DETERMINING CAPACITY: HOW BENEFICENCE CAN OPERATE IN AN AUTONOMY-FOCUSED LEGAL REGIME

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Capacity is a central issue for people with disabilities and some older adults, and its place in the legal system is the subject of debate. This Article empirically investigates one of the central issues of controversy involving judicial decisions on capacity (which may be called "competence"): whether such decisions involve an unspoken role for beneficence, despite the law's insistence that beneficence should not have a role in this determination.

This Article presents the results of a study of legal determinations made on capacity in the jurisdiction of Queensland, Australia. The particular focus of the study is how medical evidence on capacity affects the judicial determination of capacity. In circumstances where the determination of capacity involves possible risk to the person whose capacity is being determined, a finding of incapacity might be seen as a safer option because it allows the court or tribunal to make a protective order over the person. Therefore, if beneficence does have a role in judicial decision-making, it might be expected that courts and tribunals would be more likely to side with the medical opinion that said the adult lacked capacity, rather than the opinion that said the adult had capacity, at least in contexts involving potential risk. This study investigated the extent to which that was true. The results of this study show that the tribunal assessing an adult's "personal" and "financial" capacity tended to prefer the medical evidence of incapacity over that of capacity, in a manner with a high level of statistical significance. This suggests a role for beneficence in the determination of capacity, a role that is not visible in any individual judgment. The implications of this finding are discussed.

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I. Introduction:

Laws dealing with people who have mental disabilities are often conceived as balancing two different primary goods: autonomy and beneficence.[1] The promotion of autonomy is seen as important for reasons that are considered self-evident in a liberal society; each person, no matter their circumstances, ought to be able to decide things for themselves. On the other hand, most consider that people with mental disabilities ought to be provided with some special protection and assistance. This protection might extend to protecting them from their own decisions, and making substitute decisions in the person's best interests. This is an application of beneficence. This Article considers the way these two goods play out in the specific context of determinations of legal capacity.

Before setting out the issue that this Article addresses in detail, an important clarification is required, as capacity can be conceived of as two different things.[2] First, "capacity" can refer to a medical appraisal of the decision-making capabilities of a person, and the extent to which they are impaired; sometimes described as "mental capacity."[3] Second, capacity is used to describe the ability to make a legally effective decision.[4] This second measure is often described as "competence," or "legal capacity," and, unlike mental capacity, it is a yes or no decision; either someone has this capacity or they do not.[5] Legal capacity is determined by reference to mental capacity. Although it is useful to have a different term—"competence"—to describe a different concept, use of this term to describe legal capacity is not universal.[6] In the jurisdiction under consideration in this Article, cases and legislation simply use the term "capacity," without differentiation between the two specific meanings of the term.[7] The main focus of this Article is legal capacity. However, this

1. *See generally* George J. Annas & Joan E. Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 U. TOL. L. REV. 561 (1984) [hereinafter Annas & Densberger].

2. *See* Paul S. Appelbaum & Thomas Grisso, *Assessing Patients Capacities to Consent to Treatment*, 319 N. ENG. J. MED. 1635, 1635–38 (2007).

3 Jennifer Moye et al., *Assessment of Capacity in an Aging Society*, 68 AM. PSYCHOL. 159, 161 (Apr. 2013).

4. *Id.*

5. *Id.*

6. *See id.* at 159–60.

7. *See Impaired Decision-making Capacity*, LEGAL CENTRE INC. (Aug. 5, 2016), https://queenslandlaw.handbook.org.au/the-queensland-law-handbook/health-

Article will follow the convention of the jurisdiction and describe it simply as capacity.

A determination of incapacity leads to a dramatic loss of agency for the person found to lack capacity, and as such, the determination is the focus of much critical attention. Among those important life decisions for which a person may be found to lack capacity are the decisions to make a will, to accept or refuse medical treatment, to choose where to live, to marry, or how to manage one's own finances.[8] For most of us, having the legal right to make any of these decisions removed would be a fundamental intrusion on our civil liberties. Therefore, having an accurate understanding of the law that regulates such removal is important. One central area of debate on capacity regards the nature of the role of capacity within the legal system. There are two well-supported but mutually inconsistent characterisations of what capacity does. The orthodox view is that it protects autonomy.[9] According to this view, the test of capacity, however it is precisely constructed, is designed to distinguish between decisions which are autonomous and those which are not; allowing autonomous decisions to be respected, and identifying those non-autonomous decisions for which people will require outside assistance.[10] Therefore, the argument goes, any law which affirms the right of people with capacity—whether or not they have a disability—to make their own decisions is a law which supports and protects autonomy. Capacity is then the "gatekeeper" of autonomy.[11]

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and-wellbeing/laws-relating-to-individual-decision-making/impaired-decision-making-capacity/.

8. Nancy J. Knauer, *Defining Capacity: Balancing the Competing Interest of Autonomy and Need*, 12 TEMPLE POL. & C. R. L. REV. 321, 322–23 (2002) [hereinafter Knauer].

9. *Id.* at 328.

10. *See* Re Harley (2016) 334 FAM. L.R. 1, 10 (Austl.) (finding that "competency" has been explicitly equated with autonomy by Bennett J in the Australian case Re: Harley: "The declaration of competency signifies the child's attainment of autonomy in relation to medical treatment and that the child no longer needs another person with parental responsibility to make the decision"); E. HAAVI MORREIM, COMPETENCE: AT THE INTERSECTION OF LAW, MEDICINE, AND PHILOSOPHY, in COMPETENCY: A STUDY OF INFORMAL COMPETENCY DETERMINATIONS IN PRIMARY CARE (Mary Ann Gardell Cutter & Earl E. Shelp eds. 1991); Jennifer L. Wright, *Protecting Who from What, and Why, and How: A Proposal for an Integrative Approach to Adult Protective Proceedings*, 12 ELDER L.J. 53, 55 (2004).

11. MARY DONNELLY, HEALTHCARE DECISION-MAKING AND THE LAW: AUTONOMY, CAPACITY AND THE LIMITS OF LIBERALISM 90 (2010) [hereinafter Donnelly].

Although the specifics vary between jurisdictions, in general, the common law on capacity presents itself as protecting and promoting autonomy, as can be seen in a number of features of this law.[12] Firstly, adults are presumed to have capacity.[13] Thus any party alleging incapacity bears the onus of proof.[14] Secondly, in most jurisdictions and in most circumstances, the legal test of capacity is directed to *how* you decide something, not *what* you decide, and not whether you have been diagnosed with a mental disability.[15] Such tests are described as functional capacity tests, as opposed to outcome-based (focusing on what is decided) or status-based (focusing on the presence of a mental disability). Thirdly, capacity is decision-specific,[16] so that you may, for example, have capacity to decide where to live, but not to operate a bank account. Therefore, even those who lack capacity in many areas may still retain it in some; each decision needs to be assessed individually based on the relevant parameters.[17] Finally, the law of capacity acknowledges that people may make decisions that others view as unwise. United States case law states that capacitous decisions do not need to be rational,[18] and that a decision may be based on beliefs which are considered "unwise, foolish or ridiculous."[19] Similarly, British and Australian case law affirms that people have the right to make decisions "for irrational reasons, or no reason at all."[20] For these reasons, there is support for the idea that on its face, the law of capacity can be considered to support the good of autonomy.[21]

But, there is also an opposing view that sees the role of capacity in the legal system as a tool that may use the language of liberalism and

