From Lunacy to Incapacity and Beyond

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“Attitudes of U.S. Physicians toward the American pharmaceutical industry, a survey sponsored by the American Medical Association 1958”, American Medical Association, Chicago.


INTRODUCTION

1. IMAGINE

Imagine the year is 2026. The place is Toronto, Ontario. The society is aging; more than 26 per cent of the population is 65 years old and over, and more than 4 per cent are over 85 years of age. Empirical studies indicate the wide existence of elder abuse: physical, financial, psychological and sexual, most of it not handled adequately by the social or legal systems.
Two doctors in the Toronto Geriatric Medical Centre have recently made a dramatic medical and biological breakthrough. After years of research and millions of dollars spent, they have found the key to the aging process of the mind and its relation to cognitive ability. They have discovered that the human brain has an “understanding centre” which possesses cells that age, and once reaching a certain biological age (which is not parallel to chronological age), they become inactive. When that happens, the person’s mind is incapable of understanding data that the senses receive and is incapable of appreciating causal consequences that derive from that data. Those aged cells can be recognized by a novel medical test, which is called the “ACCT” (Age Cognitive Cell Test). A universal medical test could be established, as the doctors claim, and every elderly person could be tested under the ACCT to determine whether his or her understanding centre is still competent, or has become “aged” and lost its cognitive ability.

In light of this dramatic medical breakthrough, a group of geriatric doctors, social workers and lawyers, have launched an initiative to amend the existing Substitute Decisions Act and the Health Care Consent Act. In short, the initiative offers to change the current definition of “capacity” so that the legal definition will be dependent on the result of the new medical technique (“incapacity”: any person who under the ACCT is found to have lost his or her cognitive ability). This proposal is placed on the political agenda for public debate.

What should the reaction to this proposal be? Should it be praised for allowing us to resolve the difficult legal issue of the definition of legal “capacity” by way of novel invention? Should we embrace it as promoting the rights of the elderly? Or should we reject it, assuming that such a proposal harms and infringes upon the basic human rights of the elderly?

B. REALIZE

The situation and questions posed above are, of course, imaginary and naturally could have been pictured differently. However, posing this scenario could enable us to critically examine the current legal status of Ontario’s legislation with regard to the definition of “capacity” of elderly people in the context of guardianship.

The current legal definition of capacity in Ontario relies heavily, if not absolutely, on a cognitive, decision-making ability. In light of rapid technological developments, we should not assume that major medical or biological breakthroughs will indeed occur in this field, and that substantial advancement can be expected in the understanding of cognitive ability?

Further, if we do achieve a scientific understanding of human cognitive ability, and if our legal system relies on our knowledge of that ability to define incapacity, would it not be logical for us to embrace an initiative to reform our laws on incapacity in the event of any new scientific findings in this area?

This paper will attempt to illustrate that not only should the answer be contrary to the above logic, but the rejection of that apparent logic can be understood only by realizing that the current definition of incapacity under Ontario’s legislation does not serve its social and legal goals.

PART 1 — GUARDIANSHIP, INCOMPETENCE AND THE IMPORTANCE OF THE ISSUE FOR THE ELDERLY POPULATION

There are some preliminary issues that should be addressed both to clarify the legal terms and to illustrate why this discussion is valuable.

1. GUARDIANSHIP AND INCOMPETENCE

This analysis centres on the legal terms “incompetence” and “guardianship,” both of which are neither simple nor clear. Further, different legal systems in different times have used various terms such as: “lunacy”, “incompetence”, “incapacity”, “committeehip”, “trusteeship”, “tutorship” and “conservatorship”, to mention only a few examples. It is obvious that such a variety of legal terms has the potential for misunderstanding. The scope of these terms are presented as follows, for the purposes of this paper:

a. Guardianship

Guardianship will be defined as: a legal protective device which enables the state to take actions, intervene in one’s autonomy, and appoint a manager or a decision-maker over the personal and/or financial affairs of an “incompetent person.”

In very general terms, guardianship is justified according to paternalistic values and is based on the moral and legal duty of the state as parens patriae. Its goal is to promote and protect the best interests of a person who has lost his or her competence, as defined by law, who needs protection both from him or her own self and from unscrupulous third parties, and needs assistance in order to maintain a dignified life. Its means include appointing a person or legal entity to take control of the legal capacities of the
incompetent person, making his or her legal status similar to that of a child.

b. Legal Incompetence

"Legal Incompetence" is a crucial part of the definition of guardianship. "Incompetence", as opposed to "legal incompetence", may have different meanings in general usage, in everyday language, in medicine and in other scientific fields.

The Oxford English Dictionary defines "competent" as "suitable, fit, appropriate, proper... possessing the requisite qualifications for...". This definition fits the general intuitive notion of the term, with "incompetent" meaning the opposite. However, in the following discussion the inquiry will be limited to the legal definition of the term, i.e., "legal incompetence". Since the term is potentially tainted by one's own perception, it will be defined simply as the condition under which a legal system justifies the revocation of the presumption of competence of a person.

The definition is "functional", since it defines the term not by content but rather by the legal function it fulfills: revoking the presumption of competence. This definition relies on the term "presumption of competence", thus attention should also be given to the meaning of that term.

Canadian law, similar to other Western jurisprudence, has been based on the legal concept of competency. This concept means that the law presumes that every person, at adulthood, becomes "competent" under law. No special test is performed, no special qualification is needed and one does not have to prove one's legal competence. The mere fact that the person has become an adult at the age specified by the legal system gives rise to the presumption of competence. Once competent, every person is not only legally responsible for their actions, but they have the right to make legal decisions concerning themselves regardless of their wisdom or judgment. Under this presumption, the decisions are legally binding and in force unless a legal action has been taken to nullify them. Competence is, then, a legal presumption, not a picture of any empirical reality. It reflects certain judgment and perceptions about the human condition, its place in society and its legal relations with others. As such, it may reflect the historical needs of society to include or exclude persons from full participation in the community.

Thus, under the proposed definition, "legal incompetence" can include any term or condition which functionally serves for the purpose of rebutting the presumption of competence.

The functional definition raises two significant issues that in the academic discussion seem to disrupt the clarity of the subject.

(i) The legal distinction between the definition of incompetence and the definition of "mental illness"

As will be shown later in this paper, one of the main problems with the legal attempts to define guardianship and incompetence has been the blurring between these terms and the terms used in the field of mental health law. Mental health and guardianship are, however, distinct fields of law. The underlying social and legal bases are different and, although there are some overlapping elements (e.g., police powers and parens patriae authority), the primary purpose behind state intervention is quite different in each. The former is primarily a police power activity and the latter is primarily a parens patriae activity. There are different legal rules, rationale, and goals in the two legal fields.

A person could be mentally ill, but not "incompetent" for the purposes of guardianship, and vice versa. Most mentally ill persons are perfectly capable of managing many of their own personal and financial affairs while undergoing a course of treatment. For example, neither the diagnosis of schizophrenia, nor the identified psychopathology of "thought disorder", necessarily imply incompetence in managing one's financial affairs.

However, this distinction was historically blurred, and for the purposes of this paper it is important to note that under the proposed definition there is no correlation between these legal fields and terms.

(ii) The distinction between "decision-specific incompetence" and "legal incompetence"

Another common obstacle in the analysis of the term "legal incompetence" is the difficulty in distinguishing two totally different legal functions of the term.

"Incompetence" is used with widely different meanings in law. One can be incompetent to stand trial, to make a contract, to marry, to divorce, or to execute a will. In each setting the term varies with the public policy purpose which the construct is designed to advance. Thus, in order to be competent to stand trial one must understand the specific charges and the process of the criminal justice system. The object is to ensure that our sense of fairness will not be offended by a trial which convicts the incomprehending. Competence to contract depends not on intelligence, wisdom or judgment but on the ability to have a "meeting of the minds". The value inherent in that
standard is support for the orderly process of commerce. 12

As was well noted in Banton: 13

The difficulty is accentuated in this case by the existence of different legal tests for determining capacity to marry, testamentary capacity, capacity to manage property, capacity to give a power of attorney for property, capacity for personal care. Each of these is relevant in varying degrees to the issue in this case. It is clear that capacity or incapacity for one such purpose does not necessarily determine the question for other purposes.

