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BEYOND INCAPACITY

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Je suis et je reste une personne à part entière.[1]

The promise of two guiding legal principles, the presumption of capacity[2] and the safeguarding of autonomy,[3] has yet to be fulfilled.

Concepts of legal and functional capacity are poorly developed and understood; our protective regimes create rigid legal categories; and professionals and legal representatives alike are poorly educated about the rights of the person represented and the nature of role of the legal representative under a mandate (given in anticipation of incapacity), tutorship, curatorship, or as appointed by law.

Although there is no universal definition of capacity, despite a search for consensus and objectivity, case law and certain provincial statutes have recognized and incorporated the notion that capacity implies the ability to understand and articulate reasoning behind a decision and to appreciate the consequences of a decision.[4] Thoughtful commentators and various studies by medical and legal professionals would add that decision-making capacity requires a set of personal values and goals. That is, capacity is to be judged according to standards set by the person's habitual or considered standards of behavior and values rather than by conventional standards held by others. A great danger in capacity assessments is that eccentricities, disagreeable character traits, or ac-

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[1] Person with Altzheimer's disease.

[2] Arts 4, 153 *CCQ*.

[3] Art 257 *CCQ*.

[4] *Institut Philippe-Pinel v G(A)*, [1994] RJQ 2523 (CA) at 2529 [*Institut Philippe-Pinel*]; *Starson v Swayze* [2003] 1 SCR 722.

tions and risk-taking other people find difficult to understand will be confused with incapacity.[5]

Capacity is task-specific and time-specific. Consider persons with mental illness. They may be quite capable with medication or other supports, or they may need assistance or representation in limited areas or for certain tasks only. Next, consider an older person with Alzheimer's. While age is the most significant known risk factor for dementia and Alzheimer's disease, most people do not develop the disease as they age. In other words, Alzheimer's is not a normal part of aging.[6] Even where there is incapacity in older people with dementia, it often develops gradually or is only partial, with much residual capacity remaining. Thus a person may have diminished or impaired capacity and be incapable of managing his financial investments, but be entirely capable of executing a power of attorney or mandate and handling day-to-day expenditures with or without assistance; or he may be incapable to confer a mandate, but be capable of executing a simple will of his property; or he may be completely incapable of decisions relating to his property or finances, but function well in his activities of daily life and be capable of making decisions relating to health care. Consider finally the person who is dying. A terminally-ill but otherwise competent person may lapse in and out of lucidity, and hence capacity, so that his or her current wishes and consent, whether or not covered in a previously executed advance directive, would be sought, when possible, in those moments of lucidity.

While capacity is a legal determination, lawyers often do not represent the person under evaluation whose capacity and legal rights are at issue.[7] And

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[5] Commission on Law and Aging and American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, , (Washington, DC: American Bar Association & American Psychological Association, 2005), online: APA <www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf >; Charles Sabatino & Suzzanna L Bassinger, "Competency: Reforming Our Legal Fictions" (2000) 6:2 Journal of Mental Health and Aging 119.

[6] Alzheimer Society of Canada, "Myth and Reality About Alzheimer's Disease" (2011), online: ASC <www.alzheimer.ca/en/About-dementia/Alzheimer-s-disease/Myth-and-reality-about-Alzheimer-s-disease>.

[7] The Institut National du droit de la politique et du vieillissement has proposed to the Quebec government that those whose civil rights and the integrity of their person are at issue be represented by legal counsel in every judicial proceeding in which such legal rights are at stake, save in a case of reasonable refusal of legal counsel (opening of a protective regime under art 877 *CCP*; review of protective measures under arts 883-884 *CCP*; homologation of a mandate given in anticipation of incapacity under art 884.1 *CCP*; and orders for consent to care, including housing

even when representing a client in contested matters, the legal profession too often defers to clinical assessments without defining or reviewing the nature and object of the assessment, verifying the legal criteria applied by the medical and social work professional, or ensuring that areas of residual capacity are fully described. Correlatively, some doctors and social workers do not provide information that is specific enough for courts to distinguish capacity in one domain or another.

A thorough assessment which presumes and maximizes capacity and autonomy is the legal right of every person. Certainly the presumption of capacity requires that all parties in the continuum of evaluation, recommendation, and implementation of protection measures – from the medical expert and social worker, to the lawyer and judge – ensure the comprehensiveness of capacity assessments. The use of common standardized tests of cognitive functioning to determine incapacity has recognized weaknesses, and provides only a crude global assessment. These tests have given way to important additional bases of assessment which better determine and promote capacity. They include:[8]

- ❖ Ensuring enhanced communication. Techniques include multiple sessions to build confidence and trust, and to ensure that wishes do not vary with time. These session must be conducted in an optimal environment supportive of, in particular, the partially-impaired person's decision-making ability, e.g. at home and at times when the person will perform at his or her best.
- ❖ Understanding and taking into account of, *inter alia,* lifestyle, values, family history, cultural issues and mores, language and speech peculiarities, and difficulties as these may affect assessment.
- ❖ Multidisciplinary and multilevel evaluations. These include not merely the *cognitive* but the *physical* (many conditions which are treatable, reversible, and temporary, and may relate to sickness, disease, over- or under-medication, and may mimic dementia) as well as *functional* capacity. Also, the presence of *social* supports assessed by occupational therapists and social workers, respectively, is crucial.