12. *Id.* at 91.
13. Willett v. Willett, 333 Mass. 323, 324 (1955).
14. *Id.*; Re T (adult: refusal of medical treatment) (1992) 4 All E.R. 649 ¶ 21 (U.K.); KK v. STC and Others [2012] EWCOP 2136 (C.O.P.) ¶ 18 (U.K.); 20 Pa. Cons. Stat. § 5511 (a) (West 2002).
15. *See* Lane v. Candura, 6 Mass. App. 377, 378 (1978); Re C (Adult, refusal of treatment) [1994] 1 W.L.R. 290 (U.K.); 2005 Cal. Prob. Code § 810-813.
16. Gibbons v. Wright 91 C.L.R. 423, 438 (1954) (Austl.); PC v. City of York Council (2014) 2 W.L.R. 1 ¶ 35 (U.K.).
17. Annas & Densberger, *supra* note 1, at 575–77; Jennifer Moye et al., *A Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship*, 47 THE GERONTOLOGIST 591 (2007).
18. Lane, 6 Mass. App. at 379.
19. In re Estate of Brooks, 32 Ill.2d 361, 373 (1965); *see also* In Re Maida Yetter, 62 Pa. D & C 2d 619 (1973).
20. Re MB (Caesarean Section) [1997] 2 F.L.R. 426, 437 (U.K.).
21. Donnelly, *supra* note 11, at 102.

autonomy, but in fact has an ongoing, covert role for beneficence. Indeed, capacity is seen as a tool that discriminates against and disempowers people with disabilities. In this context, rather than "beneficence," critics use the pejorative term "paternalism."[22] The argument is that whatever the law of capacity may say on its face, the way it works in practice is to prevent people with mental illnesses and intellectual disabilities from making what authorities believe to be bad decisions.[23] Decisions considered unwise by the assessors—especially those made by people with these disabilities—will generally be found to be incapacitous.[24] So while the *de jure* law may present an autonomy-focused, functional standard of capacity, in actual legally binding determinations of capacity, there is a strong outcome-focus, thus a role for beneficence/paternalism.[25] An important example given in support of this position is that a decision to die, whether by active suicide or discontinuing life support, will, the argument goes, generally be taken as direct evidence of incapacity.[26] Therefore, the support for autonomy present on the face of the law of capacity is, for people with mental or intellectual disabilities at least, illusory.

This argument can be applied to determinations of capacity by healthcare professionals, who conduct the majority of legally operative capacity assessments.[27] But, this argument is also put forward with respect to judicial decisions on capacity.[28] Here, the argument takes the

22. John J. Regan, *Protecting the Elderly: The New Paternalism*, 32 HASTINGS L.J. 1111, 1114 (1980) [hereinafter Regan].

23. *Id.*

24. Annas & Densberger, *supra* note 1, at 571; *see generally* Donnelly, *supra* note 11, at 143–44; Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1992).

25. Knauer, *supra* note 8, at 341–42.

26. G. Steven Neely, *Self-directed Death, Euthanasia, and the Termination of Life-Support: Reasonable Decisions to Die*, 16 CAMPBELL L. REV. 205, 228 (1994).

27. George J. Annas & Leonard H. Glantz, *The Right of Elderly Patients to Refuse Life-Sustaining Treatment*, 64 MILBANK Q. 95, 118–19 (1986).

28. *See e.g.*, Michael L. Perlin, *Half-Wracked Prejudice Leaped Forth: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 5 (1999); Milton D. Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271 (1943). Professor Milton Green published a series of articles in the 1940s making a realist critique of the concept of legal competence in the area of contracts and wills. Green argued that the cases revealed an 'unexpressed premise' which was that the reasonableness of the will or contract was central to the courts' determination of capacity. Donnelly, *supra* note 11.

form of a legal realist[29] position that while the court may affirm autonomy-promoting principles, such as the right to make irrational decisions, in fact, the court's decision-making is guided by a paternalistic desire to protect people with mental illnesses, a desire that is not stated in the judgments.

If this realist claim is accurate, it is a matter of great importance. Generally, unstated influences on judicial decisions affect the integrity of the legal system.[30] But more significantly for the area of medical and mental health law, if this realist claim were true, it would fatally undermine the characterization of capacity as a "gatekeeper" of autonomy. That there is at least the potential for judicial decision-making on capacity to be distorted by a desire for protection has been acknowledged by judges in England and Wales.[31] In the Court of Protection (England and Wales) case *Re CA*,[32] Mr. Justice Baker stated: "The court must avoid the "protection imperative"—the danger that the court, like all professionals involved with treating and helping CA, may feel drawn towards an outcome that is more protective of her and fail to carry out an assessment of capacity that is detached and objective."[33]

Judge Peter Jackson in *Heart of England NHS Foundation Trust v JB*[34] talks of the "[t]he *temptation* to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in

29. MICHAEL FREEMAN, LLOYD'S INTRODUCTION TO JURISPRUDENCE 810 (9th ed. 2014). Legal realism, a school of thought that developed in the USA in the 20th century, holds that judges have far more discretion to reach decisions they believe to be the right decisions than is apparent on the law as written. As an approach, it is typically contrasted with formalism, the theory that judges are bound by the existing law, whether that is statute or precedent, and thereby have little room for discretion. Although legal realism is sometimes considered a controversial jurisprudential theory, modern support for realism does not usually take the radical position that legal decisions are solely products of non-legal biases. The more measured realist argument is that legal rules 'do not provide the complete answer to the actual behaviour of courts'.

30. LON L. FULLER, THE MORALITY OF LAW 81–82 (1969).

31. Re CA (Natural Delivery or Caesarean Section) [2016] EWHC (COP) 51 (U.K.).

32. *Id.*

33. *Id.* at ¶ 19, *see also* PH v. A Local Authority & Z Limited [2011] EWHC 1704, (U.K.) [16]. The same judge from previous citation made similar comments.

34. Heart of England NHS Foundation Trust v. JB [2014] EWHC (COP) 342 (U.K.).

particular on whether they have accepted or rejected medical advice," which he says "is absolutely to be avoided."[35]

Thus, courts are apparently aware of the "danger" of substituting a protective impulse—to which the court itself may be vulnerable—for a fair and objective determination of capacity. But do courts in fact avoid this danger? Although many believe that courts do not, it is difficult to demonstrate this allegation one way or the other. Firstly, it would be strange for a judge to admit succumbing to a temptation to divert from what the law prescribes.[36] Therefore, those alleging the realist critique must base their arguments on reading between the lines of the judgement in some way. Secondly, capacity is a question of fact, not law, to be decided by the court.[37] Therefore, criticisms of the legal reasoning used in cases on capacity are inherently limited, because those decisions are based on the totality of the evidence presented to the court, to which critics do not have access.[38]

An example of how the realist argument may be given, and necessary limitations involved in any such critique, can be found in Charles Foster's paper *Autonomy in the Medico-legal Courtroom: A Principle Fit for Purpose?*[39] Foster critiques the court's reasoning on capacity in the widely cited Court of Appeal (England and Wales) case of *Re MB*.[40] There, a pregnant woman was to undergo a caesarean section that

35. *Id.* at ¶ 7 (emphasis added). *See also* Ms. B. v. An NHS Hospital Trust [2002] EWHC (Fam) 429, [100], 2 All E.R. 449 (U.K.), a High Court case where Butler Sloss P made the following statement of principle: If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind.