Thus, historically, the academic discussion of ”mental incompetence” was actually focused on different kinds of ”decision-specific incompetence” with regard to specific fields of law. 14 However, these discussions are not relevant to issues that are discussed herein. The concern here is with the definition of legal incompetence in the realm of guardianship. This legal concept has nothing to do with any legal finding of incompetence respecting a specific contract, marriage, or any other legal field. Hence, this discussion does not interfere and is not intended to deal with any developed legal jurisprudence or case law regarding ”decision-specific incompetence”.

c. The Legal Relationship Between Guardianship and Incompetence

Once the terms ”guardianship” and ”incompetence” are defined, it is possible to understand the relationship between them; under the definitions above, incompetence is the legal trigger or cause for guardianship. In other words, the legal justification for appointing a guardian is embedded within the concept of incompetence. Incompetence, then, essentially designates the person as being incapable of functioning as a competent citizen in a civilized system of order. Only competent people are eligible to legally act by themselves, and those who are not competent need a guardian to act on their behalf. It is obvious that incompetence is a very powerful concept, implicit in which are far reaching social consequences for the individual. As one scholar described it, the determination of incompetence is in some cases a stronger degradation of the human being than is being declared criminal. 15

2. THE IMPORTANCE OF THE TERM ”INCOMPETENCE” TO ELDERLY PEOPLE

Now that the legal definitions and the relationship between incompetence and guardianship have been examined, it is necessary to explore why so much value is placed on these legal definitions with regard to the elderly population.

The only way to realize the importance of the issue of incompetence to the elderly is by understanding the social revolution which the elderly population has undergone and is going through. In the past century, and more specifically the last four decades, Western societies have experienced a tremendous social and demographic turnover which has totally changed the importance and relevance of the elderly population in both society and law. It is beyond the scope of this paper to fully explore the scale of the phenomenon, however, it is sufficient to point out the following.

a. The Demographic Change

From relative insignificance, both terms of numbers and percentage, the elderly have become the fastest growing segment of society, and perhaps the most substantial. The population over the age of 65 years has grown considerably since the turn of the century. In 1901, there were roughly 250,000 persons in this age range resident in Canada; by 1981, there were roughly 2.4 million. Currently, there are more than three million people who are 65 or over and this number is expected to more than double by 2021. 16 Proportionally, persons over the age of 65 represented nine per cent of the Canadian population in 1981; by 2001, that figure is expected to reach 14 per cent. 17

The growth within the Canadian population of persons over the age of 80 years has been even more dramatic. In 1901, this group numbered less than 40,000; by 1981 they numbered 451,000, a total which is expected to reach over one million by 2031. 18 Women outnumber men in all age ranges over 65, and this disparity becomes more pronounced the higher the age range. This trend is expected to continue, such that by 2001 there are expected to be twice as many women as men over the age of 80. 19

The picture is clear and startling: The elderly are becoming a massive social group within our society in dramatic contrast to the situation a few decades ago.

b. Social Change

Several social trends have led to drastic changes in the lives of elderly. It used to be the norm for elderly parents to live in the same home with their adult children, who were socially and morally obliged to take care of them. 20

Today, people are more mobile and children, even though loving and caring, who live far away from their parents cannot take care of them. Further, the reduction in the number of children, and the rise in the number of families with no children at all, has contributed to the reality of elderly persons with no close family support or care.

Thus, the traditional view of the elderly in the home where they were born, with their married children and grandchildren by their side, is becoming more of a memory than reality. 21
c. The Medical and Technological Changes

Modern medicine and technology has not only lengthened life expectancy but has also radically changed the choices and possibilities open to elderly people.

On the one hand, the elderly are increasingly developing Alzheimer's disease, other forms of dementia, and various chronic illnesses (liver disease, rheumatism, arthritis, high blood pressure, diabetes, cataracts, etc.), as life spans continue to lengthen. On the other hand, however, a wide variety of new drugs, medical procedures, and housing arrangements are now available to seniors, presenting possibilities that didn't exist only a short time ago.

To illustrate the scope of the health problems the elderly face, it should be noted that in 1991, 46 per cent of all people aged 65 or over in Canada had some physical or mental disability. This proportion increases with age, as does the severity of the disability.

d. The Economic Dimension

The aging population is poor. Half of the families whose head was over the age of 65 had an annual income under $15,000 in 1981, while only 15 per cent of families whose head was under 65 had a similarly small income. Of seniors who were "unattached" (living alone or in a household where he or she was not related to the other household members), 57 per cent had incomes under $7,000 in 1981. Social and economic barriers to the elderly's self-reliance, such as mandatory retirement, social security programs which penalize work after age 65, and pension plans which seem to be designed so that most workers never qualify for their benefits, all contribute to the proliferation of elderly persons bereft of the ability to provide for their own financial welfare.

A work ethic which equates an individual's worth with productivity, and a youth orientation which often links activity and vitality with youth, and senility with old age go further toward conditioning elderly persons to adopt for themselves the role which society has trained them to accept. Economically, seniors are far more dependent on government support than any other segment of society.

e. Elder Abuse

There is little doubt that the elderly are particularly susceptible to various forms of abuse: physical, emotional and financial, and neglect (both passive and active). It has been estimated that as many as 100,000 elderly Canadians have recently suffered some form of serious mistreatment within their own homes. It has also been shown that abuse may be a significant problem in both public institutions and private facilities that provide care for the elderly in Canada. Further, researchers admit that the extent of the problem is probably much greater than the official statistics indicate. Although public and political awareness does exist, many elderly people are still faced with the permanent potential threat of abuse.

f. Historical Perspective

The elderly have experienced, until recently, a widespread indifference to their special health needs and, accordingly, have lagged behind other sectors of society in terms of medical advances relevant to their health care. Myths and stereotypes dominated the approach to seniors, and as one author has commented:

[geriatric research] has not been perceived as being as glamorous or rewarding as high tech research in the acute care setting and has suffered from under funding and limited visibility in the scientific community.

Moreover, myths and stereotypes still pervade much of the public attitude toward the elderly. Elderly people are still often considered "senile"; age is still viewed as being associated with loss of intellectual capacities. "Be young" is the prominent social message transmitted by the media. While many of the stereotypes regarding aged people are false, they still exist and influence public policy toward the elderly population.

Admitting that "heterogeneity may be the common element that unites the elderly as a group," and knowing that one always has to be wary not to fall into generalizations or age bias, it is reasonable to assume, in light of these social changes, that our society is facing an era which will be characterized by a substantial increase in the number of elderly people who will need social and legal support in order to preserve their ability to take care of themselves, remain independent, and avoid abuse, neglect, and economic hardship.

These social factors will assist us in understanding the importance of the term "legal incompetence" to the elderly population. As the Fram Committee stated:

Laws governing incapacity involve the removal of the right to self determination from individuals subject to the legislation. The determination of when the law should permit intervention is, therefore, crucial.

The concept of legal competence is thus a key concept in the field of the elderly's rights: if present, it supports individual action and autonomy; if absent, it
triggers state intervention and alternative legal processes. Empirical data confirms our assumption: Competency assessments are increasingly about the elderly. A current estimate suggests three quarters of assessments involve subjects 70 years or older. No other social group is so directly influenced by the legal definition of “incompetence”, and never before in history has this legal definition had such importance to the aged population. The question of “incompetence” is therefore not only academic, but can potentially influence the future status of each and every one of our growing elderly population.

PART 2 — FROM “LUNACY” TO “INCOMPETENCE”

1. THE “LUNACY” ERA

The issue of legally defining “incompetence” is not new. Proceedings for the protection of the property of incompetent persons were formally conducted in Roman Law at the time of Cicero.

In medieval England, guardianship of the person and property of the mentally disabled was the function of the lord of the manor. With the enactment of the statute De Praerogativa Regis in the 14th century, guardianship was formally recognized in England as a duty of the sovereign and exercised through the Lord Chancellor. The Crown, as parens patriae (a term derived from the emerging English concept of the King’s role as father of the country) would shoulder responsibility for protection and care of the person and property of mentally-disabled people.