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under art 776 *CCP*; and orders for confinement and psychiatric assessment under art 778 *CCP*. The proposal advocates further that if there is but one legal counsel in the case seeking the opening of a regime of protection that legal counsel should represent the person whose capacity and legal rights are at issue.

[8] See eg sources *supra* note 4.

- Assessment of risk. We recognize that competent people are permitted to committ foolish acts and accept risks which others might not. However, all too often the *gravamen* of incapacity cases is the claim of risk of harm posed by the likely outcome of the individual's decision, from which the court infers a lack of insight and judgment. The objective assessor must keep in mind that risky conduct, alone, is not proof of incapacity. The ability to appreciate the consequences of a decision requires is the key to a finding of capacity. Risk assessment must take account of the nature and gravity of the risk, whether it is old or new, chosen or accidental, with the central question: is it consistent with values and a lifestyle of living at risk? As Dr. Michel Silberfeld, geriatric specialist in psychiatry reminds us, "[i]ncompetency is the inability to make choices. A competent person *chooses* to run risks. An incompetent person simply runs them."[9] Our culture is risk adverse in caring for persons with impaired capacity, particularly when present in older people. This risk aversion is driven by fear of liability, lack of resources, lack of education or misunderstandings about the guiding principles of capacity and autonomy and failure in some cases to make the effort. The result is that much risk assessment by professionals, family, and friends inclines towards trumping autonomy with safety and protection.

  A person who is about to gift a significant portion of his assets is exposed to greater risk and requires a higher level of capacity than someone who is executing a mandate in favor of a trusted family member, where the person understands and appreciates that the mandatary will be able to make decisions about finances and advocate his decisions about care. So one would look at the importance of the assets to the person concerned (for example, the value of the gift relative to total assets) but also whether a pattern of giving was consistent with goals and values.

- Advocating, when required, the least restrictive measures of protection. Art 257 *CCQ* is our cornerstone and guide in relation to protection. All decisions, from the determination of the appropriate level of protection, to the confirmation or appointment of a legal representative, to acts and decisions made by persons acting on behalf of another, must respect the individual's wishes and safeguard autonomy. The

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[9] Daniel Dochylo & Michael Silberfeld, "Capacity, Consent and Health Care Decision-Making" in Ann Soden, ed, *Advising the Older Client* (Markham: Lexis Nexis, 2005) ch 5 [emphasis added].

> principle underlying any protective action is to impose the least restrictive approach under the circumstances.
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> For example, there may be incapacity but no risk or need for formal legal representation, or there may be an easily-controlled risk which need not infringe on legal rights. Protective measures which are the least restrictive of civil rights and autonomy may be as simple as making banking arrangements for bill payment, hiring an accountant or executing a banking or general power of attorney which names a trusted representative to handle one's property and financial matters. However, such protective measures must be context-dependent, based upon the simplicity of the assets and the transparency and accountability of their management.

Capacity is not always an all-or-nothing phenomenon. The introduction of advisorship and tutorship[10] had the objective of leaving as much autonomy and determination in the hands of the individual as possible. Under tutorship, the tutor is assigned only to those duties and powers that the person is incapable of exercising. Though enshrined in the law, the actual use of tutorship and advisorship still remains the exception rather than the rule. Advisorship, which does not affect rights and is not a protective regime, is a rarity and tutorship, with its recognition of residual capacity, is outnumbered threefold by the homologation of mandates and by private and public curatorships.[11] Both these latter protective regimes require clinical findings of "total" incapacity.

Rarely is a person totally incapable. Degenerative conditions such as dementia do not justify premature determinations of total incapacity. We have a broader understanding of mental illness today when it is present in a younger adult, but ageist and paternalistic views still prevail towards older adults beset with forms of dementia.

Our asessments need to be less general and label-driven, and more finely tuned and focused on how a person functions in society. We need, in respect of care and treatment decision-making, to allow the person represented to make each and every decision, and perform every task and transaction he is capable of. Capacity to make personal decisions, including decisions as to care and treatment, can rarely be assessed in advance. The individual's ability

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[10] Bill 145, *An Act Respecthg the Public Curator and Amending the Civil Code and Other Legisliltive Provirions*, 2nd Sess, 33rd Leg, Québec, 1989 (proclaimed in force on 15 April 1990, SQ 1989, c 54).