36. *See* Frank B. Cross & Emerson H. Tiller, *Judicial Partisanship and Obedience to Legal Doctrine: Whistleblowing on the Federal Courts of Appeals*, 107 YALE L.J. 2155 (1998).

37. Grannum v. Berard, 422 P.2d 812, 814 (1967); Lane v. Candura 376 N.E.2d 1232, 1235 (1978); XYZ v. State Trustees Ltd & Anor [2006] V.S.C. 444, 200 (Austl.); Re SB [2013] EWCOP 1417 (U.K.) [38].

38. Mary Donnelly, *Capacity Assessment Under the Mental Capacity Act 2005: Delivering on the Functional Approach?*, 29 LEGAL STUDIES 464, 470 (2009) ("[O]ne cannot even attempt to assess judicial conclusions without knowing the detail of the evidence presented.") [hereinafter *Capacity*].

39. Charles Foster, *Autonomy in the Medico-Legal Coutroom: A Principle Fit for Purpose?*, 22 MED. L. REV. 48, 57 (2014) [hereinafter Foster].

40. *See generally* Re MB (Caesarean Section) [1997] 2 F.L.R. 426 (U.K.).

was considered necessary for her and the fetus' health.[41] The woman had initially consented to the procedure, but, apparently due to a fear of needles, withdrew her consent in the operating room.[42] In both the initial hearing and appeal, the woman was found to lack capacity, and doctors were authorized to override her refusal and perform the caesarean.[43] The court found that the woman lacked capacity because "[a]t the moment of panic . . . her fear dominated all," and that when she refused "she was not capable of making a decision at all."[44] Foster contrasts this reasoning with the principle that people can make decisions for "irrational reasons, or no reason at all," which was explicitly affirmed by the joint judgment of the court in this case.[45] Foster argues that on the facts of the case, the woman "fell clearly into the category of persons who choose not to have medical treatment for 'irrational reasons,'"[46] and thus this decision that she lacked capacity was legally incorrect. Foster argues that this case is an instance of beneficence operating "covertly."[47] This may well be true. But, how could we ever be sure that this covert influence is operative? The court, obviously, does not admit this. Moreover, whether the woman's fear of needles was an "irrational reason" for a decision on one hand, or an impairment causing incapacity on the other, is a question of fact, to be determined on the evidence, not by doctrinal analysis. So, although Foster makes a compelling case, it is not and cannot be definitive.

There are many other well-argued pieces making this general allegation;[48] however, they all necessarily suffer from the same ultimate limitation. How, then, may we investigate this realist claim of an unstated protection focus in judicial capacity decisions?

41. *Id.* at ¶ 3.
42. *Id.* at ¶ 12.
43. *Id.* at ¶¶ 12, 30.
44. *Id.* at ¶ 30.
45. *See generally id.*; Foster, *supra* note 39, at 57.
46. Foster, *supra* note 39, at 57.
47. *Id.* Foster does not think that this was ethically the wrong outcome, just wrong according to the law as stated in the judgment.
48. *See* John Coggon, *Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?*, 15 HEALTH CARE ANALYSIS, 235 (2007); John A. Harrington, *Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment*, 16 LEGAL STUD. 348 (1996); Alasdair R. Maclean, *Advance Directives and the Rocky Waters of Anticipatory Decision-Making*, 16 MED. L. REV. 1 (2007); Lindy Willmott, *Advance Directives Refusing Treatment as an Expression of Autonomy: Do the Courts Practise What They Preach?*, 38 COMMON L. WORLD REV. 295 (2009).

II. The Study

The purpose of the present study was to investigate the legal realist claim, but in a manner which avoids making judgments as to what was the better decision in any individual case. This required analyzing decisions on capacity in objectively measurable ways. There is one important aspect of judicial capacity decisions that can be objectively recorded: the level of agreement between courts/tribunals and the medical opinions on capacity presented in the case.

There are various ways a court can inform itself on an adult's capacity. It can question the adult directly in order to assess his or her capacity. It can question non-medical experts, friends and family, or perhaps lawyers who have had dealings with the adult. But, the most commonly used source of evidence across jurisdictions is medical evidence.[49] In fact, it is routine practice for courts making determinations of capacity to review, indeed to request if they have not been provided, medical reports specifically addressing the question of whether the adult has capacity.[50] These reports are most often provided by psychiatrists, but also by other medical professionals.[51] This medical evidence, in most cases, includes a conclusory opinion as to whether the adult has capacity to make a particular decision.[52] This opinion may be supported by the findings from a specific capacity assessment tool, like the MacCAT-T.[53]

The decision on capacity is ultimately one for the court to make.[54] Nevertheless, it is clear that the medical reports used by courts will normally have a high probative value.[55] Indeed, the weight given to medical

49. *See generally* Sam Boyle, *Medical Evidence of Capacity in a Legal Setting: To What Extent do Courts and Tribunals Make Their Own Decisions?*, 25 J. OF L. AND MED. 572 (2018) [hereinafter Boyle].

50. *See generally id.*

51. *Id.* at 583.

52. *Id.* at 589.

53. THOMAS GRISSO, EVALUATING COMPETENCIES 421–22 (2nd ed. 2003) [hereinafter GRISSO].

54. Goddard Elliott v. Fritsch [2012] VSC 87, (Austl.) ¶ 565.

55. *See* Re B (adult refusal of medical treatment) [2002] 2 All E.R. 449, 471 (U.K.) ([U]nless it is an exceptional case, the judicial approach to mental capacity must be largely dependent upon the assessments of the medical profession whose task it is on a regular basis to assess the competence of the patient to consent or refuse the medical/surgical treatment recommended to the patient.).

evidence may be a matter of some controversy;[56] courts have been accused of being "excessively deferential" to medicine on certain matters,[57] including capacity.[58] Yet, courts do, in some cases, reach conclusions different to the only medical opinion on capacity presented.[59] Moreover, in some matters, the court must deal with medical evidence which diverges on the question of capacity, so wholly delegating the decision on capacity to medical experts is not possible, even if the court were inclined to do so.[60]

If the realist critique is accurate, and courts are influenced by the 'protection imperative,' we might expect to find that courts are more likely to agree with medical experts who say that the adult does not have capacity than those who say he or she has capacity, at least in cases where the adult's well-being is seen to be at stake when capacity is determined. This study investigated whether this was true.

The focus of the legal realist critique is most commonly on capacity to make medical treatment decisions, yet legal determinations of capacity are made more often in other contexts. The three contexts for capacity assessment examined in this study were chosen because they represented the three most frequent contexts for judicial determination in published decisions in the chosen jurisdiction, and they also offered a divergence in nature which could highlight the role of beneficence if it were operative.

The first context is in the guardianship and administration jurisdiction, where the capacity to make personal or financial decisions generally (as opposed to individual decisions) is assessed. This will be described as personal/financial capacity. In Australia, the term "guardianship" is used to describe an appointment for making per-

56. GRISSO, *supra* note 53, at 17.

57. Lord Woolf, *Are the Courts Excessively Deferential to the Medical Profession?*, 9 MED. L. REV. 1 (2001).

58. DONNELLY, *supra* note 11, at 53–55.

59. *E.g.*, Re SB (A Patient; Capacity to Consent to Termination), [2013] EWCOP 1417 (U.K.).