De Praerogativa Regis divided the mentally disabled or “insane” persons into two classes, the “idiot” (the “natural fool”) and the “lunatic” (“fail of his wit and ... per lucida intervalla ...”). While an “idiot” was a person born with no understanding, a “lunatic” was one who had been born with understanding but had “lost the use of his reason”. In essence, although there were differences between the lunatic and the idiot, the King, in both cases, became a trustee, holding the property of these people for their benefit and returning it to their heirs once they died or ceased to be in that state.

As to their personal status, the “lunatics” and “idiots”, after being so declared, were categorically “infantilized”, in the sense that they had no legal control or authority over their body or property, similar to a small child.

The method for determining an individual’s mental status called for the Chancellor, upon petitions, to issue a writ “de lunatico inquirendo”, which was examined by a jury of 12 men.

If an incompetent was determined by the jury to be a lunatic, the Chancellor committed him to the care of some friend, who received an allowance with which to care for him.

The jury, which was basically 12 common men from the vicinity, determined whether the proposed ward had “lost the use of his reason”, had “failed of his wit”, or was “not in his right mind”.

In this historical context, it should be noted that the time and place was such that the non-violent manifestation of mental illness was largely ignored and the knowledge of modern psychiatry, or the concept of hospital treatment was unknown. Hence, the decision was based on common sense and “popular justice”, viewed through the layman’s vision of the state of the proposed ward. Yet, the emphasis was on the management of the property and care of assets and dependants, rather than on care of the person. As such, guardianship was basically designed to deal with men of some wealth who had property and who became incompetent to manage their affairs.

Guardianship and incompetence were then viewed both as a positive good, enabling incompetent people to preserve their assets and property through their guardian, and as a necessary evil, required to prevent harm to fragile and mentally incompetent persons.

The 18th and 19th centuries were times of great changes in the attitude toward the “lunatic”. Philosophical ideas changed dramatically and new scientific approaches emerged. Case law on incompetence developed and the rigid criteria of “lunatics” and “idiots” gradually changed and expanded to include persons who, while not lunatics in the technical sense of the term, had become incompetent to manage their affairs. Typical of common law, this change was gradual, based on case-to-case law, with no “black letter” law reform.

This historical legal background was the basis for the definition of competence in the early days of Ontario law, as seen in the 1887 Act Respecting Lunatics. The Act used the same legal terms (and the same paternalistic rationale) as the historical lunatic mediaeval Legis. The first legislation adopted by Ontario was therefore no more than a consolidation of the existing common law. The Act was clear and simple:

An Act respecting Lunatics:

1. The word “lunatic” in this Act shall include an idiot or other person of unsound mind.

This definition basically remained unchanged in the new Lunacy Act that was enacted in 1909.
2(e) "Lunatic" and "Lunatics" shall include an idiot and a person of unsound mind.

(f) "Lunacy" shall include idiocy and unsoundness of mind.

Thus, incompetence was defined by Ontario law in mediaeval terms, which could be characterized as "status-based incompetence", a classification designed to protect one's property rather than one's mental health. One had to fit into a special "status" which, although it didn't have a clear legal definition (what is "unsoundness of mind"?), was socially and historically recognizable through the eyes of societies' morals and customs.

Historically, then, the elderly population didn't fall into the status-based definition of incompetence. This legal fact could be explained in two ways: (1) 

Demographically: there were no "elderly" people (or at least no significant elderly population) at that time. One has to remember that at the beginning of this century, the average life span was not more than 45 years, and proportionally the population beyond 65 was insignificant. 

(2) Historically: At the beginning of the century the social morals and customs provided that care for the incompetent elderly fell to close family members. The elderly who were not taken care of by their families were considered lunatic, and thus entered the legal status that justified guardianship.

2. THE "INCOMPETENCE" ERA

As noted, the early lunacy legislation in Ontario was an adoption of the traditional common law. The first signs of a shift in legal and social thought in Ontario in the field of guardianship was made only in 1911, when an amendment to the Lunacy Act was enacted, introducing a new definition to legal incompetence:

The powers and provisions of the Lunacy Act, relating to management and administration, shall apply to every person not declared to be a lunatic with regard to whom it is proved, to the satisfaction of the court, that he is, through mental infirmity, arising from disease, age or other cause, or by reason of habitual drunkenness or the use of drugs, incapable of managing his affairs. [Emphasis added]

The change in Ontario law was not an original legal development but rather a reflection of the developments in English law. In 1853, the English Lunacy Regulation Act made a provision for a "Master in Lunacy" to hold inquisition with regard to lunatics. In 1862, the Act was amended to introduce a new system of "official visitors" (two physicians and one barrister, who were charged with the task of visiting the lunatics), and more important, the Act introduced for the first time a new category of lunatics: "People whose unsoundness of mind was established to the satisfaction of the Master or Judge in Lunacy, not by judicial enquiry but by medical evidence of incompetence".

The shift was clear, obvious and dramatic as not only the lunatics and idiots were subject to guardianship, but a much wider segment of the population was suddenly covered under this legal umbrella: people who were medically infirm.

Moreover, a special category was formed, the "age" group, which theoretically included both minors and elders. However, with regard to the elderly, it was the first time in Ontario law that the elderly, due to the legal correlation between their "age" and their ability "to manage their affairs", became potentially subject to guardianship by definition.

This development culminated in 1937, when the Lunacy Act was amended once more, and the legal terms "lunacy" and "lunatic" were replaced by the terms "mental incompetence" and "mentally incompetent person".

The definitions were also amended, such that ss. 1(e) and (f) were replaced with the following provisions:

(e) "Mentally incompetent person" shall mean a person

(i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or

(ii) who is suffering from such a disorder of the mind, that he requires care, supervision and control for his protection and the protection of his property;

(f) "Mental incompetency" shall mean the condition of mind of a mentally incompetent person. [Emphasis added]

The change in the legal terminology and the change in the procedure signified something much more basic and reflected the broader social changes that occurred during that time period. The development of medicine, biology, a more "scientific" legal culture, and especially the emergence of modern psychiatry, with its then novel perspective on human behaviour, established the groundwork for changes in the historical language. Thus, lunacy was replaced by incompetence.

The legislation passed during that period tended to place greater importance on the medical models of insanity and treatment. The term "incompetence" in itself often appears to be perceived, or even intended by the statute, as a "diagnostic entity" rather than a term of legal status identifying or suggesting a limitation on legal rights. This perception, therefore, produces the rather startling logic that a person is incompetent because the person is incompetent.

The use of the term "incompetence", then, reflected the rise of medical authority that occurred at the same time, which led to incompetence becoming a medical,
rather than legal, question. Courts turned to medical experts who testified about matters beyond the knowledge of the layman. Consequently, the medical opinion as to mental competency became the ultimate legal question.

Not surprisingly, under the Mental Hospitals Act, which was in force at that time, the definition of "mental defective" and "mentally defective person" were very similar. Law and society were now interested not only in one's property but also with one's health and the medical treatment that could be provided. The legislatures and courts found it much easier to rely on medical classifications in order to avoid making judgments about what kind of behaviour amounts to mental incompetence. There was a natural reluctance to impose guardianship on the basis of merely abnormal, inappropriate or irritating behaviour, and the medical model afforded the law a scientific, "neutral" justification for its decisions.

In fact, only very few published precedents for the appointment of guardians under the Mental Incompetence Act can be found. Therefore, a detailed account of the law governing this procedure is impossible. However, it is clear that the words of the statute, by themselves and without the medical model, are meaningless. It is only the medical model (i.e., the basic idea that behavioural variances are analogous to disease in the physical body), that gives the legal concept of mental incompetence any real content.

This legal stage could be characterized as the "disabling condition test" — meaning a medical approach that requires the finding of one or more types of disorders or disabling conditions as a prerequisite for determining incompetence. Specifically, such disabling conditions could be a mental disease or another cause, for example, old age.

However, the changes in the definition of incompetence did not change the legal result, which was the total loss of legal control and autonomy by the incompetent person.

Thus, historically, the legal shift from lunacy to incompetence was based on changes in values and power. Although the paternalistic rationale of guardianship remained unchanged, the scope was extended not only to property management but also to the medical treatment given to the person. Moreover, in terms of social power, it reflected a shift of power from the "father of the country" (the King) and the "community" (the jury) to "medical professionalism" and "scientific authority". This power shift was brought about by scientific advancement (or what was perceived then as advancement) and acceptance of the values embedded in scientific authority, and by the legal adoption of these values in case law and legislation.

