IS THE WISDOM OF A PERSON'S DECISION RELEVANT TO THEIR CAPACITY TO MAKE THAT DECISION?

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Significant uncertainty exists around the current test of capacity. It is agreed that the law is primarily directed at 'function'; that is, an assessment of a person's decision-making ability. However, there is conflicting authority over whether there is an ongoing role for 'outcome', that is, consideration of the perceived wisdom of the decision made by the person whose capacity is assessed. Recent cases in Australia and England and Wales have indicated that 'outcomes' are irrelevant to capacity, meaning any decision in which the perceived wisdom of a decision was weighed in the determination of capacity would be incorrectly decided. However, this article argues that these recent statements are incorrect interpretations of the applicable law in those jurisdictions. Moreover, it is argued that assessing capacity, even under a functional test, is an inherently normative procedure, from which consideration of the outcome of the decision cannot be fully extricated. Therefore, the challenge is not to prohibit consideration of outcomes in capacity assessment, but rather to manage their consideration, to ensure that they do not overwhelm functional capacity assessment. Suggestions for how this difficult balance can be performed are made.

I INTRODUCTION

For people with mental disabilities,[1] the law of capacity plays a central role, determining whether their right to make medical treatment decisions, instruct lawyers, make wills, and make financial decisions, as well as many other

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1 This is used as an umbrella term, encompassing people experiencing mental illness, intellectual disability or cognitive impairment.

important personal decisions, will be recognised.[2] For much of common law history, people with mental disabilities were in various ways prevented from participating in their own decision-making. During the 1990s, some landmark cases[3] and a Law Commission (England and Wales) report[4] made what was seen to be an important move away from paternalistic law, to a regime more supportive of autonomy.[5] Legal capacity was recast as a question of 'function', ie the process by which a decision was made, not 'status' (whether the decision-maker had a mental illness or intellectual disability) and not 'outcome' (whether that person made what was seen to be a good or bad decision). The Law Commission found that the outcome-based approach to capacity assessment 'penalises individuality and demands conformity at the expense of personal autonomy', and that the status approach was 'quite out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take'.[6] The so-called 'functional' approach to capacity was enshrined in the *Mental Capacity Act 2005* (UK) and a number of equivalent statutes in Australia.[7]

Nevertheless, analysis of recent case law demonstrates that despite this legislative affirmation of the functional approach to capacity, significant uncertainties remain. This paper addresses an important question that the law has not definitively answered. Under the current test of capacity, is it permissible for those evaluating a person's capacity to take the apparent wisdom of a decision into consideration when determining capacity? Capacity, as noted, may be a question of 'function', but does that mean that there is no role for 'outcome'? Recent case law has stated

2 Despite some differences, the concept of capacity is comparable across these different domains of civil law. This is shown by the fact that courts tasked with assessing capacity in one of those domains often look to statements of law made when assessing capacity in a different domain. For example, in *Masterman-Lister v Brutton & Co* [2003] 3 All ER 162 ('*Masterman-Lister*'), the Court of Appeal (England and Wales) considered the question of capacity to enter into a compromise in litigation. Chadwick LJ used authorities from cases considering testamentary capacity (*Harwood v Baker* (1840) 3 Moo PC 282; 13 ER 117, 120 (Erskine J for the Court)), capacity to make an enduring power of attorney (*Re K (Enduring Power of Attorney)* [1988] Ch 310; *Re W (Enduring Power of Attorney)* [2001] Ch 609) and capacity for medical treatment decisions (*Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819 ('*Re C*')) amongst others (see, eg, *Re Beaney (Deceased)* [1978] 2 All ER 595 (capacity to make an inter vivos gift)) to explain the nature of capacity as relevant to the matter at hand. This comparability is also reflected in the fact that central principles have been found to apply across the different specific contexts. One such principle is that whichever type of capacity is being assessed, the law assumes that the person has capacity until it has been demonstrated otherwise: *Timbury v Coffee* (1941) 66 CLR 277, 283 (Dixon J); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Lord Donaldson MR, Butler-Sloss LJ agreeing at 116) ('*Re T*'); *Masterman-Lister* (n 2) 169 (Kennedy LJ). Another is that capacity determinations may be assisted by medical evidence, however, they are ultimately a matter for the court: *Ric Developments Pty Ltd v Muir* (2008) 71 NSWLR 593, 598 (Campbell JA); *Zorbas v Sidiropoulous [No 2]* [2009] NSWCA 197, [65] (Hodgson JA) ('*Zorbas*'); *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449, 450 (Butler-Sloss P); *Masterman-Lister* (n 2) 173 (Kennedy LJ). The focus of this article similarly has relevance across the case law on different types of capacity.

3 *Re T* (n 2); *Re C* (n 2); *Re MB (Medical Treatment)* [1997] 2 FLR 426 ('*Re MB*').

4 Law Commission, *Mental Incapacity* (Report No 231, 28 February 1995) ('*Mental Incapacity*').

5 Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) 108.

6 *Mental Incapacity* (n 4) 33.

7 See, eg, *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4 ('*Medical Treatment Act*'); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4(2)(a) ('*Consent to Medical Treatment Act*'); *Powers of Attorney Act 1998* (Qld) sch 3 (definition of 'capacity') ('*Power of Attorney Act*').

that the outcome of a decision is irrelevant to capacity, which would mean that any capacity assessment in which outcome was taken into consideration would be incorrectly decided. However, analysis of the legislation and seminal cases in this area raises questions over whether this interpretation is correct. Resolving this ambiguity in the law is a matter of importance. Courts, medical professionals and lawyers are all at different times called upon to assess capacity. There are already numerous practical and methodological challenges to this task;[8] uncertainty around the test that is being applied can only make the situation more difficult.

