requires that these private (generally family-member) guardians be supported in carrying out that task. The inter-disciplinary guardianship tribunal structure outlined

⁴⁵ Terry Carney “Too Much Access? The Case for Intermediate Options to Guardianship” (1995) 30(4) *Australian Journal of Social Issues* 445. See also, Carney, Terry & David Tait. *The Adult Guardianship Experiment: Tribunals and Popular Justice* (Leichardt, NSW: Federation Press, 1997).

⁴⁶ Additional evidence could be brought in contested cases, as at present.

above would be capable of providing advice and information about a wide range of available supports (although it could not provide them directly, or compel their provision).

The 4 steps set out in this model (including the evaluation of thinking processes) need not be carried out by physicians, with the exception of information regarding diagnosis and prognosis provided at Step 1 and medical representation on the proposed inter-disciplinary tribunal. The 2014 amendments to the statutory guardianship scheme in British Columbia (*Adult Guardianship Act 2.1*), enabling nurses, psychiatric nurses, occupational therapists, psychologists and social workers to become “qualified health providers” (for the purpose of carrying out one of the two stages in the statutory guardianship capacity assessment process) provides one template for identifying/qualifying professionals for the purpose of carrying out Steps 1 and 2 in the vulnerability based guardianship model set out above.⁴⁷ This factor is significant; responses received from Set B participants indicated that physicians (including both family doctors and psychiatrists) are increasingly reluctant to provide the kind of capacity assessments that adult guardianship currently requires.⁴⁸ Steps 3 and 4 would be carried out, in the preliminary vulnerability-based guardianship model set out here, by an inter-disciplinary guardianship tribunal.

7.2.5 Judgment

On the basis of the analysis and 4 Step model set out in this Chapter, I conclude that vulnerability can provide a more coherent and workable “organizing idea” (in terms of both theoretical coherence and potential for consistent implementation) in the adult guardianship field of practice. A vulnerability-based guardianship model would be most completely operationalised through legislative and structural change (a guardianship tribunal). A more modest change to existing court appointed guardianship legislation (incorporating Steps 1, 2 and 4) would also effect positive change, although the barrier of costs associated with court processes would remain, and decision-making would be limited to guardianship appointment (as opposed to the range of options contemplated in Step 3). In this scenario (legislative change to court appointed

⁴⁷ Nurses, psychiatric nurses, occupational therapists, psychologists and social workers may become qualified health providers if they meet the standards required by their professional organisation. See *Statutory Property Guardianship Regulation*, BC Reg 115/2014, Part 2.

⁴⁸ Anecdotal evidence indicates this problem is especially acute in outside of urban centres.

guardianship), the requirement of contextual evidence, by adding more steps, would increase the cost and cumbersomeness of the process. The new approach to evaluating the performance of thinking processes would seem to be cost neutral (although a checklist or tool would need to be developed through inter-disciplinary work before implementation). On the other hand, decreased reliance on physicians to provide evidence of mental capacity may have the effect of increasing accessibility. The more radical proposal for a guardianship tribunal would decrease costs and time delays for system users generally,⁴⁹ although a more detailed economic analysis of the implications of that model would need to be carried out in a subsequent research stage. The structure of an interdisciplinary guardianship tribunal would also provide for a more informed approach to decision making about a wide range of alternative responses, and the ability of a tribunal to consider a range of options would be a valuable aspect of the 4 Step model set out in this Chapter.

As stated in Chapter 1, the purpose of this research was to construct a model of adult guardianship that addresses the problems arising from medico-legal guardianship while filling the gaps in the supported decision-making paradigm. Achieving this purpose has required constructing a basis for appointment of a substitute decision-maker other than impaired mental capacity or decision-making ability. Consistent with the pragmatic inquiry methodology used in this research study, that process of construction has been carried out with a focus on two organizing concepts- mental capacity and vulnerability- at all three stages of pragmatic inquiry. At phase 2, this focus set the limits for the participant groups in the empirical research, the kinds of questions participants were asked in the open-ended interview process (and therefore the answers they provided), and informed the identification of themes through applied thematic analysis (as discussed in Chapter 5). Those limits mean that the empirical research carried out at phase 2 cannot provide the basis for an implementation-ready vulnerability based guardianship model, and further work is needed to develop the framework for a preliminary model set out in this Chapter. The three phase pragmatic inquiry carried out in this research study provides a justified basis for moving forward with that development, and identifies a “third way” out of the medico-legal guardianship vs. the supported decision-making paradigm impasse in the discourse

⁴⁹ See, Peter Whitehead “A Review of the Response of the Courts and the NSW Guardianship Tribunal to Cases of Financial Abuse” 5 [2008] Elder Law Review 6.

around adult guardianship and the meaning and implementation of the *Convention on the Rights of Persons with Disabilities*. The framework for a preliminary model set out in this Chapter fits with current practice (as described in this Chapter and Chapter 6), and within the broader context of legal principles described in Chapter 4, in the way described by the pragmatist philosophers as essential for the workability of new organizing ideas.