PART 3 — FROM INCOMpetENCE TO INCAPACITY

1. NEW VALUES

As already discussed, both the legal concept of lunacy and incompetence were based on good intentions. Both assumed that in certain cases, someone other than the individual in question could better manage their personal and economic affairs.

However, by the end of World War II, and especially in the mid 50s and early 60s, new values were gaining social and political standing in the legal realm, fueled by the human rights movement in the United States and the use of legal rights rhetoric as a tool for social change. The right to autonomy, personal freedom, self-determination, personal beliefs, freedom from unnecessary intervention, in short, the democratic concept of liberty as letting people live as they choose without interference so long as they do not break the law or endanger others, were all part of the human rights movement.

Under these new values, guardianship, as a power to determine where people shall live and with whom what they shall eat, what they shall wear, how they are to spend their time or money, etc., was seen as one of the most intrusive encroachments that a democratic society could impose.

Benevolence was now viewed in a totally different perspective:

We must beware of the dangers which lie in our most generous wishes. Some paradox of our nature leads us, when once we have made our fellow men the object of our enlightened interest, to go on to make them the object of our pity, then of our wisdom, ultimately of our coercion.

Paternalism was now perceived as a "tragic paradox":

Perhaps the most important of all, when dealing with all issues of competency, we must be ever mindful of the fact that decisions in this area, most often made with the best of motivation in an attempt to help the individual, frequently have the tragic and unintended effect of depriving an individual of his/her feeling of self worth and sense of autonomy and freedom.

Thus, the incompetence concept was criticized as failing to "recognize the possible damaging effects of excessive benign paternalism".

Moreover, beyond the ideological resistance to the traditional definition, there was also public awareness of the abuse of guardianship by guardians, who in many cases did not protect but controlled and exploited their ward, along with a social decline in the force and authority of the conventional medical and psychiatric establishment.
Influenced both by this new ideology and by the critics of the existing concept of incompetence, Ontario sought to reform its law. However, it wasn't guardianship law that was first to be reformed, but rather the field of mental health and the rights of patients. In 1967, a new Mental Health Act was enacted that replaced the older Mental Hospitals Act of 1950. The new Act introduced not only procedural rights and due process safeguards for the mentally ill but also separated the legal assessment of competency to manage one's estate from the diagnosis and legal determination. As more research was conducted, doubts regarding the most basic premises of psychiatry were becoming widespread. In 1978, the time was right for further amendments to the Mental Health Act. The amendments further recognized patients' rights and gave some regard to the concept of incompetence in the estate-management sphere.

Meanwhile, since the early 70s, representatives of the ministries of the Attorney General, Health and Community and Social Services began meeting over the problem of guardianship legislation. The issues in the broader community in the late 70s and early 80s tended to be about the management of the estates of persons found incompetent, rather than the determination of incompetence. However, by 1984, the then Attorney General, Roy McMurtry, appointed an advisory committee on “the law related to the management of the property of persons incapable of managing their own property”. The committee was comprised of representatives of a wide range of government departments, lawyers, financial experts and specific human rights groups. The committee issued an interim report in August 1985, which provided a broad discussion of the existing law and necessary reforms. For the first time, it was recognized that a determination of competency was an essential element of law reform, and the committee formulated a recommended test of competency to manage property.

During that time, the Supreme Court of Canada rendered its decision in Re Eve, which was widely publicized. The case involved an application by a mother for committeehip of the person for her developmentally handicapped adult daughter, and authorization for the performance of non-therapeutic sterilization. The case had a significant impact on defining the scope of parens patriae power. In response to the mounting issues surrounding the questions of competency and guardianship, the Government of Ontario expanded the mandate of the Fram Committee to include all aspects of substitute decision-making for mentally incapable persons. The 1987 report included draft legislation and proposed a totally new definition of “legal incompetence”.

In response to the difficult issues raised by the Fram report, in 1988, the Ontario Minister of Health arranged for the creation of another committee, which was designed to make an “Enquiry on Mental Competency.” The committee was headed by Professor David N. Weisstub. The Weisstub Committee handed down its report in September 1990.

Following the 1990 provincial election, the newly elected NDP government carried out the task of enacting the recommendations of these committees into legislation.

2. ONTARIO'S GUARDIANSHIP LAW REFORM

In very general terms, the law governing guardianship and the new definition of “competence” (or rather “capacity”) could be described as three-tiered legislation: The Substitute Decisions Act covered both decision-making regarding property and personal care; the Consent to Treatment Act covered decision-making with regard to medical treatment, admission to care facilities and personal assistance services; and the Advocacy Act provided advocacy support for those who were subjected to the authority of the other two Acts. Functionally, the whole field of decision-making was divided into: (1) property management; (2) personal care (which consisted of health-care, nutrition, shelter, clothing, hygiene and safety); (3) medical treatment; (4) personal assistance; and (5) admission to care facilities.

With regard to the concept of “competence”, the legal term was replaced by “capacity”, and the basic components of the new definition were the same in all three Acts. For example, under the Substitute Decisions Act, incapacity to manage property was defined as follows:

6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. [Emphasis added].

Incapacity for personal care was defined as follows:

45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision [Emphasis added].

And in the Consent to Treatment Act, “capacity” was defined as follows:
4. A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision [Emphasis added].

Both the Substitute Decisions Act and the Consent to Treatment Act gave further specific definitions of capacity, such as in the capacity to give continuing power of attorney for property (s. 7 of the Substitute Decisions Act) and for personal care (s. 46), and in all cases used the same basic cognitive requirements of the ability to understand the relevant information and the ability to appreciate the reasonable foreseeable consequences.

To complete the historical picture it should be noted that Ontario’s legislation has since changed. Three years ago, shortly after the election of a new Conservative government in Ontario, the Advocacy Act (which was an important, if not the most important, building block within the whole legislative product of the law reform) was repealed, based on strong ideological grounds and the Consent to Treatment Act was replaced by the Health Care Consent Act, 1996. However, no changes were made to the definitions of “incapacity”, and for the purposes of our discussion, the current Ontario legislation as a whole will be referred to as “Ontario’s guardianship law reform”.

The most important features of Ontario’s guardianship law reform with regard to the definition of incapacity can be summarized as follows.

a. The Presumption of Competency

Ontario’s guardianship law reform put into black letter law what was well known to common law — the presumption of competence. As stated in s. 2 of the Substitute Decisions Act, every person who is 16 years of age or more is presumed to be competent with regard to his or her own personal care. Although not a novel invention, this new legislative declaration made a clear statement about the general rule of the legal presumption of competency.

b. The Distinction Between Old Age and Incompetence

Not only did the new legislation introduce the presumption of competence into Ontario’s black letter law, but it very clearly separated the new criteria of incapacity from old age. In that sense, the new legislation broke down the incompetence era, which was ruled by the myth that there was a correlation between age and competence. Absent the appointment of a guardian or a substitute decision-maker, elderly persons are presumed capable to make legal decisions and have the same rights and legal status as any other competent person in society. Age, per se, is not relevant, and is an illegal factor in the determination of capacity under the new law. The elderly, as a group, cannot and should not be treated any differently with respect to guardianship than any other capable adult.

It should be emphasized that the separation between old age and any concept of incompetence is well supported by scientific research. As studies show, individuals vary enormously at any given age with respect to almost all human characteristics. The findings are that any generalizations about the aged are unsound, making chronological age a poor indicator as to the state of a person’s mental alertness. The new presumption of competence along with the separation of age from the definition of incompetence is of significant importance in a reality where elderly people have to prove they are competent and autonomous.

c. The Separation Between Mental Illness and Physical Disability from Incompetence

As already mentioned, the incompetence era was closely related to the field of mental health, to the extent that similar standards were applied in both fields. Legally, however, the two fields of law were distinct, but as a matter of fact they were blurred by the use of similar terms and by the way the courts applied the law.