While the shift in capacity law that began in the 1990s was lauded at the time, the role of capacity in the current law is subject to significant critique. A prominent United Nations ('UN') committee has argued that laws that allow for substitute decision-making — as authorised by Australia's and the United Kingdom's capacity laws — are in violation of the *Convention on the Rights of Persons with Disabilities*,[9] to which both Australia and the United Kingdom are signatories.[10] According to this view, using 'perceived or actual deficits in mental capacity' to deny legal capacity represents discrimination against people with mental disabilities;[11] however, this interpretation is subject to a significant amount of debate.[12] Whether capacity in its current or altered form should continue to be a part of the law is beyond the scope of this article. Nevertheless, it seems set to remain for the foreseeable future. A review by Then et al has shown that all law reform bodies of the English-speaking world which have looked at this issue have declined to implement the UN committee's interpretation, opting to retain some form of substitute decision-making, determined by a test of capacity.[13] Therefore, on whichever side of the debate over capacity one sits, it is imperative that the nature of the test of capacity as it currently exists is properly understood.

II CAPACITY: ARE OUTCOMES IRRELEVANT?

It is well established that the current test of capacity in Australia and England and Wales is based on function. The High Court (England and Wales) case of *Re C (Adult: Refusal of Medical Treatment)* is often cited as an authority for this

8 Kelly J Purser and Tuly Rosenfeld, 'Evaluation of Legal Capacity by Doctors and Lawyers: The Need for Collaborative Assessment' (2014) 201(8) *Medical Journal of Australia* 483.

9 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) ('*CRPD*'); Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12 (Equal Recognition Before the Law)*, UN Doc CRPD/C/GC/1 (19 May 2014) ('*General Comment No 1*').

10 *CRPD* (n 9) art 50(2).

11 *General Comment No 1*, UN Doc CRPD/C/GC/1 (n 9) 3 [13].

12 See Eilionoir Flynn and Anna Arstein-Kerslake, 'Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity' (2014) 10(1) *International Journal of Law in Context* 81. Cf John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

13 Shih-Ning Then et al, 'Supporting Decision-Making of Adults with Cognitive Disabilities: The Role of Law Reform Agencies' (2018) 61 *International Journal of Law and Psychiatry* 64.

position.[14] There, a man with schizophrenia, C, who was being detained under the *Mental Health Act 1983* (UK), refused to have a gangrenous foot amputated.[15] The treating authority sought judicial resolution, arguing that the man ought to be required to have the surgery for his own protection. In the judgment, Thorpe J set out what he saw as the constitutive requirements of capacity to make this medical treatment decision: 'For the patient offered amputation to save life, there are three stages to the decision: (1) to take in and retain treatment information, (2) to believe it and (3) to weigh that information, balancing risks and needs.'[16]

For Thorpe J, if C was capable of doing this, he had capacity, and his decisions could not be interfered with; whether or not others might view his decision as unwise, and whether or not he had a mental illness. Thorpe J found that the evidence suggested that C was capable of these things, and therefore had the capacity to refuse the treatment.[17] Thorpe J's formulation was reworded in the later Court of Appeal case *Re MB (Medical Treatment)* ('*Re MB*').[18] This case forms the basis for the statutory position in England and Wales, where the *Mental Capacity Act 2005* (UK) defines incapacity as being unable:

> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).[19]

This definition is used for medical treatment decisions, and for many other legal, financial and personal decisions in England and Wales.[20] The statement of law in *Re MB* is part of the common law of capacity to make medical treatment decisions in Australia.[21] Legislation in Australian states adopt different precise wording of capacity for this and other types of capacity; however, most of the various legislation similarly defines it as a functional issue.[22] Given that the functional test

14 *Re C* (n 2).

15 Ibid 821 (Thorpe J).

16 Ibid 822.

17 Ibid 822–3.

18 *Re MB* (n 3) 437.

19 *Mental Capacity Act 2005* (UK) s 3(1).

20 Ibid ss 16–18.

21 It was quoted with approval in Australia in the NSW Supreme Court in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88 ('*Hunter*') and *Re JS* [2014] NSWSC 302, as well as the Victorian Supreme Court in *PBU v Mental Health Tribunal* (2018) 56 VR 141 ('*PBU*').

22 See, eg, *Powers of Attorney Act* (n 7) sch 3 (definition of 'capacity'); *Consent to Medical Act* (n 7) s 4(2)(a); *Medical Treatment Act* (n 7) s 4.

allows people to make what are seen by others to be poor decisions, it is easy to see why it was considered a positive development, especially in contrast to earlier laws that were primarily paternalistic in character. Current texts on capacity often cite the trichotomy of 'function', 'status' and 'outcome' approaches, before concluding approvingly that the law settled on function.[23] However, while it is the case that the current law requires the *primary* focus of an assessment of capacity to be on a person's decision-making abilities, this does not finally resolve the nature of the test.

It is certainly clear that outcomes cannot be determinative of capacity or incapacity. If a person was found to lack capacity because, and only because, their decision was thought to be unwise, this would be an incorrect application of the current law of Australia and England and Wales. This has been stated by Gleeson CJ in relation to testamentary capacity:

> Testamentary capacity is not reserved for people who are wise, or fair, or reasonable, or whose values conform to generally accepted community standards. A person may disinherit a child for reasons that would shock the conscience of most ordinary members of the community, but that does not make the will invalid.[24]

In relation to medical treatment decisions, Peter Jackson J in *Heart of England NHS Foundation Trust v JB* stated:[25]

> The temptation to base a judgement of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided. That would be to put the cart before the horse or, expressed another way, to allow the tail of welfare to wag the dog of capacity.[26]

Considering a person's capacity to manage her financial affairs in the Supreme Court of New South Wales, Young J stated that 'it is not a question of whether the Protective Commissioner or somebody else could manage the affairs of the

23 *R v Cooper* [2009] 4 All ER 1033, 1037 (Baroness Hale); JG Wong et al, 'Capacity to Make Health Care Decisions: Its Importance in Clinical Practice' (1999) 29(2) *Psychological Medicine* 437, 438–40; *Mental Incapacity* (n 4) 32–3; Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws* (Report No 67, September 2010) vol 1, 266; Charlotte Emmett et al, 'Homeward Bound or Bound for a Home? Assessing the Capacity of Dementia Patients to Make Decisions about Hospital Discharge' (2013) 36(1) *International Journal of Law and Psychiatry* 73, 75; Cameron Stewart and Paul Biegler, 'A Primer on the Law of Competence to Refuse Medical Treatment' (2004) 78(5) *Australian Law Journal* 325, 326–333; Victorian Law Reform Commission, *Guardianship* (Final Report No 24, January 2012) 16, 120; John Devereux and Malcolm Parker, 'Competency Issues for Young Persons and Older Persons' in Ian Freckelton and Kerry Petersen (eds), *Disputes and Dilemmas in Health Law* (Federation Press, 2006) 54, 57; Philip Bielby, 'The Conflation of Competence and Capacity in English Medical Law: A Philosophical Critique' (2005) 8(3) *Medicine, Health Care and Philosophy* 357, 361 n 34.