60. *See, e.g.*, Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978); Re C (Adult: Refusal of Treatment) [1994] EWHC (Fam.) 1 LWR 290 (U.K.); *see also* Malcolm Parker, *Patient Competence and Professional Incompetence: Disagreements in Capacity Assessments in One Australian Jurisdiction, and Their Educational Implications*, 16 J. L. AND MED. 25 (2008).

sonal decisions (e.g. where to live or whether to have medical treatment), and "administration" for financial and property matters.[61] The second context is testamentary capacity: the capacity to make a will. This is most commonly assessed by a court after a testator has passed away and a family member has challenged the validity of a will. The third context is "legal matters" capacity, or capacity to run a civil legal case, either as a self-represented litigant, or as one instructing a solicitor.

These three types of capacity, while differing in aspects, are all similar in many features. Significantly, in the jurisdiction under consideration, all of them are determined by a "functional" definition of capacity, rather than outcome-based or status-based.[62] Moreover, all of them have influence in civil law, and determine whether someone will have legal capacity to perform an act or acts that, absent a determination in the negative, they would have the right to perform.[63] All of them are frequently determined in the context of a mental disability of the person whose capacity is being assessed.[64] And, in all of them, medical evidence of capacity is frequently used by the court/tribunal that is making the determination.[65]

61. In most U.S. states, the term 'guardianship' is used for appointments covering both fields of decision making, when an appointment is made only for finances, this is called "conservatorship," JENNIFER MOYE, GUARDIANSHIP AND CONSERVATORSHIP in GRISSO, *supra* note 53, at 309. The equivalent order in England and Wales is the appointment of a 'deputy'; a 'property and financial affairs deputy' is equivalent to an administrator in the Australian system and a 'personal welfare deputy' is equivalent to a guardian. *See* Mental Capacity Act 2005, 9 § 16 (U.K.).

62. KELLY PURSER, CAPACITY ASSESSMENT AND THE LAW: PROBLEMS AND SOLUTIONS 145 (2017).

63. *See* Jillian Craigie, *Against a Singular Understanding of Legal Capacity: Criminal Responsibility and the Convention on the Rights of Persons with Disabilities*, 40 INT., J. L. AND PSYCHIATRY 6 (2015). In this regard, they can be contrasted with capacity to stand trial in a criminal matter, the subject of significant philosophical interest, but less frequent reported judicial consideration in Queensland. In that context, a finding of 'incapacity' may be of considerable benefit to the subject of the assessment. As such, there are very profound differences between 'criminal' and 'civil' capacity, conceptually and with respect to the underlying political and ethical justification for the tests, which complicate any attempt to compare decision making between civil and criminal capacities. Capacity to make medical treatment decisions is another capacity context that is the subject of much philosophical and ethical debate, but at least in the target jurisdiction has a far fewer published legal determinations.

64. Boyle, *supra* note 49, at 574.

65. *Id.* at 579.

But despite the similarities between these different types of capacity assessment by courts, the "protective impulse" alleged in the realist critique will not be universally present. The court's powers to determine personal/financial and legal matters capacity ultimately derive from the *parens patriae* jurisdiction.[66] This is the jurisdiction that derives from the sovereign's status as guardian of the people, which entailed a duty to take care of children and people of "mental incapacity."[67] Thus, the sovereign's power in this role was one with an explicitly protective imperative. Although now governed wholly by statute, the protective function of these jurisdictions is still visible. In most personal/financial capacity cases, the reason a person's capacity is being assessed may be that a healthcare worker or family member is concerned about the welfare of the adult. Legislation directs the tribunal to make an appointment only when it believes that, without one, either an "adult's needs will not be adequately met," or "the adult's interests will not be adequately *protected*."[68] Thus, although the test of capacity is supposed to be functional, and not guided by a protection imperative, the overall process of application to the tribunal and appointment of a guardian or administrator can be seen as a protective function. Court decisions on "legal matters" capacity may similarly have been prompted by a party's concern for the adult's welfare, at least with respect to an individual case.

On the other hand, testamentary capacity decisions are of a different nature. The court's power to determine the validity of a will does not derive from the *parens patriae* jurisdiction.[69] Clearly, protection of the adult whose capacity is being assessed is not a relevant concern to the court in these matters because the adult has passed away.

66. CJ v. AKJ [2015] NSWSC 498 ¶ 26 (Austl.); *see* Regan, *supra* note 22, at 1114. TERRY CARNEY & DAVID TAIT, THE ADULT GUARDIANSHIP EXPERIMENT: TRIBUNALS AND POPULAR JUSTICE 25 (1997) [hereinafter CARNEY & TAIT]; Joan L. O'Sullivan, *Role of the Attorney for the Alleged Incapacitated Person*, 31 STETSON L. REV. 687 (2002).

67. *See* JOSEPH CHITTY, A TREATISE ON THE LAW OF THE PREROGATIVE OF THE CROWN AND THE RELATIVE DUTIES AND RIGHTS OF THE SUBJECT 155 (1820); George B. Curtis, *The Checkered Career of Parens Patriae: The State as Parent or Tyrant*, 25 DEPAUL L. REV. 895, 896 (1975).

68. *Guardianship and Administration Act 2000*, § 12(1)(c) (Austl.) (emphasis added).

69. *See generally* Thomas E. Atkinson, *Brief History of English Testamentary Jurisdiction*, 8 MO. L. REV. 107 (1943) (describing of the complex provenance of this jurisdiction).

Having a set of judicial capacity determinations from the same time and place, but in a jurisdiction not rooted in a protective function, allows for some analysis and assessment of the role of the protective function in the way capacity decisions are reached.

III. Methodology

It was decided to focus on a single jurisdiction to eliminate any variables in procedures and judicial practice which might exist between different jurisdictions. Queensland was chosen from the Australian jurisdictions because its definition of capacity for guardianship and administration matters—the type of capacity decision with the highest volume of published decisions—uses an explicitly functional definition of capacity. This allows for the realist critique of an unstated protection focus diverting judicial decisions from the *de jure* law to be examined more directly. Other states and territories (with the exception of the Australian Capital Territory, which has a much smaller volume of legal decisions) have definitions of capacity for guardianship and administration which are not functional, but rather are outcome-focused.[70]

The three types of capacity—personal/financial, testamentary, and "legal matters" capacity—were chosen because they provided the largest number of cases in reported, accessible decisions in Queensland in the study period, with 317, 55, and 26 cases respectively.[71] This allows for some statistical comparison to be made between the different types of decisions. It also allows a comparison between capacity determinations that are and are not made under the historical *parens patriae* protective jurisdiction.

Australia has a unique system for guardianship and administration matters, in that they are not decided in courts, but in tribunals.[72] Decision-making under the tribunal is different from that in a court; the normal rules of evidence do not apply, and the tribunals are able to inform themselves of any matter they see fit, while conforming to the

70. *See Guardianship Act 1987* § 22(1) (N.S.W.) (Austl.); *Guardianship and Administration Act* 1986 § 46(1) (Vic) (Austl.).

71. Hundreds of decisions are made each year in the Mental Health Review Tribunal, however those matters are not publicly available.

72. *See* CARNEY & TAIT, *supra* note 66. Most states originally had a dedicated guardianship and administration tribunal, however a recent trend is for that function to be subsumed into a generalist larger tribunal, sometimes with a guardianship and administration "division."

rules natural justice.[73] Nevertheless, the decisions of the tribunal are binding on all parties, and their function in the legal system is the equivalent to courts which make guardianship orders in the United States and appoint deputies in England and Wales.