7.3 Conclusions

We cannot regard truth as a goal of inquiry. The purpose of inquiry is to achieve agreement among human beings about what to do, to bring consensus on the end to be achieved and the means used to achieve those ends. Inquiry that does not achieve co-ordination of behaviour is not inquiry but simply wordplay.⁵⁰

The relative disuse of court appointed guardianship suggests that, in its current form, guardianship is something of a relic, a marginal response of little utility. The problematic nature of the mental capacity construct in medico-legal guardianship provides one reason for this; as a social truth (in the pragmatist sense that “truth happens to an idea”), the mental capacity construct is in the process of becoming un-true. The current debate around the interpretation and implementation of Article 12 of the CRPD is both a symptom and a part of that process. An apparent increasing reluctance on the part of physicians to engage with the process may be another.

A role remains, however, for the authority that guardianship uniquely provides to over-ride mere choices (where mere choices are a source of unreasonable risk, including exploitation) and to make decisions in the kind of “black and white” circumstances described in the empirical research, where need (and risk arising from un-met need) cannot be perceived or acted upon. Without guardianship, (unless a functional advance planning arrangement has been made) the alternatives in both cases are non-response, or decision-making and management carried out as a last resort by “stranger” health and health-allied professionals. The purpose of guardianship remains valid: safeguarding the individual’s assets (and ability to provide for her comfort and needs) and safeguarding her dignity and physical and emotional integrity in situations where an

⁵⁰ Richard Rorty, *Philosophy and Social Hope* (London: Penguin Books, 1999) at xxv.

individual's performance of thinking processes is one source of heightened vulnerability. That purpose involves the public interest, in addition to the interests of the individual involved.

Medico-legal guardianship has reached a crisis point, however, and the continuing viability of the guardianship response requires its re-organization- a re-invention of adult guardianship. The vulnerability based model developed through this research (and the conceptualisation of vulnerability at its core) is, I suggest, conceptually compatible with supported decision-making and responsive to the critique of mental capacity within the discourse around the implementation of the *Convention on the Rights of Persons with Disabilities*. As indicated by the empirical research described in Chapter 6, rethinking guardianship as a response to vulnerability is also compatible with, while not identical to, current medical and legal understandings and practices. Compatibility does not mean that medical practitioners and judges already apply the vulnerability approach described in this study but refers to the kind of fit or “minimum of jolt” and “maximum of continuity” described by the pragmatist philosopher William James as essential to the successful adoption of a new idea as valid, and true.⁵¹ That success, according to James, required the new idea to “graft[s] itself then upon the ancient body of truth, which thus grows much as a tree grows by the activity of a new layer of cambium”⁵² The theoretical connections discussed in Chapter 4 between vulnerability and theories of genuine decision-making in equity and the common law (as law's “ancient body of truth”) are, therefore, also integral to the success of vulnerability as the organizing idea for a new adult guardianship situation.

As a pragmatic inquiry, this research study has been premised on the belief that ideas matter: that practice is inextricably intertwined with, and organized by, framing ideas or paradigms. Accordingly, this study has incorporated both a theoretical and an empirical examination of the concepts of mental capacity and vulnerability in the field of adult guardianship, a focus on ideas that is consistent with the title “Re-thinking adult guardianship.” *Re-making* adult guardianship will require empirical research beyond that carried out at phase 2 of this pragmatic inquiry, in terms of research participation and the kinds of questions asked and data collected. Further

⁵¹ Margaret Radin, “The Pragmatist and the Feminist” (1990) 63:6 S Cal L Rev 1699 at 1709.

⁵² William James, *Pragmatism* (Cambridge: Harvard University Press, 1975) at 36, quoted in Radin, *supra* note 20 at 1709.

development of the preliminary model set out in this Chapter will require direct input by researchers from other disciplines (including medicine, social work, dementia-care, and health-allied practices), in addition to research carried out with persons directly and personally impacted by adult guardianship and further examination of the guardianship tribunal model.

As a legal academic, the interdisciplinary nature of this research study has both deepened and broadened my intellectual perspectives in addition to my knowledge of other subjects and practices. Consistent with pragmatic epistemology, I also believe that the “outside” perspective I brought to carrying out health related research was very valuable, and perhaps let me see things in novel ways. Certainly, the ability this research provided me to learn about legal subjects from non-legal perspectives (especially those of my Set B participants) was an invaluable experience, and one which will alter my approach to doing legal research in the future. Most fundamentally, the ideas of philosophical pragmatism, and the experience of using those ideas in my own field of practice, have indelibly changed my understanding of social structures and proven to me the importance of critically examining “taken-for-granted” truths and premises.

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