24 *Re Griffith (Deceased); Easter v Griffith* (1995) 217 ALR 284, 291 (Gleeson CJ, Handley JA agreeing at 302).

25 [2014] EWHC 342 (COP).

26 Ibid [7]. See also *NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2005] 1 All ER 387.

applicant better, or that if the applicant was left on her own the likelihood would be that her funds would soon be dissipated'.[27]

Thus, outcomes must not be considered *determinative* of capacity. However, the question remains whether outcome can still have some residual relevance. This question was directly considered in the high profile High Court (England and Wales) 2015 case of *Kings College Hospital NHS Foundation Trust v C* ('*Kings College Hospital*').[28] There, MacDonald J stated that 'the outcome of the decision made *is not relevant* to the question of whether the person taking the decision has capacity for the purposes of the *Mental Capacity Act 2005*'.[29]

MacDonald J later quoted this and other statements of the law he made in that case as 'cardinal principles' of capacity law.[30] In 2018, Bell J, in the Supreme Court of Victoria, made the equivalent statement in *PBU v Mental Health Tribunal* ('*PBU*') when he stated that '[i]t is therefore well-established that *the outcome of the decision* (as distinct from the reasons for the patient's decision if reasons were given) *is not relevant to whether the person has capacity* and the focus must be upon the functioning of the person as assessed against the capacity criteria'.[31]

These statements indicate that a determination of capacity that treated an outcome of a decision as relevant to that determination would be in error.

However, there are contrary authorities, albeit pre-dating those above, which allow for outcome to be considered as *one* factor in a capacity determination in some circumstances. In 1992 the Court of Appeal (England and Wales) case *Re T (Adult: Refusal of Treatment)* ('*Re T*'),[32] Lord Donaldson MR stated '[t]hat his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his capacity to decide. The nature of his choice or the terms in which it is expressed may then tip the balance'.[33]

The words 'contrary to what is to be expected of the vast majority of adults' in this sentence refer to the person's 'choice', not, for example, to the person's 'decision-making process'. Lord Donaldson MR is therefore referring to the actual decision, that is, the outcome of the decision; the words 'contrary to what is to be expected' connoting a normative judgment of that outcome. By stating that this normative judgment of the outcome of a decision 'may tip the balance',

27 *Re C (TH) and the Protected Estates Act* [1999] NSWSC 456, [10]. This is quoted with approval in *Re GHI (a Protected Person)* (2005) 221 ALR 589, 592 [9] (Campbell J).

28 [2015] EWCOP 80 ('*Kings College Hospital*').

29 Ibid [29] (emphasis added) (citations omitted).

30 *Cambridge University Hospitals NHS Foundation Trust v BF* [2016] EWCOP 26, [20] (MacDonald J).

31 *PBU* (n 21) 193 [168] (emphasis added), citing *Starson v Swayze* [2003] 1 SCR 722 and *Kings College Hospital* (n 28), citing *R v Cooper* [2009] 1 WLR 1786, 1790 [13] and *York City Council v C* [2014] Fam 10, 31 [53]–[54] (McFarlane LJ).

32 *Re T* (n 2).

33 Ibid 113.

Lord Donaldson MR did not hold that outcomes are determinative of capacity. Therefore, this statement is not inconsistent with a characterisation of capacity as *primarily* functional. However, the statement *is* inconsistent with the view that outcomes are *irrelevant* to capacity. If outcomes may 'tip the balance', they are not irrelevant.

The potential relevance of outcomes also appears to be accepted in the 1997 case of *Re MB*.[34] In that case, Butler-Sloss LJ firstly stated that a person with capacity may 'for rational or irrational reasons or for no reason at all, choose not to have medical intervention'.[35] Her Ladyship explained that '[i]rrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided it could have arrived at it.'[36]

Here, Butler-Sloss LJ has reaffirmed that outcomes do not determine capacity, because the fact that 'no sensible person … could have arrived at' the decision under review does not mean the decision-maker lacked capacity.[37] However, her Ladyship then held that 'panic, indecisiveness and *irrationality* in themselves do not as such amount to incompetence, but they may be symptoms or *evidence of incompetence*'.[38]

Thus, the fact that 'no sensible person' could have reached the decision in question may be evidence of incapacity. Therefore, 'outcomes' may be relevant to capacity, according to this judgment.

The view that outcomes are not determinative, but may be relevant, is also explicitly stated by Kennedy LJ in *Masterman-Lister v Brutton & Co* ('*Masterman-Lister*'):

> A litigant who meets the criteria for capacity [sic][39] should still be regarded as a patient even if it can be shown that he has in fact made wise decisions and taken good advice. What he has done *is relevant but not determinative* in considering whether the criteria are or were satisfied at the relevant time.[40]

Here, Kennedy LJ is stating that a person cannot be found to have capacity *simply* because they have made what are seen to be good decisions; other evidence is

34 *Re MB* (n 3).

35 Ibid 436.

36 Ibid 437.

37 Ibid.

38 Ibid (emphasis added).

39 Given the rest of this passage, the intended meaning of this phrase appears to be 'a litigant who meets the criteria for *in*capacity'.