The breakthrough of Ontario’s guardianship law reform is in its total separation between the mental health of a person and his or her legal capacity in the guardianship realm. Mental health has nothing to do with one’s capacity, and one’s legal capacity does not necessarily imply anything about one’s mental health. This legal distinction and separation is of great importance to both the mentally ill, who do not automatically lose their legal capacity, and to the elderly, who are not assumed to be mentally ill, even if found legally incapable.

The same is true with regard to the separation of physical disability and incompetence. Although previous case law had established the rule, Ontario’s guardianship law reform deliberately defined “incapacity” to make it clear that it excludes any physical disability.

d. Competency as Capacity to Make Decisions

The most significant breakthrough in Ontario’s guardianship law reform was the replacement of the “legal incompetence” concept with the “legal incapacity” concept. The change in terms is nothing less than a revolution in the legal understanding of the concept.
The new legal concept was actually part of the recommendations of both the Weisstub and Fram committees. The rationale behind the change in legal terms was to minimize the social stigma ("incapacity" being less stigmatizing than "incompetent"), and to focus more attention on functional parameters and the abilities of the person within the context of the decision to be made.

However, the change was much more than an attempt to find a more neutral linguistic term. In contrast to competency, decision-making capacity is defined as the ability to make an acceptable choice with respect to a specific decision and not with any general ability to be legally independent. Both the Weisstub and Fram committees actually recommended a total change in the basic understanding of the concept of "incompetence". Instead of a tool to bring about a loss of legal standing, a new understanding of the concept was introduced, defining and associating it with a decision-specific capacity. Or, in the words of the Weisstub Report: "...the ability to make an informed choice is the essence of mental capacity." 84

The ideological and legal theory that equates legal capacity in the guardianship realm with the ability to make decisions forces the legal evaluation and assessment of that human ability, making the decision-making process the subject of our legal concern. It is usually thought that decision-making means an evaluation of alternative choices. The alternatives and their outcome have to be delineated. The preferences for each particular outcome need to be specified and understood in light of values held. The trade-offs made in selecting an outcome need to be articulated. 85 The essence of this approach is testing one's ability to understand relevant information and appreciate the reasonable consequences of the decision. 86 The rationale of this approach is a liberal one: if a person has those cognitive abilities, then he or she is the only and final decision-maker, and no one, including the state, even the court, is required to specify whether guardianship will be partial or full, but if partial, the court is required to provide the exact scope of the specific functions referred to in s. 45 of the Act. 91

f. Capacity as a Dynamic Status

A different aspect of the change in terms was the understanding that an individual's capacity may alter over time. While "incompetence" tends to suggest a more permanent status, "incapacity" tends to suggest a temporary condition. Thus, it is agreed that a finding of incapacity ought to be easily reviewable and by no means final or conclusive. A finding of legal incapacity should not be perpetual, but should merely extend as long as the actual incapacity of the subject persists. 92

Again, this dynamic perception of incapacity is not only implicit in the term itself, but also explicitly set out in different sections of the new legislation. 93

g. Overall

Similar to the legal shift from lunacy to incompetence, the legal change from incompetence to incapacity was a mix of social values and a revolution with respect to the balance of power. This time it wasn't only about the scope and content, it touched the very essence of the social rationale behind guardianship too. Paternalism was replaced by individualism. Driven and motivated by new social values and individual rights ideology, the new legislation "...shifts the power balance from the
knowledge, technology, and authority of the professional to the wishes and autonomy of the patient.\textsuperscript{94} This power-balance revolution was part of a wider social movement — a reaction to a historical paternalistic concept of the state and authoritative medical models — and adopted a liberal, individual-rights ideology that took aim at the wrongs perceived to be inherent in the previous incompetence concept.\textsuperscript{95}

PART 4 — BEYOND “CAPACITY”?

As we have seen, Ontario’s legal definition of incompetence in the realm of guardianship has changed dramatically, being transformed from archaic “lunatic” status to the novel concept of “incapacity”. Nothing less than the term “legal revolution” can truly describe this change, with “incapacity” replacing “incompetence” as the threshold for guardianship and substitute decision-making.

However, we now face our imaginary scenario, and thus the obvious questions: Did Ontario achieve the desired social and legal balance? Does the new legal concept and its underlying values create the correct balance between elder freedom and elder protection? Does the reliance on cognitive rationale imply support of scientific cognitive tests?

As I will now try to show, not only is the new “incapacity” concept inappropriate, but its inappropriateness may lead us to the wrong answer in our imaginary scenario. The flaws and problems will be introduced in two levels: (1) the internal level, which will represent flaws within the legislation itself; and (2) the external level, which will represent flaws that can be recognized from a wider perspective.

1. THE INTERNAL LEVEL

a. The Self-Contradictory Nature of Classification and Categorization

If incapacity is, or should be, “decision-specific”, how can one justify the gross classifications within the new legislation? Are the legal classifications of “health care”, “nutrition”, “shelter”, “clothing”, “hygiene” or “safety” really justifiable? Is it not possible, for example, that a person will have capacity to handle a bank account but not stock market investments? Can we really separate the different aspects of daily life within the context of guardianship? Do decisions regarding property not affect personal care decisions and vice versa? Does a decision to accept certain personal care not involve economic decisions too?

If the new legislation were honest in its commitment to a decision-specific orientation of incapacity, no such classifications would have been adopted. The new legislation tried, and failed in my view, to join two contradicting concepts: first, a specific decision-making criteria similar to that which is required in an informed consent scenario; and, second, the non-specific character and nature of guardianship that involves areas of human behaviour (i.e., taking care of oneself), which by nature cannot be treated or viewed as a singular, one-time, specific decision-making process; rather, it is a total, ongoing, complex social relationship.

b. The Artificial Nature of the “Decision-Specific” Relationship Between the Ward and the Guardian

Can the relationship between a person and his or her legal guardian be truly described as a decision-making relationship? Do we wish to characterize the people whom we nominate as guardians of the elderly as “decisions-makers” only? Does the legal concept of decision-making capacity imply that after the guardian has made the decision for the incapable person, he or she then disappears into thin air leaving the ward to him or herself? Can the true or right relationship between the ward and his or her guardian be incidental and decision-specific?\textsuperscript{96}

Take the extreme example, which all proponents typically use as an undisputed example for the social justification of nominating a guardian — a patient in a vegetative state. Can we describe the relationship between that person and the guardian as a “decision-making” relationship?

In that sense, the adoption of the incapacity concept totally contradicts our social expectations of the guardian and the nature of his or her social interaction with the person for whom he or she is supposed to care.\textsuperscript{96}

c. The Fallacies of Cognitive Ability as a Sole Criteria for Incapacity

The vast majority of current academic literature on assessment of the elderly acknowledges that the term “incompetence” is multidimensional, encompassing a wide range of interpersonal, social, psychological and environmental factors.\textsuperscript{97}

Ontario’s legal focus on the individual’s decision-making capacity gives short shrift to the array of external factors that could facilitate or inhibit the exercise of such capacity. In particular, the law has not attempted in any way to assess the relationship between the social environment and the person’s capacity to make decisions (a relationship that psychologists view as paramount in assessing decisional capacity).\textsuperscript{98}

Social functioning is interactive: it involves people in interaction with each other and their environment, filling social roles and coping with socially derived
stress. Conventional wisdom now holds that the physical, mental and social well-being of an elderly individual are very closely interrelated. Thus, functional independence, despite disease, physical or mental disability is a more relevant indicator than the cognitive indicator. As one scholar concluded:

Another conclusion that emerges from the accumulative experience with capacity standards is that, while a cognitive functioning test may be a necessary component, it is not sufficient in itself to establish incapacity in the guardianship context. Some form of consequential behaviour elements remains essential to tests of capacity.

The total separation of physical disability from the concept of “incapacity” is not simple. In some cases, physical disability could be very relevant to the overall assessment of the older person’s ability to take care of him or herself, making limited guardianship very helpful, while the current definition does not allow for such considerations.

The sole reliance on cognitive ability also assumes that this ability could be characterized as either existing or non-existent. However, in reality, this ability may diminish gradually over a long period of time. During this gradual process, while still medically or psychologically “capable” (under the cognitive standard), the elderly may be victimized or neglected by others. The “incapacity” concept makes it difficult for us to look beyond those cognitive boundaries, into the very important social considerations that are relevant in understanding the limits on the autonomy and true self-determination of the elderly.