[11] Curateur Publique, "Statistics: Characteristics of Represented Persons", online: Curateur Publique <www.curateur.gouv.qc.ca/cura/en/curateur/statistiques.html>.

for a particular decision needs to be assessed on an *ad hoc* basis,[12] at the time the decision is to be made, decision by decision, task by task, transaction by transaction.

Despite recognition that capacity is task-specific, when a clinical determination is made that a person lacks insight and judgment as to his finances and/or his person, society intervenes in a global and generalized way to take away rights and to name a legal representative. A "best interests" and substituted decision-making standard then seem to prevail over wishes and over recognition that the person may well continue to be capable of many tasks and personal decisions. This is neither the substance nor the spirit of our law.

There has to be a paradigm shift in the application of the law. Amongst those with diminished capacity, some have more capacity. Some have less. To the extent that a person retains any residual capacity, this capacity to decide, and not merely to express wishes, should be recognized and asserted. It is more than an ethical duty imposed on the legal representative. It is the very essence of the representative's role and the corresponding legal right of the person represented.

The person represented may be quite capable with support, assistance, and advocacy of his decisions in given instances, to make many everyday decisions on a range of matters. He may be capable of defining, with his representative and a health care team, a care plan and making and modifying end-of-life decisions. He may even be capable to vote or to marry. Most personal decisions will not be complex and can be readily assessed by the legal representative. Others will involve advice and verification with other experts, in less or more formal ways, depending on the matter.

Even if the person represented is unable to make or communicate a decision, the decision is conceptually still his. The primary role of the representative is to advocate the person's prior expressed competent wishes on the matter, if known. The essence of legal representation as to one's person, regardless of appointment under a protective regime or under the law, is one of support and advocacy. These are the principles underlying arts 12, 257 *CCQ*. If the person's exact wishes are unknown, then the representative, consistent with the promotion of autonomy, would be called upon to make the decision that the person represented is unable to make or to communicate, based on that person's life values. Only if the person's wishes and values are unknown or inappropriate in the circumstances, and only after due consideration and consultation, should a legal representative employ a "best interests" and "reasonable

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[12] See eg *Institut Philippe-Pinel*, *supra* note 3 at 2529; *Institut Philippe-Pinel v Blais* [1991] RJQ 1969 (CS).

person" standard in making the decision in question subject to the represented person's rights under art 16 CCQ

Article 16 of the CCQ sets forth an additional legal duty of the legal representative and provides a further and corresponding protection of the integrity and autonomy of the person represented. This duty is often lost sight of in daily practice, particularly in the matters of transition to residential and institutional care. A legal representative may decide or be encouraged by a health or social services professional to "place" an older relative, or other person he represents, in an assisted-living or other residence providing care. The practice of "placement" without consent does not reflect the underlying intention of article 16. An incapable person, regardless of degree of incapacity or level of representation, has the right to refuse care and must be informed of this right. If he refuses,[13] and the matter cannot be resolved through internal health and social service channels with the represented person, the legal representative has no legal standing to override the person's refusal.

Article 16 implicitly, it is submitted, calls upon the legal representative to ensure that the person represented gives his consent to every care and treatment decision that the legal representative recommends, save for cases of hygiene and emergency care. If the person consciously and clearly expresses his refusal of the recommendation (i.e. he does not consent to what is proposed), then the issues of his capacity to make his own decision, the appropriateness of the refusal and the appropriateness of the care or treatment recommendation by the legal representative, taking account of the person's wishes, values and interests, must be submitted to the court for its review and authorization.

We must move away from the practice model of substituted judgment, except very specific cases, to one of *supported judgment*. This move is most needed in the areas of personal and health care decision-making. Quebec's tutorship model is based on this fundamental understanding of capacity despite impairment, but its potential is not yet fully developed and applied in all areas of representation.[14]

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[13] J-P Menard, "L'impact de la Loi sur la protection de personnes dont l'état mental présente un danger pour elle-même ou pour autrui sur le consentement aux soins" in *Développements récents en droit de la santé mentale* (Cowansville: Yvon Blais, 1998) 237 at 257; Robert P Kouri & Suzanne Philips-Nootens, "Le majeur inapte et le refus catégorique de soins de santé : un concept pour le moins ambigu" (2003) 63:11 R du B 1 at 24-25.

[14] Legislative reform of the protective regime of mandates given in anticipation of incapacity to allow for *inter alia* representation and recognition in the case of partial

The goals of maximizing capacity and autonomy require commitment, rigor, and often creativity by professionals, including lawyers and judges, and better assistance to, and understandings by, legal representatives of the true nature of their roles.

incapacity is under discussion. Presently a person with partial incapacity may express his wish to have his mandate homologated (*PL v NG* 2009 QCCS 6211). In addition, a mandate, if so drafted to permit it, may be partially homologated (*SB et al v Suzanne Kemp* (21 December 2004), Montreal, 500-14-020215-34 (CS)), however, in all instances, once the mandate is homologated, partially or fully, the result is full loss of all legal rights in the area homologated (administration of one's property and/or person).