40 *Masterman-Lister* (n 2) 171 [21] (emphasis added). There, 'patient' is within the meaning in *Mental Health Act 1983* (UK), that is a person who 'is incapable, by reason of mental disorder, of managing and administering his property and affairs': at s 94(2). Although in this paragraph Kennedy LJ sets out the views of counsel, Burnton J believes that this view is his Lordship's own: *Lindsay v Wood* [2006] EWHC 2895 (QB), [14].

required. Nevertheless, this statement acknowledges that those 'good' decisions were relevant to the question of capacity. Therefore, this position corresponds with those expressed in *Re T* and *Re MB*, ie that outcomes are not determinative of capacity, but do have some relevance.

As noted, *Masterman-Lister*, *Re T* and *Re MB* pre-date *PBU* and *Kings College Hospital*, and the legislation under which those cases were decided.[41] Nevertheless, those earlier authorities are appellate decisions, and they have not been overruled. In fact, *Re T* and *Re MB* are two of the most widely cited cases elucidating the law of capacity in England and Wales and Australia,[42] including since the enactment of the *Mental Capacity Act 2005* (UK).[43] Indeed, in *PBU*, Bell J cites *Re T* as one of the authorities for the stated position that outcomes are irrelevant to capacity,[44] despite the fact that as set out above, *Re T* can be taken as authority for a contradictory position.

Therefore, the decisions of Bell and MacDonald JJ, which conclude that there is no role for outcome in capacity assessment, are contrary to earlier appellate decisions. Moreover, there is additional reason to question their Honours' statements of the law. Both Justices supported their conclusion with the authority of *R v Cooper*.[45] The paragraph of *R v Cooper* cited by their Honours itself references the Law Commission's discussion of the 'outcome' approach to capacity, [46] in which '[a]ny decision which is *inconsistent with conventional values,* or with which the assessor disagrees, may be *classified as incompetent*.'[47]

On the face of this statement, what the Law Commission was ruling out is an approach by which capacity would be *determined* by outcome; it says nothing about the possible ongoing *relevance* of outcome. In addition, MacDonald J cites *York City Council v C*;[48] however, that judgment simply states: 'the court's jurisdiction is not founded on professional concern as to the "outcome" of an individual's decision'.[49] Again, this source only states that outcomes must not be determinative of capacity. Therefore, none of the sources relied on by MacDonald and Bell JJ state that outcomes are irrelevant to capacity, and cannot be considered

41 For *PBU* (n 21) the *Mental Health Act 2014* (Vic) and for *Kings College Hospital* (n 28) the *Mental Capacity Act 2005* (UK).

42 See, eg, *Re Bridges* [2001] 1 Qd R 574; *Brightwater Care Group Inc v Rossiter* (2009) 40 WAR 84; *Hunter* (n 21); *R v Cooper* (n 23) 1040.

43 Indeed, Munby J stated that '*there is no relevant distinction between the test* as formulated in *Re MB* and the test set out in section 3(1) of the [*Mental Capacity*] *Act* [2005]': *Re MM (an Adult); Local Authority X v MM* [2007] EWHC 2003 (Fam) [80] (emphasis added).

44 *PBU* (n 21) 192, citing *Re T* (n 2) 102 (Lord Donaldson MR, Butler-Sloss LJ agreeing at 116), 116 (Butler-Sloss LJ).

45 *R v Cooper* (n 23), cited in *PBU* (n 21) 193 (Bell J), *Kings College Hospital* (n 28) [29] (MacDonald J).

46 *R v Cooper* (n 23) 1037 (Baroness Hale), citing *Mental Incapacity* (n 4) 33 [3.4].

47 *Mental Incapacity* (n 4) 33 [3.4] (emphasis added).

48 *Kings College Hospital* (n 28) [29], citing *York City Council v C* [2014] Fam 10, 31 [53]–[54] (McFarlane LJ).

49 *York City Council v C* [2014] Fam 10, 31 [53] (McFarlane LJ).

authority for that position. As a matter of logic, stating that something is not determinative is very different from saying that it is irrelevant. Therefore, there is no line of authority to support the statements that outcomes are irrelevant to capacity.

Precisely the same interpretative issue arises regarding the following provision of the *Mental Capacity Act 2005* (UK), which states that '[a] person is not to be treated as unable to make a decision merely because he makes an unwise decision'.[50]

It has been argued that this section requires that outcomes be irrelevant to the determination of someone's capacity.[51] However, again, this section only states that outcomes must not be determinative. In fact, by using the word 'merely', the Act appears to assume that the wisdom of a decision is a legitimate part of the determination of whether the decision-maker has capacity.[52] Various Australian legislation includes equivalent provisions, which disallow the determination of capacity based solely on outcomes, but as a matter of logic, allow their consideration,[53] including the *Mental Health Act 2014* (Vic), which was under consideration in *PBU*. It states that 'a determination that a person does not have capacity to give informed consent should not be made *only* because the person makes a decision that could be considered to be unwise'.[54]

Therefore, despite the statements in *Kings College Hospital* and *PBU*, the better view is that the law allows consideration of outcome as part of the determination of capacity.

III SHOULD 'OUTCOME' BE REMOVED FROM THE TEST OF CAPACITY?

If it is the case that outcomes are not irrelevant to capacity under the current test, the next question is whether they ought to be, in the interests of furthering decision-making autonomy and the 'dignity of risk'.[55] Capacity legislation could be modified to reflect MacDonald and Bell JJ's statements in *Kings College Hospital* and *PBU* respectively, by including a provision that the wisdom or otherwise of a person's decision was *irrelevant* to their capacity to make that decision. At face

50 *Mental Capacity Act 2005* (UK) s 1(4).

51 Donnelly (n 5) 101–2; Emmett et al (n 23) 75.

52 Paul Skowron, 'Evidence and Causation in Mental Capacity Assessments: *PC v City of York Council* [2013] EWCA CIV 478' (2014) 22(4) *Medical Law Review* 631, 634.

53 See, eg, *Guardianship and Administration Act 2000* (Qld) s 5(b); *Mental Health Act 2009* (SA) s 5A(3)(d); *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4(4)(c)(ii). See also New South Wales Law Reform Commission, *Review of the Guardianship Act 1987* (Report No 145, 21 May 2018) 58–9.

54 *Mental Health Act 2014* (Vic) s 68(2)(d) (emphasis added).