Moreover, the concept of cognitive decision-making capacity completely ignores the ability to function on a daily basis. Research indicates that mental status testing does not predict one’s functional status. For example, one study found that patients’ scores on the Short Portable Mental Status Questionnaire (SMPSQ) were only weakly correlated with the ability of the patients to take care of themselves. Thus, different states in the United States have chosen to mix and match the cognitive legal standard with other conventional legal criteria (such as the “functional behaviour test”) in order to overcome the limits of the narrow social perspective inherent to the cognitive test.

Defining capacity, in the context of guardianship using a cognitive, decision-making ability test, is therefore both overly inclusive and overly exclusive. It can unjustifiably include elderly people who do not possess cognitive ability but who have social support and thus no need for guardianship, and it can also exclude elderly people who are in real need of protection and support, while formally still with the cognitive ability to make decisions.

d. The Actual Assessment of “Decision-Making Capability”

Under the basic logic and values of the incapacity concept, the assessment of the person’s capability should be oriented to assess his or her specific capability with regard to the specific decision. However, under the new legislation, the assessment has major similarities for all decisions or classifications, and the weight of the specific decision made, with respect to the whole assessment, can be outweighed by other, non-specific components of the assessment.

Moreover, none of the current “non-legal” cognitive tests (and there are many different cognitive ability tests, each with its own emphasis and specific flaws) can be characterized as “decision-specific” oriented. For example, the following cognitive tests: VIRC Orientation Scale; Mental Status Questionnaire Dementia Rating Scale (DRS); Quick Test (QT); Min Mental State; and Geriatric Interpersonal Evaluation Scale (GIES) are all general psychological tests, each with its own method and orientation, but none an decision-specific. In the context of guardianship, can useful distinction be made between the answers to questions such as: Where do you live? Where is your room? Is it morning or afternoon? How do you fee today? Have you noticed any change in your worries about your health?, and answers to a question like: “Do you understand that the risk involved in taking the medicine is that you will lose your hair?” The existin,cognitive tests are inherently non-decision specific and methodologically and scientifically, were not intended to be.

Finally, another inconsistency with regard to the “capacity” concept can be found in the qualification needed to become an assessor under the new legislation. Under s. 1(1) of the Capacity Assessment Regulations of the Substitute Decisions Act, one of the required qualifications for an assessor is his or her professional affiliation. The candidate has to be member of one of a closed list of colleges that are, for the most part, medical (physicians and surgeon psychologists, occupational therapists, nurses, or social workers). How can this medical orientation of the assessors be reconciled with the aim of the incapacity concept to be separate from the medical model?

e. The Vagueness of “Incapacity”

One of the goals of Ontario’s guardianship law reform was to dissolve the vague nature incompetence. However, the new incapacity concep
through its legal definition and use of terms such as “understanding” and “appreciating foreseeable consequences”, is vague all the same and subject to widely different interpretations and applications. What do we mean by “understanding”? Are there not different levels of the ability to understand? Are we talking about ability to understand or are we taking about actual understanding? Do you need the person to demonstrate actual understanding or is disclosure of the information of the nature and purpose of the treatment, its risks and benefits and available alternatives, sufficient? What do we mean by “appreciate”? The terms themselves are vague, and do not give us clear criteria on how to apply them or decide to what extent they exist? The truth is that although they are much clearer when compared to the previous terms, the new terms are also vague and ambiguous.

f. The “All-or-Nothing” Result

Another absurd result of the new legislation is the fact that changing the legal definition of incompetence didn’t change the total result of such a finding. In this respect, the change of definition did not resolve the extreme result of the total loss of legal ability to make decisions in the specific areas where incapability was found. Once a person is found to be “incapacitated” in a specific area, the person loses all legal rights in that area. Incapacity, as with incompetence, leads to nothing less than the full loss of legal rights. Other less restrictive legal options, such as the appointment of a friend or assistant decision-maker, without the actual loss of legal competence, were not adopted under the new legislation. Thus, Ontario’s incapacity concept ignores the gray areas of cognitive status. As was stated in the Banto case:

“Mental incapacity... is a matter of degree, and the degree of weakness differs in the same individual under different circumstances, according to the different habits existing and the different situations in which he is placed, at one time or another of his life.”

The decision-making capacity of an elderly person may be in a process of gradual or rapid decline, or it may be subject to fluctuation as a result of a variety of environmental, emotional or even pharmacological reasons. Accordingly, elderly persons may remain in a state of questionable capacity for an extensive period. Adopting a cognitive-based test, with an all-or-nothing result, may limit the scope of the loss of autonomy and freedom. However, in the specific field of incapacity, the totality of the result is the same. Other jurisdictions adopted legal alternatives, such as the nomination of an “assistant” or a “tutor” who, while legally authorized to help and support the person in need, are not legally excluding the decision-making capacity of that person.

At this point, it should also be noted that one might challenge altogether the presentation of incompetence as an all-or-nothing concept. If the guardian has a legal duty to honour his or her ward’s wishes, even if found incompetent, in reality, some large portion of autonomy could still be in the hands of the ward. For example, a guardian may well honour the ward’s autonomy and will not intervene in the ward’s decisions on dress or attire, but at the same time will not allow him or her to go on a trip alone. Anyone who has been a parent knows the daily “negotiations” between respecting a child’s self-determination and exercising parental duties, a negotiation that, although paternalistic, leaves room for autonomy (which widely differs and depends on the specific case). Is the legal result of nominating a decision-maker with narrow parameters better than full personal guardianship? I believe the answer depends on a number of considerations; Ontario believes the sole consideration should be the elderly person’s cognitive ability.

2. THE EXTERNAL LEVEL

a. The Social Utility of Guardianship and its Correlation with the Definition of “Incompetence” or “Incapacity”

If the social importance and value of guardianship is in its protection of the potentially vulnerable elderly population, it is clear (or should be clear) that “incapacity” (either in the wide “incompetence” sense, or in the narrower “incapacity” sense), cannot be the only relevant consideration in the legal decision to utilize guardianship.

On the one hand, an elderly person may be de facto incompetent and have no cognitive capacity to make decisions, but there will be no need to nominate a legal guardian or decision-maker, as the elderly person has a family member or friend to care for him or her and serve as his or her de facto guardian. This de facto guardianship, which in my view has enormous importance, is ignored by the new incapacity concept. In the case of a dispute before the court between the de facto guardian and a family member, for example, the court will be forced to nominate a guardian in light of the undisputed finding of mental incapacity.

On the other hand, an elderly person could be mentally capable but in need of protection and support, owing to any number of factors, such as being alone, having a physical disability, etc. Under the incapacity test, however, no legal justification will be found to intervene with his or her autonomy. The absurdity is that in exactly these types of cases,
guardianship is justifiable despite the philosophical and constitutional considerations of autonomy, self-determination and other liberal values.

Thus, the categorical view which was stated by the Fram Committee, and adopted under the new legislation — "...opposed to any legislation that would authorize involuntary intervention into the lives of those who are mentally capable" — ignores, in my view, both the complexities of life and the social values that should stand behind guardianship. Such an approach could actually cause harm to the elderly in the name of non-existent freedom or autonomy.

b. The Fallacy that Individual Rights should be Paramount in the Realm of Guardianship of the Elderly

Individual values are not the only worthy values that shape our society or personal lives. Values such as collective rights, family rights, feminine concepts of caring and human relationships with one's surrounding society play a significant role in our social behaviour and a special role in the lives of the elderly.

In that sense, it has been realized, at least to a certain extent, that using the legal rhetoric of individual rights to describe a human being oversimplifies the reality. The interests of the community, family, caregivers, medical professionals, as well as the interests of the individual, become lost in the artificially narrow ideology of individual rights. The elderly and society become legal adversaries, instead of encompassing a human, caring, reciprocal relationship. The simplistic adoption of arguments for individual rights promotes "the short run over the long term, sporadic crisis intervention over systemic prevention measures, and particular interests over the common good".