The timeframe of the study was January 2000 to the end of 2015, or from the date the decision-making body commenced to the end of 2015. All reported Supreme Court of Queensland decisions from that study period were included. The Queensland Civil and Administrative Tribunal (QCAT) was established in 2009, so only those decisions from its start date to the end of the study period were included.[74]

Each decision was read in full and the medical experts who provided evidence to the trial were recorded. Whether those individual experts gave an opinion on capacity was then recorded. The opinions of the medical experts were then compared with the actual decisions reached by the court/tribunal to see the level of agreement. The extent to which this was possible depended on the detail of the evidence provided in the judgment. It was not always possible to determine with certainty whether the expert had provided a conclusory opinion capacity or what that opinion was. Instances were not recorded if the evidence of a medical expert was recorded in the judgment but no conclusion on the question of capacity as formed by the expert is discernible from the judgment. These instances were not recorded in the data as an expert opinion on capacity, even if that specific medical evidence provided is used by the court/tribunal to reach a conclusion on capacity.

Therefore, there were cases that did not have any recorded individual opinions on capacity. Whether the medical opinions used by the court/tribunal were in agreement with each other was also recorded. There were a small number of cases where, although no individual opinions on capacity were discernible, the fact that there was no disagreement between the medical opinions was discernible due to an explicit statement to that effect by the tribunal.

The various measures were then statistically assessed using a chi square analysis. The results are recorded below.

73. *See, e.g.*, *Victorian Civil and Administrative Tribunal Act 1998* § 98 (Vic.) (Austl.); *Queensland Civil and Administrative Tribunal Act 2009* § 23 (Qld) (Austl.).

74. Before 2009, personal/financial capacity decisions were made by the Guardianship and Administration Tribunal.

1. Personal/financial capacity

In the study period, there were 205 published QCAT decisions in which matters financial and/or personal capacity were decided. These were all considered in the context of an application to make, continue, or remove a guardianship or administration order under section 12 of the Guardianship and Administration Act, 2000. Sometimes only financial or personal capacity was decided, sometimes both. When considering both, QCAT decided on personal and financial capacity separately, and in some matters, it concluded that an adult had one type of capacity but lacked the other.[75] The 205 guardianship/administration cases comprised 52 on financial capacity, 41 on personal capacity, and 112 on both. Thus, there was a total of 317 individual decisions on capacity.

Not all QCAT decisions on personal/financial capacity cases are available, as QCAT only publishes them when reasons for the decision are requested by a party, or when QCAT itself decides to publish the decision. QCAT does not keep records on the proportion of cases which are published, but it estimates the proportion to be 30%.[76] Those matters that are published are easily accessible, as all QCAT matters are published on Austlii,[77] and personal/financial capacity decisions can be located by looking for "matter type: Guardianship and Administration."[78]

2. Testamentary capacity

In the study period there were fifty-three reported matters in which a decision was made on testamentary capacity. In two of those matters, capacity with respect to two different wills was determined;[79] therefore, there were fifty-five individual decisions on capacity in total. These cases were identified through a series of searches on the Austlii, LexisNexis, and Westlaw databases. The first search was for "testamentary capacity." Then searches were done for cases that cited important

75. *See, e.g.*, MGC [2015] QCAT 80 (Austl.)

76. Personal communication with author from QCAT staff member (Feb. 12, 2016).

77. *See* QUEENSLAND CIVIL AND ADMIN. TRIBUNAL, http://www.qcat.qld.gov.au/qcat-decisions/published-decisions (last visited Feb. 2, 2018).

78. *See generally* Australian Legal Information Institute, http://www6.austlii.edu.au (last visited Feb. 2, 2018).

79. *See generally* Lando v. Sutton [2011] QSC 339 (Qld); *see also* Calabrese v. Calabrese [2010] QSC 277 (Qld).

international and Australian cases on testamentary capacity e.g. *Banks v Goodfellow*,[80] *Bailey v Bailey*[81] and *Timbury v Coffee*.[82] Finally, searches were done for cases that cited major Queensland cases on testamentary capacity. Not all decisions were available, only those which were reported.[83] Cases from the Supreme Court and Court of Appeal were used.

3. Legal matters capacity

The third category of capacity was that of legal matters, on which there were twenty-six reported decisions in the study period. This category brings three specific decision types together.[84] They all involve the capacity to take part in legal matters, but the contexts differ. The first context is the application for the appointment of a guardian or administrator under section 12 of the Guardianship and Administration Act, 2000. Under this section, QCAT can also draft a guardianship or administration order to cover a specific legal matter.[85] These decisions were located by searching within those QCAT matters listed as "guardianship and administration" types for legal matters capacity. There were ten of these decisions.

The second context is the question of whether an adult has capacity to run particular legal proceedings, and therefore whether a litigation guardian needs to be appointed under rules 72 and 95(2) of the Uniform Civil Procedure Rules, 1999. This is determined in the Supreme Court, not QCAT.[86] The capacity definition is taken from Schedule 5, Supreme Court of Queensland Act, 1991: A "person with impaired capacity means a person who is not capable of making the decisions required of a litigant for conducting proceedings or who is deemed by an Act to be incapable of conducting proceedings."

80. Banks v. Goodfellow [1870] 5 C.L.R 549 (U.K.).
81. Bailey v. Bailey [1924] 34 C.L.R 558 (Austl.).
82. Timbury v. Coffee [1941] 66 C.L.R 277 (Austl.).
83. *See, e.g.*, Flemming v. Gibson [2001] QCA 244 (Austl.) This case was used in the data here, was appealed from a Supreme Court decision, but the Supreme Court decision is not available.
84. A fourth context: extension of limitations under the *Limitation of Actions Act 1974* § 29 (Qld) (Austl.) for parties found to be under a legal disability due to 'unsound mind.' There were six of these matters in the study period. They were not included, as the definition of capacity associated with 'unsound mind' is clearly one of outcome, in contrast to the other contexts of capacity decisions considered here.
85. *Guardianship and Administration Act 2000* § 12(i)(c) (Qld) (Austl.).
86. *Uniform Civil Procedure Rules 1999* § 3(2) (Qld) (Austl.).

Case law confirms that like the other capacity definitions considered in this study, this is a functional standard, not "outcome"[87] or "status."[88] These matters were located by searching Austlii, LexisNexis, and Westlaw for cases citing the relevant legislation. Further searches were done for the phrase "capacity to instruct" and for cases which cited other cases in the area, but they did not uncover any cases not found in the initial legislation search. There were seven of these decisions.

The final context is where the Supreme Court is required, under section 59 of the Public Trustee Act, 1978 and rule 72 of the Uniform Civil Procedure Rules, to sanction to settlements reached with parties who lack capacity.[89] The capacity to reach a settlement is an individual decision, unlike the other contexts considered in legal matters capacity. But it is a decision which requires understanding and consideration of the whole legal process of bringing a claim to court. In the Supreme Court case of *Aziz*,[90] it was described as a question of "whether he has impaired capacity in relation to legal matters and particularly whether he has capacity to bring or defend a proceeding including settling a claim."[91] Therefore, this type of capacity is the same as that being considered in the other two contexts. The definition of capacity is taken from the Guardianship and Administration Act, 2000, so it is the same as for all other guardianship/administration matters. These matters were located by searching the three databases for cases citing the relevant legislation, and for cases citing other cases in the area. There were nine of these decisions.