55 Craig Parsons, 'The Dignity of Risk: Challenges in Moving On' (2008) 15(9) *Australian Nursing Journal* 28.

value, such a move may appear to be a positive step towards greater decision-making freedom for people with mental disabilities. Nevertheless, there are reasons to question the desirability of such a move.

Firstly, it is questionable as to whether such a move would have any effect. This is because there is an apparently accepted role played by outcomes in the legal system that is outside the operation of the written law, and therefore would probably be unaffected by any change in legislation. In their widely cited text on capacity,[56] Dārziņš, Molloy and Strang argue that outcomes are irrelevant to capacity, implicitly endorsing the functional approach to capacity.[57] Nevertheless, they argue that one of the 'triggers' for capacity assessment should be when 'people have demonstrated behaviour which has put them, or others, at risk of significant harm'.[58] The New South Wales Attorney General's *Capacity Toolkit: Information for Government and Community Workers, Professionals, Families and Carers in New South Wales* similarly states that a person's capacity may be questioned when they make a decision that 'puts them at significant risk of harm or mistreatment'.[59] Biegler and Stewart, like Dārziņš, Molloy and Strang, argue for a functional approach to capacity, but then state that '[a] seemingly irrational outcome does not preclude competence, but it should heighten suspicion that the patient may not be competent'.[60] Ryan, Callaghan and Peisah, in their guide to assessing capacity to refuse psychiatric treatment acknowledge that 'a seemingly unwise decision may form part of a rationale to begin to question whether a person has decision-making capacity'.[61] In other words, capacity is to be tested when someone is making decisions that put them at risk of harm, or is making decisions that are seen to be unwise or irrational. These writers' views are reflected by what happens in practice. In the medical sphere, it has been noted that patients who accept treatment are assumed to have capacity, whereas those who refuse treatment have their capacity assessed.[62]

If assessment of capacity occurs because of an 'outcome' adjudged to be unwise,

56 Pēteris Dārziņš, D William Molloy and David Strang (eds), *Who Can Decide? The Six Step Capacity Assessment Process* (Memory Australia Press, 2000).

57 Pēteris Dārziņš et al, 'Limitations of Capacity Assessments' in Pēteris Dārziņš, D William Molloy and David Strang (eds), *Who Can Decide? The Six Step Capacity Assessment Process* (Memory Australia Press, 2000) 111, 131.

58 Pēteris Dārziņš, D William Molloy and David Strang, 'The Capacity Assessment Process' in Pēteris Dārziņš, D William Molloy and David Strang (eds), *Who Can Decide? The Six Step Capacity Assessment Process* (Memory Australia Press, 2000) 12, 13.

59 New South Wales Government, Attorney General's Department, *Capacity Toolkit: Information for Government and Community Workers, Professionals, Families and Carers in New South Wales* (2008) 36.

60 Paul Biegler and Cameron Stewart, 'Assessing Competence to Refuse Medical Treatment' (2001) 174(10) *Medical Journal of Australia* 522, 524.

61 Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49(4) *Australian and New Zealand Journal of Psychiatry* 324, 326. See also John Bellhouse et al, 'Decision-Making Capacity in Adults: Its Assessment in Clinical Practice' (2001) 7(4) *Advances in Psychiatric Treatment* 294, 295.

62 Helen J Taylor, 'What Are "Best Interests": A Critical Evaluation of "Best Interests" Decision-Making in Clinical Practice' (2016) 24(2) *Medical Law Review* 176, 186–7.

outcome is plainly relevant to the test. It means that two people with the same mental abilities may be found to have differing legal capacity. This is because a person who makes a decision seen as unwise will have his or her capacity assessed; another person, who has the same mental abilities, who makes a decision seen as wise, will not, and so their presumption of capacity is maintained. Therefore, unless the practice of assessing capacity when the decision-maker makes a decision seen by others as poor is also stopped, prohibiting courts from considering outcomes when deciding capacity would not make outcomes *irrelevant* to capacity.

It may be argued that this practice of allowing 'seemingly unwise decisions' to be a trigger for capacity is misguided, and should be discontinued. Clearly, the fact that the practice exists does not, on its own, give any necessary guidance on how capacity assessment ought to occur. However, this practice points to a deeper issue. Understanding this issue requires consideration of what a functional assessment of capacity comprises. Embedded in capacity assessment is an element of normativity; one that is understandably overlooked in a body of law that seems to emphasise procedural decision-making freedom, including this pronouncement from Lord Donaldson MR in *Re T*:

> An adult patient who … suffers from no mental incapacity has an *absolute right to choose* whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. … This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent …[63]

Morgan and Veitch explain that there is a dissonance between the freedom seemingly offered by statements like this and the normative assessment involved in applying the current test of capacity, which requires a person to be able to understand information relevant to the decision, and use or weigh that information in order to reach a decision.[64] As they ask, 'why, if an individual need give no reasons for making a decision, he or she must demonstrate that they have taken account of anything when making that decision?'.[65] The fact is that this decision-making freedom, as acknowledged in Lord Donaldson MR's quote, is for people already found to have capacity. Therefore, despite appearances, it does not discount the important role for normativity in assessing capacity. The inherent role for normativity, and connectedly, outcomes, in the assessment of someone's functional decision-making ability is explained by Banner's example:

> [S]ay I were to tell a person standing at a set of traffic lights that a lorry was

63 *Re T* (n 2) 102 (emphasis added) (citations omitted).

64 Derek Morgan and Kenneth Veitch, 'Being Ms B: *B*, Autonomy and the Nature of Legal Regulation' (2004) 26(1) *Sydney Law Review* 107.