Thus, an elderly person's rights may be violated by both the state's failure to protect him or her and the state's constraints on his or her freedom. A different legal balance, and a wider perception as to the legal ingredients of "incapacity", will be achieved only through an approach that considers all of the different values and interests involved, and not simply individual values and interests.

c. The Contradiction Between the Nature of Guardianship and "Decision-Specific" Capacity

As emphasized in the first part of the discussion, there has always been recognition of situation-specific standards of competency: capacity to make a will capacity to marry; capacity to enter a contract capacity to drive, etc. A finding of incapacity in any of these matters could nullify only the specific legal action made by that person. In other words, a person could be found without the capacity to drive a car and such a finding would have no effect on any other legal obligation he or she made. In guardianship historically, the finding of incompetence led to the opposite, meaning it had a global application with respect to the inability of a person to legally handle his or her own affairs. Further, in the capacity-specific realm, the two sides are usually private parties, while in the guardianship realm, the parties are the individual, on one side, and the state (or society), on the other. Finally, unlike guardianship laws, situation specific legal doctrines were never concerned with the general status of the person.

Guardianship, unlike situation-specific capacity, is a dynamic, continuous relationship. For example, in the context of long-term care:

Legal precedents rarely view decisional capacity as a dynamism process involving the interplay of a variety of variables that constantly change over time. The element of time is crucial to the extent that external events, for example moving into a nursing home, might cause temporary incapacity that could be restored over time.

In other words, the essence of guardianship is not about any specific decision-making. The rationale an aim of guardianship is to serve as a legal and social safety net when all other social mechanisms have failed, and to allow intervention in order to protect the elderly from abuse, neglect, or harm. Such an intervention, by its nature, is not decision-specific as its scope is much wider than simply to make decisions on behalf of the ward. Intentional or not, the change in the legal concept and the adoption of the incapacitation standard actually diminished the social value of guardianship without proposing a legal alternative. Thus, the elderly were stripped of an important legal tool that could have been used to protect them.

d. Is the Heart of the Problem Within the Definition of Incompetence?

The outstanding characteristic of Ontario’s labour reform was in the intellectual effort in finding the correct legal definition for capacity, disregarding the natural inherent limits of the term:

No matter how articulate, detailed, or comprehensive the legislative definitions or substantive standards, incapacitation for all but the most clear cases will depend on a malleable weighing process — that is, the judicial task ultimately, is to weigh medical variables, social variables, a
a constellation of very practical variables, relating to the need for state intervention in a unique situation.\textsuperscript{124}

Hence, if we really care for the elderly and wish to preserve their rights, autonomy and self-identity, we must realize that it is not a clearer legal or medical definition of incapacity we should be looking for but rather a clearer definition of guardianship. In my view, the questions should not be about the legal definition of competency or capacity. The real question, from a legal and social perspective is what, under the current social and constitutional order, justifies guardianship for an elderly person.\textsuperscript{125}

Competence tries to balance personal autonomy with the need for security through paternalistic intervention. The balance is indeed the true question, but the balance should be based on a holistic approach to guardianship and not on the specific definition of competence. Only through a legal analysis of guardianship as a whole, with its procedural safeguards, legal alternatives and wider legal and social perspective, will a balanced definition of the term be realized. Incompetence or incapacity, in this context, are only one of many legal factors of that balance. Nevertheless, standing by itself, the concept should reflect the correct social balance — something the incapacity concept failed to do. For example, in the case where a person claims that a contract should be declared void, the question is whether, for the purposes of the contractual policy consideration, should a specific party be considered incapable. Thus, the field of commercial contracts can hold specific social interests or values, which will lead the judicial system to adopt a certain balance. In its attempt to find the correct definition of incapacity, Ontario overlooked the most important questions: What are the social goals of guardianship? What is its rationale? What and where is the correct balance and what are the competing interests and rights? Where should guardianship stand with regard to other legal alternatives?

The correct answers can be given, ultimately, only from a totally different perspective, not from any attempt to define or refine "lunacy", "competency", or "capacity", but rather from the attempt to legally and socially define, or perhaps re-invent guardianship and its relationship to other legal instruments, such as substitute decision-making, other protective social services for the elderly, legal planning tools, advocacy programs, etc. This was never done by the Ontario legislature and this is the major problem with the current law in Ontario.

CONCLUSION

Competence is a legal term that exists in a permanent state of tension: on the one hand, it is an important legal tenet that serves to protect and promote the autonomy of the elderly population. On the other hand, it represents the threshold of a most offensive legal procedure — taking away from the elderly person his or her legal autonomy and basic rights. To find the "golden balance" within this tension is one of the greatest challenges facing our legal system and society.

As we have seen, the different terms used in this field such as "lunacy", "incompetence" and "incapacity" are all fictional terms. Not only are they vague, but they are neither scientifically-based nor neutral in content. They encompass social values and reflect the balance of political powers.

Historically, Ontario, by adopting an easy way to resolve this conflict, connected the decision to appoint a guardian with the traditional, all-or-nothing, "lunatic" concept of the popular social understanding of incompetence. As medical understanding and knowledge shifted from the archaic concept of lunacy to a more "scientific" approach to mental illness, the law went along with it, adopting a medical model as having authority over the understanding of incompetence.

Ontario's shift to the capacity concept of guardianship was, in that respect, a historical breakthrough which, for the first time, disconnected guardianship from its paternalistic values, from its "mental health" attitude, and from its ageist stereotype. The new concept adopted a true ideological agenda of individualism and autonomy, transferring the decision-making power from the medical profession to the individual.

However, a detailed assessment of the Ontario experience indicates, in my view, that it failed to find the "golden balance" between the competing values. Three main reasons should be recognized for this failure: (1) Historically, the incapacity concept was a reaction to the incompetence and lunacy doctrines. It was not a neutral, scientific evaluation of the needs of the elderly with respect to guardianship. One may assert that all legislative reform is a reaction, but sometimes the outcome is not balanced precisely because of the reactive nature of the reform. Ontario's good intentions in trying to break away from the historical wrongs of the incompetence concept made it blind to other values and interests that should have been taken into consideration. (2) Ideologically, the liberal, individual rights theme ruled Ontario's legislation. The adoption and promotion of liberal and individual values was done without sufficient scrutiny as to its application to the special needs of the elderly. A wide range of factors — biological, physical, social, environmental, etc. — were disregarded, with the result that the elderly now find themselves in need of a more careful and
cautious attitude in applying purely individual rights.

(3) Transferring guardianship into a decision-specific legal concept without a true analysis of the roles and functions of guardianship. The true questions with regard to the aim and social function of guardianship were never asked by the Ontario legislature. The needs of the elderly and empirical data about the essence of guardianship were never checked. The functional differences between guardianship and specific decision-making were overlooked. Thus, the attempt to resolve the question of guardianship was made from the perspective of the definition of competence and through solving the problem of decision-making. However, the only way to resolve the internal tension within the context of guardianship is to define its rationale, purpose and scope in becoming part of a larger legal framework to protect the elderly.

While there is no dispute that Ontario's original intent (which included the Advocacy Act), was for a good cause, and while the result is a substantial improvement compared to the concept it replaced, there is still a need to further develop, and maybe re-invent, guardianship with regard to the elderly.

What then is the answer to the ACCT initiative? Well, the answer by now should be clear. Neither the ACCT test nor any other biological or scientific test could resolve or replace the legal definition of “incapacity” in the context of guardianship. Assessment of capacity of elderly people involves conflicting values and powers that only a broad social and political process can resolve.

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The data is based on a statistical prediction made by Statistics Canada in: A Portrait of Seniors in Canada, 2nd ed. (Statistics Canada, 1996), at 12.

This assumption is based on current research about elder abuse and neglect. See P.L. McDonald et al., Elder Abuse and Neglect in Canada (Toronto, Butterworths, 1991), at 17.

Substitute Decisions Act, S.O. 1996, c. 2, ss. 3-60.

Health Care Consent Act, S.O. 1996, c. 2, Sch. A.

The Oxford English Dictionary, 2nd ed., see “competence”.


B. Quarrington, Approaches to the Assessment of Mental Competency (1994), 15 Health Law in Canada, 35 at 36.


Enquiry on Mental Competency - Final Report, (Chairman Prof. David N. Weisstub, Toronto, 1990), at 30.

Supra, note 1, at 12. It should be noted that this demographic trend is not unique and is shared by other Western societies; see ibid., at 19.