IV. Results

TABLE 1: TOTAL DECISIONS

Capacity type	Number of decisions	Adult found to have capacity	Medical evidence used	Average number of medical experts used	Mental disability present
Personal/ financial	317	11 (3.5%)	315 (99%)	2.4	302 (95%)

87. Thomson v. Smith [2005] QCA 446 (Austl.) ¶ 132.
88. Steindl Nominees Pty. Ltd. v. Laghaifar [2003] QCA 49 (Austl.).
89. *Public Trustee Act 1978* § 59 (Qld).
90. Aziz v. Prestige Property Services P/L & Anor [2007] QSCR 265 (Austl.).
91. *Id.* at ¶ 23.

Testamentary	55	27 (49%)	50 (91%)	2.5	42 (76%)
Legal matters	26	14 (54%)	26 (100%)	2.5	20 (77%)

Table 1 shows that the instances of medical evidence being used and the average number of medical experts used were similar between the different types of capacity decision. It also shows that in the majority of all cases, some type of mental disability was noted in the trial, whether that was a named mental illness or intellectual disability.

The most significant distinction in the data is the proportion of cases in which the adult is found to have capacity was significantly lower in personal/financial capacity matters compared to the other two contexts. Results of a chi square analysis indicated that there is a relationship between the context of capacity determination and whether an adult is found to have or not have capacity. This finding has a high level of statistical significance; the chi squared value is 158.378, 2 degrees freedom with $p < 0.001$.

TABLE 2: CAPACITY DETERMINATION BY COURT/TRIBUNAL WHEN MEDICAL OPINION WAS DIVIDED

	Number of matters with disagreement within medical opinion on the question of capacity[92]	Court decision: incapacity	Court decision: capacity
Personal/ financial	25	23 (92%)	2 (8%)
Testamentary	10	4 (40%)	6 (60%)
Legal matters	6	2 (33%)	4 (66%)

Table 2 shows that in matters where medical opinion was divided on the question of capacity, personal/financial capacity matters were more likely to find incapacity. Analysis indicated that there was a significant difference between the contexts; the chi squared value is 14.078, 2 degrees freedom 2, with $p < 0.001$. However, three out of the six expected values were below five, and chi squared analysis is usually only performed where 25% or less of expected values are below five.

TABLE 3: CAPACITY DETERMINATION BY COURT/TRIBUNAL WHEN ITS DECISION DIFFERED FROM MEDICAL OPINION

	Number of matters with disagreement between court/tribunal and undivided medical opinion	Court decision: incapacity	Court decision: capacity
Personal/ financial	8	7 (88%)	1 (12%)
Testamentary	7	2 (29%)	5 (71%)

92. For the purposes of the study, medical opinion disagreement was counted when more than one expert considered the same type of capacity and reached different conclusions.

Legal matters	2	0 (0%)	2 (100%)

Table 3 shows the results of the cases of where all of the medical opinion was in one direction and the court/tribunal decision was in the other. It shows that in personal/financial capacity cases, unlike the other two contexts, the most common decision of the tribunal in these matters was incapacity. The numbers for this measure are too small to perform statistical analysis.

TABLES 4.1–4.3: AGREEMENT BETWEEN INDIVIDUAL MEDICAL OPINIONS AND COURT/TRIBUNAL DECISION BY WHETHER OPINION WAS CAPACITY OR INCAPACITY.

TABLE 4.1: PERSONAL/FINANCIAL CAPACITY

Medical opinion provided	Number of individual opinions	Tribunal: Agree	Tribunal: Disagree
Capacity	45	12 (27%)	33 (73%)
Incapacity	374	370 (99%)	4 (1%)

TABLE 4.2: TESTAMENTARY CAPACITY

Medical opinion provided	Number of individual opinions	Court: Agree	Court: Disagree
Capacity	39	32 (82%)	7 (18%)
Incapacity	42	27 (64%)	15 (36%)

TABLE 4.3: LEGAL MATTERS CAPACITY

Medical opinion provided	Number of individual opinions	Court/Tribunal: Agree	Court/Tribunal: Disagree
Capacity	22	20 (91%)	2 (9%)
Incapacity	20	13 (65%)	7 (35%)

Tables 4.1–4.3 show all of the individual medical opinions found in all of the decisions where it was possible to discern whether that opinion was capacity or incapacity. It divides those opinions into capacity and incapacity and shows the frequency at which those individual decisions were the same as the ultimate court/tribunal decision.

Table 4.1 shows that in personal/financial capacity matters, the tribunal agreed with medical opinions that the adult did not have capacity 99% of the time; whereas the rate of agreement when the opinion was that the adult had capacity was 27%. This difference was highly significant; the chi square value 260.54, 1 degree of freedom, $p < 0.001$. Therefore, it is possible to say that the tribunal had a preference for evidence of incapacity over capacity in personal/financial capacity cases. Tables 4.2 and 4.3 show that for testamentary capacity and legal matters capacity, the difference was less pronounced, but importantly, it was in the other direction, i.e., it was more likely for the court to agree with the medical opinions finding capacity than incapacity. For testamentary capacity the chi square 3.22, 1 degree of freedom, $p=0.072$. Therefore, there is a greater than one in ten chance that the court does prefer evidence of capacity over incapacity, although this does not meet the usually used level for statistical significance of one in twenty. For legal matters capacity, the chi square value is 4.177, 1 degree of freedom, $p=0.041$. Two of the four expected values are less than five, however, lowest of these two totals is 4.29.

The lower numbers for testamentary capacity and legal matters capacity mean that statistical analysis is less powerful. But, although there are limitations to the analysis for those two contexts, the important point is that the differences, if they exist, are in the other direction from personal/financial capacity. That means that in the unlikely event that these results do not represent a preference for evidence of

capacity over incapacity, and that there was in fact no preference either way in testamentary capacity and legal matters capacity, this would still be an important result. This is because it would mean that there would remain a distinction between those two contexts and personal/financial capacity, because in personal/financial capacity matters there is a significant preference for one type of medical opinion over the other.

The following graphs make clear the dramatic differences in how medical evidence is treated in the different capacity contexts.

FIGURES 1.1–1.3: AGREEMENT BETWEEN INDIVIDUAL MEDICAL OPINIONS AND COURT/TRIBUNAL DECISION BY WHETHER OPINION WAS CAPACITY OR INCAPACITY.