65 Ibid 118 (emphasis omitted).

> hurtling along the road ignoring red lights, and I have every reason to believe he understands my utterances. He then proceeds to step directly into the lorry's oncoming path. Without being able to delve into his reasoning, I would judge that this person had failed to use or weigh the information I had given him, because he did not respond to that information in the way that he ought to (taken with the assumption that he had an interest in preserving his own life). … The person's failure to use or weigh information is, in this case, indicated by the fact that his action was the wrong thing to do in those circumstances, as it would likely lead to his death or serious injury.[66]

This does not mean that a person who steps in front of a truck does not have capacity, he or she might have good reason to do so. It just means that if someone has been told that information, understood it, and then stepped forward, it is more likely that something has gone wrong with the use of the information than it would be had the person stayed on the curb. Particular decisions, although not constitutive of incapacity, may be considered potentially indicative of incapacity. Care must be taken by those assessing capacity to limit outcomes to this indicative role. To this end, it is useful that the law reminds assessors not to base their determination 'merely' on a characterisation of the wisdom of the decision. Nevertheless, the potentially indicative relationship between outcomes and capacity means that the complete separation of this characterisation and the normative appraisal of decision-making abilities that a functional assessment of capacity requires, could at most be artificial.

This inevitable role for outcomes in capacity assessment may be used to strengthen the arguments of those who believe that tests that remove people's legal capacity are unacceptably paternalistic, and must be removed from the legal system.[67] Whether or not it is acceptable, this aspect of capacity law should not be surprising. The functional definition of capacity is rightly seen as an improvement on previous law with regards to the autonomy of people with mental disabilities. However, even under capacity legislation in which capacity is defined in functional terms, the determination of capacity remains, in part, a moral and political judgement. Many commentators have made this simple but

66 Natalie F Banner, 'Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity' (2012) 18(5) *Journal of Evaluation in Clinical Practice* 1038, 1040 (emphasis omitted).

67 *General Comment No 1*, UN Doc CRPD/C/GC/1 (n 9); Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75(5) *Modern Law Review* 752; Flynn and Arstein-Kerslake (n 12).

often forgotten observation.[68] Capacity is not a feature of a person that can be determined by medical assessment, nor any purely objective assessment. While being based on observable facts about a person's decision-making abilities, assessment of legal capacity requires a determination of where on a spectrum of those abilities a person needs to be.[69] It thus involves a normative judgment in which the freedom to make one's own decisions is balanced against society's interest in protecting vulnerable people.[70]

Therefore, if it is believed that the current test of capacity intrudes unacceptably on the decision-making freedom of people with mental disabilities, then the solution to this is not to prevent the consideration of outcome when determining capacity, but to remove the test of capacity from the legal system. This would be a dramatic step. Although some do argue for this,[71] as noted, an ongoing role for a functional definition of capacity seems likely to continue for the foreseeable future.[72] If the functional test of capacity were to be maintained, but those assessing capacity were prohibited from considering outcome in their determination of a person's capacity, the only likely change would be in the growth of artificial reasoning on the topic of capacity. It is surely better to acknowledge the normative role of capacity assessment than to pretend it does not exist.

68 United States National Bioethics Advisory Commission, *Research Involving Persons with Mental Disorders that May Affect Decisionmaking Capacity* (Report, December 1998) 19. See also Thomas Grisso, *Evaluating Competencies: Forensic Assessments and Instruments* (Kluwer Academic Publishers, 2nd ed, 2005) 15; Loren H Roth, Alan Meisel and Charles W Lidz, 'Tests of Competency to Consent to Treatment' (1977) 134(3) *American Journal of Psychiatry* 279, 283; Louis C Charland, 'Mental Competence and Value: The Problem of Normativity in the Assessment of Decision-Making Capacity' (2001) 8(2) *Psychiatry, Psychology and Law* 135; Banner (n 66); Jules Holroyd, 'Clarifying Capacity: Value and Reasons' in Lubomira Radoilska (ed), *Autonomy and Mental Disorder* (Oxford University Press, 2012) 145; Bruce J Winick, 'Competency to Consent to Treatment: The Distinction between Assent and Objection' (1991) 28(1) *Houston Law Review* 15, 25–6; Jennifer Moye and Daniel C Marson, 'Assessment of Decision-Making Capacity in Older Adults: An Emerging Area of Practice and Research' (2007) 62B(1) *Journal of Gerontology* 3, 3; Scott YH Kim, *Evaluation of Capacity to Consent to Treatment and Research* (Oxford University Press, 2010); Loretta M Kopelman, 'On the Evaluative Nature of Competency and Capacity Judgments' (1990) 13(4) *International Journal of Law and Psychiatry* 309; Charles M Culver and Bernard Gert, 'The Inadequacy of Incompetence' (1990) 68(4) *Milbank Quarterly* 619; Carl Elliott, 'Caring about Risks: Are Severely Depressed Patients Competent to Consent to Research?' (1997) 54(2) *Archives of General Psychiatry* 113; Elyn R Saks and Stephen H Behnke, 'Competency to Decide on Treatment and Research: MacArthur and Beyond' (1999) 10 *Journal of Contemporary Legal Issues* 103, 105; Alec Buchanan, 'Mental Capacity, Legal Competence and Consent to Treatment' (2004) 97(9) *Journal of the Royal Society of Medicine* 415; Kirsty Keywood, 'Rethinking the Anorexic Body: How English Law and Psychiatry "Think"' (2003) 26(6) *International Journal of Law and Psychiatry* 599, 607; C Foster, 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2013) 22(1) *Medical Law Review* 48.

69 Marshall B Kapp and Douglas Mossman, 'Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"' (1996) 2(1) *Psychology, Public Policy, and Law* 73, 88–92.

70 Jillian Craigie, 'Against a Singular Understanding of Legal Capacity: Criminal Responsibility and the Convention on the Rights of Persons with Disabilities' (2015) 40 *International Journal of Law and Psychiatry* 6, 10.

71 *General Comment No 1*, UN Doc CRPD/C/GC/1 (n 9) 2–3; Bartlett (n 67); Flynn and Arstein-Kerslake (n 12).

72 Then et al (n 13) 73; Dawson (n 12).

IV HOW TO MANAGE THE ONGOING ROLE FOR 'OUTCOME'

It must be acknowledged that the ongoing role for outcome carries with it a danger of allowing the law of capacity to enforce existing prejudice against people with mental disabilities, and to unacceptably curtail their decision-making freedom. Therefore, if, as predicted, capacity plays an ongoing role in our legal system, the challenge that must be faced is to manage that role appropriately. This balance is difficult to strike, but the remainder of this article will give some suggestions as to how this difficult task may be pursued.