Ibid., at 12.

Ibid., at 20.

Supra, note 15, at 156.

Ibid., at 29.

In 1991, 8 per cent of all seniors in Canada lived in an institution, a figure which represents the large majority of all people in Canada living in institutions; ibid., at 27.

Currently, more than 8 per cent of all people aged 65 and over suffer from Alzheimer’s Disease or other forms of dementia; ibid., at 55.

Ibid., at 17. In 1995, 81 per cent of all non-institutionalized people aged 65 and over had some chronic health condition and the likelihood of being diagnosed increases substantially with age; ibid., at 56.

Ibid., at 94 and 102.

Supra, note 9, at 228.

Ibid., at 228.


Supra, note 29, at 97.

See *Peel v. Peel* (1912), 3 O.W.N. 1127, at 1128 (Ont. H.C.).


Supra, note 35, at 231.


*Lunacy Act*, R.S.O. 1887, c. 54, s. 1.


*Supra*, note 33 at 5.

In 1921, the senior population was less than 5 per cent of the Canadian population. See *A Portrait of Seniors in Canada*, 2nd ed. (Statistics Canada, 1996), at 1.

This is an interesting point, which I will study further in my thesis.

*Lunacy Law Amendment Act*, 1 George V (1911), c. 20.


*Enquiry on Mental Competency - Final Report*, (Chairman Prof. David N. Weisstub, Toronto, 1990), at 295 and see s. 32 of the Act.

It was only after the "informed consent" legal doctrine was settled that the logical extension could have been made between the right to refuse "care"/medical treatment, to the right to refuse "caring"/housekeeping assistance, visiting nurse supervision and other community interventions. See N. Dubler, *The Dependent Elderly: Legal Rights and Responsibilities in Agent Custody*, in S.F. Spicker, S.R. Ingman & I.R. Lawson, eds., *Ethical Dimensions of Geriatric Care - Value Conflicts for the 21st Century* (D. Reidel Publishing Company, 1987), at 137-39.

*Enquiry on Mental Competency: Final Report*, (Chairman Prof. David N. Weisstub, Toronto, 1990), at 295 and see s. 32 of the Act.

 Ibid., at 297.

 Ibid., at 305.


For a detailed analysis of the political and legal background that brought about the repeal of the Advocacy Act, see E. Lightman & U. Aviram, Too Much Too Late (not yet published).

Both the repeal of the Advocacy Act and the replacement of the Consent to Treatment Act were done in the Advocacy, Consent and Substitute Decision Amendment Act, S.O. 1996. For the purposes of this paper it should be noted that the definitions of “incapacity” were not changed in this legal replacement.

See also s. 4(2) of the Consent to Treatment Act.

Supra, note 61, at 227.

See the definition of “competence” as quoted in part 1 of this article.

See Clark v. Clark (1982), 40 O.R. (2d) 383 (Co. Ct.).

See s. 1 of the Substitute Decisions Act, “incapable means mentally incapable, and “incapacity” has a corresponding meaning”. (Emphasis added).

Supra, note 70.


It should be noted that neither of these requirements is simple or straight forward. In the legal field of informed consent there is a large philosophical debate as to the nature and scope of these requirements.

See W. Altman, P. Parmelee & M. Smyer, “Autonomy, Competence and Informed Consent in Long Term Care: Legal and Psychological Perspectives” (1992), 37 Villanova L.R. 1680, at 1682. Actually, the legal terms are the same. And for a general discussion which reflects the similarities in values see: I. Kenned & A. Grubb, Medical Law, Texts and Materials (London, Butterworths, 1989) at 190-96.


Supra, note 85, at B-2.

Supra, note 70, at 35.

See another example of marginality in s. 15(l) of the HCCA - a person may be incapable with respect to some types of treatment and capable with regard to others.

Enquiry on Mental Competency - Final Report, (Chairman Prof. David N. Weisstub, Toronto, 1990) at 35.

For example see s. 15(2) of the HCCA - a person may be capable with respect to a treatment at one time and incapable at another.


Oddly enough, and only to demonstrate how misunderstood the change was from “incompetence” to “incapacity”, in Simmons Estate (8 E.T.R. (2d) 210) the respondent objected to the conversion of the original application, which was under the Mental Incompetence Act, to an application under the Substitute Decisions Act - since under the previous “she had more rights”. The court correctly rejected that argument.

To be fair with the Ontario legislation, it could be claimed that the Advocacy Act should have provided the gap between the narrow “decision-making” legal function, and the broader “advocacy and support” social function. However, the Advocacy Act was repealed and Ontario’s concept of “incapacity” stands alone, without any wider legal support or advocacy for the elderly person. This only emphasizes the risk of adopting too narrow a concept.

Supra, note 87 at 1685.

Ibid., at 1681.


Ibid., at 1.

Supra, note 88, at 17.


For this critique see also Adult Guardianship Law in Canada, ibid., at 1-21. The most obvious example is abuse by family members. In many cases, the dependency of the elderly person on the family member, makes him or her afraid and unable to resist or dissent to the abuse, thus “consent” is given to the decisions made.


Supra, note 88, at 15-16.

One may correctly assert that this “over inclusive” character can be solved under the “least restrictive form of action” which is embedded into Ontario’s law reform (s. 55(2) of the Substitute Decisions Act). However, once the test under the law IS cognitve, and once the elderly person failed this test, the natural tendency of the courts will be to nominate a decision-maker, especially when no clear or trivial alternative will exist, or when the judicial action is the result of some sort of a conflict between different care-taking persons.

See part 4 of the assessment of property decision-making capacity, which includes medical, psychiatric, developmental or physical conditions along with the social and cultural context, all of which have been taken into account, potentially, by the assessor. Conducting Assessments of Capacity under the Ontario’s Substitute Decision Act: An Assessor Manual (1995).

For a thorough review of the different tests, description of the aim of each test and methodology, and the problems of validity and reliability of each test see...
both The Weisstub Report, supra, note 92 at 2-20 and Assessing the Elderly, supra, note 99, at Chapter 3 “Measures of Mental Functioning in Long Term Care”.

As a matter of fact, 70 per cent of the current assessors (as of March 1977) were from medical professions. See The Law of Consent to Treatment in Ontario, supra, note 94, at 127-28.

But see an attempt to clarify and define these terms in The Law of Consent to Treatment in Ontario, ibid., at 130-32.


For an overview of the difficulties of these legal terms see D.N. Weisstub, Law and Psychiatry in the Canadian Context, (Toronto: Pergamon Press, 1980), at 793-95.

Ibid., at 49.

Supra, note 102, at 107.

Not in the scope but in the loss of all legal rights in that specific legal field.

For an example of such a legal solution see the Quebec guardianship law which establishes three different levels of protective supervision: Curatorship (full guardianship), Tutorship (partial guardianship), and Advisorship (assisted decision-making), see L. Landry, “Models of Adult Guardianship”, in S.N. Verdun-Jones & M. Layton, eds., Mental Health Law and Practice Through the Life Cycle, (British Columbia: Simon Fraser University, 1994) 58 at 59.

Statistical data supports my assumption: The vast majority of elderly people live in private households. In 1992, 85 per cent of all person aged 65 and over, with disabilities, lived in a private household. (see A Portrait of Seniors in Canada, 2nd ed, (Statistics Canada, 1996) at 28). The majority of them received help and support with household and other personal chores (ibid., at 32). This support is given either by the spouse, children, other family members, neighbours or volunteers (ibid., at 32); if you add to these factors the statistical data from 1995, 33 per cent of all people aged 65 and over had some problem with cognition (ibid., at 58). The conclusion is that the “de-facto” guardianship is widespread in our society.


It should be repeated, that the Advocacy Act was, at least partially, the reply to this critic. Yet again, since repealed, it does not exist. I would further argue that it is questionable whether the Advocacy Act could have filled the legal gap which was created by the legal loss under the “incapacity” concept.


Under our definition one might claim that the questions are the same. This is true, however the intellectual process, and the logical direction in answering the questions is totally different: one is approaching it from the guardianship perspective, the other is approaching it from the “competence” perspective. Selecting the correct legal approach is vital, in my view, in reaching the correct result.