FIGURE 1.1: PERSONAL/FINANCIAL CAPACITY

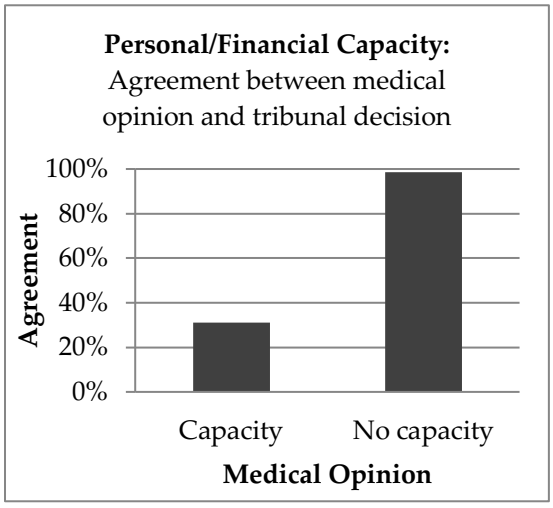


FIGURE 1.2 TESTAMENTARY CAPACITY

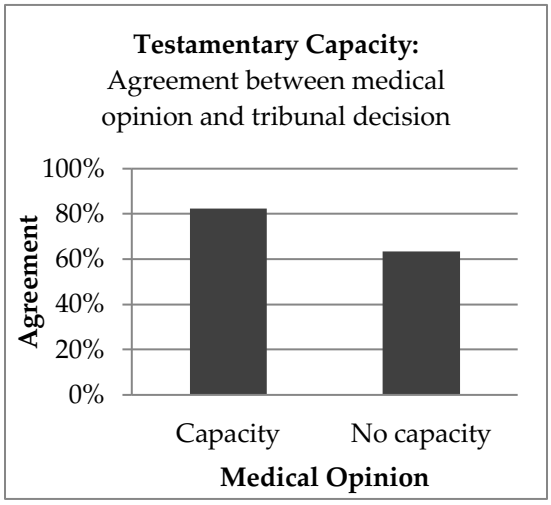
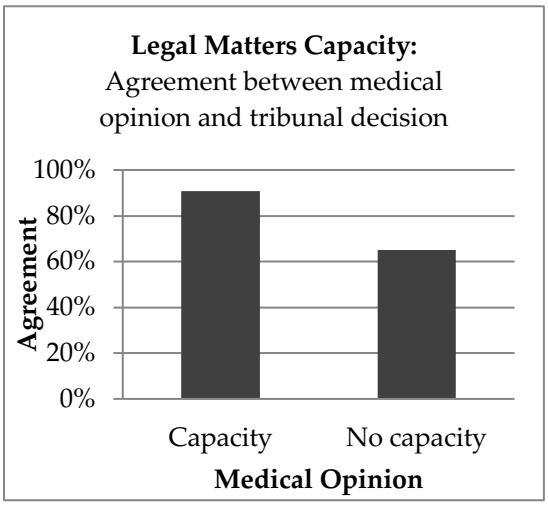


FIGURE 1.3 LEGAL MATTERS CAPACITY



V. Discussion

The most significant finding of this study is the rate of agreement between court/tribunal decision on capacity and medical opinion provided to the court/tribunal on capacity, as measured by whether that

opinion was capacity or incapacity. The preference for evidence of incapacity in personal/financial capacity decisions gives support to the realist critique that judicial decision-making on capacity, in that context at least, involves an unstated protection focus, despite the autonomy-supporting elements of the law of capacity.

As shown in Tables 4.1–4.3 and Figures 1.1–1.3, while legal matters and testamentary capacity matters results showed a higher level of agreement when the opinion was capacity, the data for personal/financial capacity was significantly in the other direction. If the law were to be taken at face value, the rates of agreement between medical opinion and court/tribunal decision in legal matters and testamentary capacity cases are not surprising. Case law has stated that medical evidence is very probative, but not determinative.[93] It also has stated that there is a presumption of capacity. Therefore, agreement in the majority of cases with medical evidence, with a slight preference for opinion indicating capacity, is consistent with the stated law.[94]

The outlier here is clearly personal/financial capacity. In those decisions, there appears to be a clear preference for medical opinion of incapacity for personal/financial capacity matters. The agreement rate between tribunal decision and medical opinion went from almost universal when medical opinion was "incapacity," to less than a third when opinion was "capacity." Remarkably, those doctors who thought the adult had capacity are more likely than not to be on the "losing" side. This preference cannot be explained by the tribunal preferring opinions that were in the "majority" in the individual case. It is true that there is a greater number of opinions provided that indicated incapacity than capacity, and in many cases when the tribunal finds incapacity, it is siding with numerical balance of medical opinion in the individual case, as measured by the number of medical experts on each "side." However, there are several cases where the tribunal's decision for capacity goes against the numbers.[95] Also, seven of the eight times where the tribunal reached a different conclusion from unanimous

93. *See generally Capacity*, *supra* note 38.

94. Timbury v. Coffee [1941] 66 C.L.R 277, 283 (Austl.). Testamentary capacity does not have a presumption of capacity in the same way as other types; however, if a will is presented for probate that is duly executed and rational on its face, there arises a presumption of validity, which includes a presumption the testator had capacity, unless evidence of the contrary is put.

95. *See, e.g.*, HM [2013] QCAT 351 (Austl.); MEA [2011] QCAT 617, SFW [2011] QCAT 237 (Austl.).

medical opinion (Table 3), it did so to find incapacity. Moreover, in six of those seven cases, it did so in the face of more than one expert.

It is submitted that there could be no rational reason why the probity of medical evidence should diverge so greatly depending on the valence of that opinion. The divergence is especially telling given that there is a legislated presumption of capacity in these matters, so the law mandates a preference in the other direction. Therefore, it is possible to conclude that in the personal/financial capacity jurisdiction, there is an unstated preference for evidence showing the adult lacks capacity. The most likely explanation for this is the tribunal's desire to protect what it sees as vulnerable people. Therefore, we can conclude that beneficence, or to put it critically, paternalism, does play an unstated role in the determination of capacity.

One interesting question that arises is why legal matters capacity cases did not follow the results of personal/financial capacity. Personal/financial capacity matters were clearly more likely to engage the protective impulse of the tribunal more than testamentary capacity. But, legal matters regarding capacity may also be seen as part of the protective function of the court, they too emanate from the *parens patriae* jurisdiction. Why then did legal matters capacity cases not display a similar protective pattern as that for personal/financial capacity decisions?

There are possible explanations for this. Firstly, what was at stake in legal matters capacity decisions was less significant, and potentially less likely to engage the courts' protective impulse. Personal/financial capacity matters have broad application and can have a very significant potential impact on the well-being of the person whose capacity is being assessed. Legal matters capacity cases, on the other hand, have the effect of determining the adult's ability to run a particular civil case, not legal matters generally, nor criminal matters. Therefore, although a finding of capacity might expose the adult to the risk of a negative costs order, the risk was far more contained. In those cases where the particular case the adult was involved in was itself before the tribunal, each party is usually self-represented and only bears its own costs,[96] so there the only risk was losing the case.

96. *Queensland Civil and Administrative Tribunal Act 2009* § 100.

Secondly, in the third category of legal matters capacity—determinations made under section 59 of the Public Trustee Act—the decision on capacity did not make any difference to the adult in a way that would enliven the court's putative protective instincts. In those matters, if the court found the adult lacked capacity to reach the settlement, the next step would be for the court to sanction it if they thought it was a reasonable compromise, or not if it did not. Therefore, in the case where a compromise is put before the court, which the court thinks is reasonable and would sanction if the person lacked capacity, the determination of capacity only has administrative implications. Either way, given the court's power to refuse to sanction an agreement it thought unreasonable, the vulnerability of the adult was not at stake in these decisions on capacity.

Although those explanations may be accurate, it is not possible to be certain that they do fully explain the pattern shown here, where legal matters capacity cases cohere more to the testamentary capacity pattern than personal/financial matters. Therefore, the explanation for this result is an interesting open question.

VI. Implications of Findings

There are two important implications of these findings. Firstly, these results appear to confirm the operation of an unstated protection focus in legal decision-making on capacity, at least for personal/financial capacity matters. Therefore, the results offer support to the significant number of authors who have made this realist argument.[97] But, these results have the benefit of being objectively measured, they do not rely on any appraisal of what ought to have been the correct result in any particular case, nor the strength of the evidence in any case.