One promising path is to focus assessment of capacity, as much as possible, on the subjective elements of the decision-making. Banner lists the following factors that are inevitably involved in a medical treatment decision: 'the patient's own perceptions and evaluations of his condition, attitudes towards his health, aspirations or expectations of the future, belief in the efficacy of treatment, trust in the medical professionals treating him [and] relationships with caregivers'.[73]

Myriad subjective, contextual factors will surround all decision-making, whether that decision is a medical one, or whether to pursue litigation, whom to marry, or what to put in a will. Without understanding these factors from the decision-maker's perspective, the determination of capacity is far more likely to be led by 'objective' factors, like the characterisation of the outcome of the decision, thereby sidelining the functional test of capacity. Therefore, capacity should only be decided after proper engagement with the decision-maker, exploring his or her values, attitudes and relationships. In fact, MacDonald J's judgment in *Kings College Hospital* provides a positive example of this. There, a woman who had attempted suicide was found to have the capacity to refuse life-saving dialysis. Doctors presenting evidence to the Court argued that she had a personality disorder,[74] and lacked capacity under the functional test.[75] C's decision to refuse life-sustaining treatment was one that many would have seen as foolish, given her age and health. Although C was not present for the trial, the Court carefully considered evidence from C's children. It heard from one daughter that '[her] mother's values, and the choices that [her mother] made have always been based on looks (hers and other people's), money, and living (at all costs) what she called her "sparkly" lifestyle'.[76]

The Court also heard from that daughter that C had stated that she wanted to 'go

73 Natalie F Banner, 'Can Procedural and Substantive Elements of Decision-Making be Reconciled in Assessments of Mental Capacity?' (2013) 9(1) *International Journal of Law in Context* 71, 84.

74 *Kings College Hospital* (n 28) [44]–[45], [48], [55].

75 Ibid [42], [49].

76 Ibid [12] (emphasis omitted).

out with a bang', and did not want to grow old.[77] That daughter told the Court that C's 'entire identity has been built around being a self-described "vivacious and sociable person who lives life to the full and enjoys having fun"'.[78] This information was central to MacDonald J's determination that C had the capacity to refuse this life-saving treatment. His Honour found that C had made her decision 'on the basis of placing in the balance many factors relevant to the decision',[79] including this attitude to life. His Honour said that her decision may be considered by some to be 'unreasonable, illogical or even immoral within the context of the sanctity accorded to life by society in general'.[80] Nevertheless, considered in the context of C's particular values and attitude, abilities sufficient to meet the functional test of capacity were identified.

This case demonstrates Banner's point that capacity can only be understood in the context of the decision-maker's subjective experience of the world. Given that capacity will often be evaluated in the context of a decision characterised by someone in authority as poor or unwise, it is particularly important for the assessor — whether that be a court, lawyer, or medical professional — to put that characterisation to one side, and to engage closely with the decision-maker, in order to elucidate these contextual factors.

A second suggestion relates to determinations of capacity made by courts and tribunals. While medical evidence will clearly be relevant to any determination of capacity, for courts and tribunals, it is suggested that there is more room for other evidence to assist in this determination than is sometimes acknowledged. My previous work found that capacity determinations in historically protective jurisdictions relied more heavily on medical evidence than those in non-protective jurisdictions, in a manner that was arguably inappropriate.[81] A good example of this tendency is provided in the case of *Re Bridges*,[82] where Ambrose J had to decide whether Bridges had capacity to refuse renal dialysis. Ambrose J noted that Bridges' son thought that she had capacity to make that decision. His Honour then stated that 'I must say, having watched her give evidence and answer questions, she would impress one from what she says and the way she says it that she does have a capacity to make a decision.'[83]

His Honour then described the evidence from three medical experts — all of whom believed that Bridges lacked capacity — and then without further

77 Ibid [10].

78 Ibid [63].

79 Ibid [91].

80 Ibid [97].

81 Sam Boyle, 'Medical Evidence of Capacity in a Legal Setting: To What Extent Do Courts and Tribunals Make Their Own Decisions?' (2018) 25(2) *Journal of Law and Medicine* 572.

82 *Re Bridges* (n 42).

83 Ibid 578.

consideration, concluded that Bridges lacked capacity.[84] Thus, despite the son's views, and the judges' own impression of the witness's capacity, his Honour privileged the medical evidence, without explanation as to why the impression he gained of Bridges' capacity was incorrect. This deference to medical opinion on capacity contrasts with the more critical reception it is given in testamentary capacity cases. In those cases, courts appear more willing to reach different conclusions from that presented to the court by doctors, even when that evidence is unanimous.[85] On the matter of medical evidence, Hodgson JA of the NSW Court of Appeal stated:

> The criteria [of testamentary capacity] are not matters that are directly medical questions, in the way that a question whether a person is suffering from cancer is a medical question. They are matters for *commonsense judicial judgment on the basis of the whole of the evidence*. Medical evidence as to the medical condition of a deceased may of course be highly relevant, and may sometimes directly support or deny a capacity in the deceased to have understanding of the matters in the [testamentary capacity] criteria. However, evidence of such understanding may come from non-expert witnesses. Indeed, perhaps the most compelling evidence of understanding would be reliable evidence (for example, a tape recording) of a detailed conversation with the deceased at this time of the will displaying understanding of the deceased's assets, the deceased's family and the effect of the will. It is extremely unlikely that medical evidence that the deceased did not understand these things would overcome the effect of evidence of such a conversation.[86]

The Court of Protection decisions *Kings College Hospital* and *Re SB (a Patient: Capacity to Consent to Termination)*[87] provide examples of instances where evidence directly from the adult has been preferred to medical evidence of incapacity in protective jurisdictions in England and Wales. However, these decisions are exceptions rather than the rule,[88] and it is difficult to find similar examples in the Australian context. The importance of looking beyond medical evidence of capacity was shown by the Victorian Supreme Court Decision *XYZ v*

84 Ibid 581–4.

85 Boyle (n 81).

86 *Zorbas* (n 2) [65] (emphasis added), discussing *Banks v Goodfellow* (1870) LR 5 QB 549. For similar statements in testamentary capacity matters see *Bailey v Bailey* (1924) 34 CLR 558, 573 (Isaacs J); *Sargent v Brangwin* [2013] QSC 306, [97] (Dalton J), quoting *Zorbas* (n 2) [65], [89] (Hodgson JA), *Nicholson v Knaggs* [2009] VSC 64, [41] (Vickery J).

87 [2013] 3 FCR 384.

88 See generally Mary Ford, 'The Personhood Paradox and the "Right to Die"' (2005) 13(1) *Medical Law Review* 80, 97; John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15(3) *Health Care Analysis* 235; Lindy Willmott, 'Advance Directives Refusing Treatment as an Expression of Autonomy: Do the Courts Practise What They Preach?' (2009) 38(4) *Common Law World Review* 295; Genevra Richardson, 'Mental Capacity in the Shadow of Suicide: What Can the Law Do?' (2013) 9(1) *International Journal of Law in Context* 87, 90.

State Trustees Ltd,[89] in which a decision by the Victorian Civil and Administrative Tribunal ('VCAT') on the capacity of XYZ to manage his finances was appealed. In the VCAT hearing, the Tribunal was presented with a report from a neuropsychologist, Dr Vowels, stating that '[XYZ's] compromised planning and organisation is also a serious disability which needs to be considered as a source of increased vulnerability and possible manipulation by others'.[90]

During the VCAT hearing, XYZ's counsel attempted to allow XYZ to explain his circumstances, including his life history. However, as revealed in the transcript of the proceedings, the Tribunal member was of the opinion that hearing from XYZ was not going to assist in the Tribunal's assessment of his capacity, due to the effect of the neuropsychologist's report. The decision was appealed to the Supreme Court of Victoria, which described the Tribunal proceedings thus:

> Before VCAT, [XYZ's counsel] Mr Sharp submitted repeatedly that a neuropsychological assessment could only be a part (and a small part at that) of a full and proper assessment by VCAT of real life capacity or ability. The senior member apparently disagreed. Within minutes of the plaintiff beginning to give evidence, she stopped the examination in chief to say that she was not sure that it was relevant to hear the plaintiff's life story. Mr Sharp responded that the evidence was relevant to show that the plaintiff was perfectly lucid and perfectly capable of looking after his own affairs. The senior member replied: 'Mr Sharp, he appears pretty lucid to me, but I'm not a neuropsychologist and I'm not testing [XYZ].'[91]

Later in the hearing, the same member stated that '"I accept that my hearing from [XYZ] is going to be relevant to the issue of need but because disability and effect on capacity are matters for expert opinion I don't believe that I am going to be able to decide, after hearing from [XYZ], that Dr Vowels is wrong"'.[92]

The following statement then appeared in the Tribunal's written reasons: '"[e]xpert reports of disability and its effect on capacity can not however be ignored. The Tribunal should not substitute its own inexpert views on these matters for expert opinion"'.[93]

However, the Supreme Court criticised this approach to evidence regarding XYZ's capacity. Cavanough J found that it was not open to treat the neuropsychologist's report as '"presumptively correct"'.[94] It was found that the Tribunal ought

89 (2006) 25 VAR 402.

90 Ibid 407 [12] (Cavanough J).

91 Ibid 421 [48] (citations omitted).

92 Ibid.

93 Ibid 422 [51].

94 Ibid 422 [53].

to have taken lay evidence into consideration as well as medical evidence.[95] Cavanough J ultimately concluded that the Tribunal had 'effectively abdicated its role as decision-maker' to the neuropsychologist in a manner which 'went beyond legitimate use by VCAT of expert evidence and involved an inappropriate delegation of the "ultimate issue" to the expert'.[96] The case was referred back to VCAT to be reheard, and based on more inclusive evidence, including evidence directly from the adult, who was asked to discuss his history and perspective, the Tribunal found the adult in fact had financial capacity.[97]

This case demonstrates two things. It shows that 'objective' mental assessments can fail to detect positive evidence of capacity that surfaces when a person's subjective views and experience are shared, and therefore lends support to my suggestion of endeavouring to understand these factors and use them when assessing capacity. Secondly, it shows that medical evidence is not the only relevant source when determining capacity; lay evidence, including that gathered directly by a court or tribunal, ought to also be considered.

V CONCLUSION

The aim of this article has been to clarify an important point about the current nature of the law of capacity, and to make some suggestions as to how decision-making under this current law can be improved. This article has shown that recent cases that assert that outcomes are irrelevant to capacity under the current law are incorrect; earlier appellate cases and current legislation make this clear. Although a common response to this conclusion may be to argue for the law to be changed, I question this course of action for two reasons. Firstly, owing to the apparently accepted role for outcomes as a *trigger* for capacity assessment, it is unlikely for that change in the law to be effective. Secondly, and more importantly, while the functional test of capacity is procedural, there is an unavoidably normative element to the assessment of capacity. The ongoing potential relevance of outcomes in capacity assessment is simply evidence of this normative element, and to seek to remove it is to misunderstand this basic fact about capacity. Rather than deny this aspect of capacity, as recent judgments have done, it is surely better to recognise it explicitly so that it can be managed. To this end, two suggestions were made here; firstly, people determining capacity should seek to understand to the greatest extent possible the subjective views and values of the person whose capacity is assessed, and use that information as the reference point for their determination. Secondly, it was argued that courts and tribunals determining capacity should seek and make use of evidence from more

95 Ibid 424 [57].

96 Ibid 423 [55].

97 *XYZ (Guardianship)* [2007] VCAT 1196.

than just medical sources.

For those who accept an ongoing role for capacity in the legal system, clarity in the nature of the legal test it provides is surely an important goal, and the fact that case law appears to include contradictory statements is a matter for concern. It is hoped that this article provides some clarity in this area. However, although suggestions were given regarding the task of managing the normativity of capacity, this will be a significant ongoing challenge, and something to which a great deal more attention can be given.