In this regard, it should be noted that none of the cases appeared to display errors of logic, nor tendency towards protection on the face of the judgment that were visible to this researcher. For example, in those seven cases of personal/financial capacity where the tribunal goes against undivided medical opinion, it does so by using other legitimate sources of evidence. In a number of cases the source of evidence

97. Heart of England NHS Foundation Trust v. JB [2014] EWHC (COP) 342 (U.K.).

is direct communication with the adult,[98] which seems a very reasonable source of evidence of capacity. In fact, direct discussion with and engagement with the adult in decision-making is encouraged by disability advocates; it is one of the reasons that Carney and Tait concluded that Australia's tribunal system for guardianship and administration provided better outcomes than the previous system of court determination.[99]

Also, in those cases where the tribunal finds incapacity in the face of outnumbered medical opinion, it does so on logically justifiable grounds. For example, in *HM*,[100] if one was to attempt to assess the *prima facie* strength of the medical evidence for and against capacity (accepting the limitations in doing so), one would probably conclude that the medical arguments in favor of capacity were stronger. In that case, there were contemporaneous opinions from the adult's treating psychiatrist and treating physician stating the adult had capacity.[101] This was opposed by a year and a half old report from a psychiatry registrar, performed while the adult was in the hospital, from which he had subsequently been released, which stated the adult lacked financial capacity.[102] The tribunal sided with the psychiatric registrar, despite the registrar not giving oral evidence and the report being potentially out-of-date and not from the treating physician.[103] Yet, this specific decision on financial capacity was taken not just on the medical evidence, but also on discussion with the adult, and discussion with the Public Trustee, who had been administrator for the adult.[104] Noting difficulties the adult had with management of his finances that emerged in that evidence, the tribunal stated that it placed "greater weight on evidence that includes observation and description of the manner in which HM attends to his day to day finances, income and investments."[105] At face value, this seems logical and reasonable. Other cases in which either the balance or totality of medical opinion stating capacity was not followed

98. *See, e.g.*, Re: FM [2013] QCAT 135 (Austl.), FAJ [2013] QCAT 703 (Austl.), CJP [2013] QCAT 663 (Austl.), PM [2011] QCAT 363 (Austl.).
99. CARNEY & TAIT, *supra* note 66, at 123.
100. HM [2013] QCAT 351 (Austl.).
101. *See generally id.*
102. *Id.* at ¶ 8.
103. *See generally id.*
104. *Id.* at ¶ 19.
105. *Id.* at ¶ 23.

include a *prima facie* rational justification for why it is happening in the instant case.[106]

Therefore, even acknowledging the weakness of proposing an unstated protectionist approach by relying on uncovering logical inconsistencies and failures of reasoning in individual cases, such an investigation, it is submitted, could not have uncovered the extent of, or perhaps even the existence of, the unstated protection-focus present here. It was only through a scientific review of objective data from these decisions that this tendency became visible. This is an important point to consider in further research in this area.

Secondly, these results come in a jurisdiction which, on its face, presents one of the more 'progressive' regimes,[107] which, by having an explicit presumption of capacity, using a functional test of capacity, and having no prescribed association between incapacity and disability, more closely follows the rights and equality movement reflected in the United Nations' *Convention on the Rights of Persons with Disabilities*. This reflects the current trend in mental health and capacity law, moving away from a protection focus and towards an autonomy focus.[108] Yet the difference in legislative approach in Queensland does not seem to be associated with a difference in legal decisions made under the regime. It is hard to envisage a more striking difference in agreement regarding medical opinion than 99% to 27%. This result coheres with other studies that have shown that legal regimes are not necessarily responsive to rights and autonomy-focused legislative changes.[109]

106. *See, e.g.*, MEA [2011] QCAT 617 (Austl.) (finding the tribunal sides with one expert who said incapacity over three who said capacity, the tribunal discussed MEA's situation with her, and found that MEA was significantly mistaken about important points; e.g. she did not understand the nature of an Enduring Power of Attorney that she herself had made four years earlier.).

107. John Chesterman, *Capacity in Victorian Guardianship Law: Options for Reform*, 36 MONASH U. L. REV. 84 (2010).

108. *See, e.g.*, Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 U. COLO. L. REV. 157, 171–73 (2010). Queensland's more progressive guardianship and administration regime may therefore be attributed to its being updated more recently than most other Australian states.

109. Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of 'Ordinary Common Sense' Heuristic Reasoning, and Cognitive Dissonance*, 19 J. AM. ACAD. PSYCHIATRY L. ONLINE 131, 132 (1991); *see also* Terry Carney, *Guardianship, "Social" Citizenship and Theorising Substitute Decision-Making Law*, *in* BEYOND ELDER LAW (Israel Doron & Ann M Soden eds. 2012).

One question that overhangs this research is: To what extent is all of this a problem? This Article does not make any conclusions as to whether the outcomes for the people before the tribunal ought to have been different. That normative question is very important, but has not been addressed in this Article. What can be said is that the legislation—specifically, the presumption of capacity—is not being followed in personal/financial capacity decisions. Moreover, in relation to Australia's involvement with the United Nations' *Convention on the Rights of Persons with Disabilities*, there appears to be a problem, at least at the level of international law. There is a prominent, if controversial, view of capacity law which states that any law that provides for substituted decision-making for people who lack capacity (as almost all modern capacity law, including that considered in this Article, does) is in violation of Article 12 of the Convention.[110] In its engagement with the Convention, in response to this interpretation, Australia took the unusual step of issuing an Interpretative Declaration on the meaning of Article 12, which states: "Australia acknowledges the importance of supporting decision-making where this is possible, but considers that a human rights-based model of disability does not preclude all substituted decision-making. Such decisions should only be made on behalf of others where this is necessary, *as a last resort*, and subject to safeguards."[111]

Given the tendency to find incapacity and appoint a substitute decision maker shown in this research, there is no way the Queensland regime could be described as substituted decision making as a "last resort." As Queensland has the most progressive of the Australian states' legal construction of capacity for guardianship and administration matters, it is doubtful that any jurisdictions are meeting the standard apparently set by the Australian government. Therefore, overall, there appears to be a striking dissonance between the Australian government's engagement with the international community and actual decision making in this area.

VII. Conclusion

110. *Committee on the Rights of Persons with Disabilities: Article 12*, U.N. (Jan. 24, 2007), http://www.un.org/disabilities/documents/convention/convotprot-e.pdf.

111. *Australian Human Rights Commission Submission to the UN Committee on the Rights of Persons with Disabilities*, U.N. (Feb. 28, 2014), http://www.ohchr.org/Documents/HRBodies/CRPD/GC/AustralianHRCArt12.doc (emphasis added).

As noted at the beginning, there are two very different ways of viewing the role of capacity in the legal system. To those who believe that the proper role of capacity is to support and protect autonomy, the results of this study should be a cause for concern. At the very least, they provide a significant challenge to the concept of the presumption of capacity. To those who criticize the existence of a test of capacity in the legal system, the results of this study will be of no surprise; indeed they may view the tendencies shown here to be self-evident. Either way, it is submitted that the results shown here ought to encourage similar investigations in other jurisdictions. Whether or not one supports an ongoing role for a test of capacity in the legal system, it is vital that we fully understand what current role this test plays. Therefore, the extent to which the tendencies uncovered here are replicated in other jurisdictions is an interesting question, and one which ought to be investigated.

Nevertheless, the results as they stand do need to be borne in mind when considering the role of capacity in the legal system. They are evidence that a legal regime that on its face supports autonomy may have a different character when actual decisions made under the regime are assessed.