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Article

Conceptual and Ethical Problems in the Mental Capacity Act 2005: An Interrogation of the Assessment Process

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Abstract: Central to the Mental Capacity Act 2005 (MCA) is the claim that a conferral of incapacity may not be based on the wisdom of a decision alone. This paper problematizes this position. Values-based medicine is drawn on to explore the process of capacity assessment, highlighting the presence of preconceptions throughout assessment. Two cases before the Court of Protection are examined to bring into focus the complexity of conducting assessment without reference to wisdom. The paper proposes that every stage in the assessment of capacity is undertaken with reference to preconceptions and that an acknowledgement of these, along with transparency about when they are to be employed, would allow for greater clarity about what the MCA demands of practitioners.

Keywords: capacity assessment; Mental Capacity Act 2005; values-based medicine; Anorexia Nervosa; preconceptions

1. Introduction

On coming into force in October 2007, the Mental Capacity Act 2005 (MCA) formalised an approach for the categorising of personal action. Therein a distinction is made between individuals who have the capacity to make decisions and those who lack the capacity to make decisions. To facilitate the identification of an individual's action(s) as either capacitous or incapacitous, a definition of mental capacity is established, a set of principles governing the categorisation process is proposed, and a best interests procedure is established for decision-making where an individual's decision is

found to be incapacitous [1]. Central to the understanding endorsed in the MCA is a distinction between the perceived wisdom of a decision and a determination of a lack of capacity to make a decision ([2], para. 3). The fourth principle holds "a person is not to be treated as unable to make a decision merely because he makes an unwise decision" ([1], Part 1, Section 1). Thus any determination of a lack of capacity must rely on some additional requirement or issue other than a judgement about the relative wisdom of the decision. This requirement, however, does not imply that the wisdom of a decision plays no part in determining whether a person has capacity or not, simply that there is no direct equivalence.

In this paper, the continued support for the MCA and therein the distinction between wisdom and capacity is identified as ethically questionable in two regards. Firstly, what is this "other than wisdom" quality in any determination of capacity and how is the quality distinct from a judgement about the perceived wisdom of the decision? As the MCA allows for the actions of individuals to be interfered with, the basis on which such interference is permitted is of ethical significance. If the additional requirement goes unstated then the justification for such classification is obscured but also the basis on which individuals may challenge determinations of capacity is curtailed. Secondly, the proposed distinction between the wisdom of an action and the capacity of an action places a demand on healthcare practitioners to adhere to such a distinction. If capacity determinations are to rely on a judgement distinct from the wisdom of the decision then how the assessment of this "other than wisdom" quality must be achievable. Otherwise, the requirement that assessors comply with the MCA seems unclear at best and perhaps impracticable.

This paper begins by proposing an understanding of capacity in which legal capacity is distinguished from mental capacity. An awareness of this distinction allows for different approaches to capacity to be understood by the relationship, if any, they propose between legal and mental capacity. The approach adopted in the MCA, as situated in a historical context, is characterized by prohibitive and prescriptive aspirations. A disjunction is proposed between these two aspirations, whereby the MCA is clear in identifying what practice it seeks to relegate to the past but is unclear in how practice in the future should proceed. The distinction between wisdom and capacity and the requirement set out in the explanatory notes of Section 2(3) that the assessment of capacity is to be free from "preconceptions and prejudicial assumptions" ([3], para. 23) are evaluated from the perspective of values-based medicine. The MCA is interpreted as endorsing a distinction between sanctioned and unsanctioned preconceptions. Two cases before the Court of Protection, which concerned the capacity of two women diagnosed with severe Anorexia Nervosa, are examined. The purpose here is not to engage with the question of how the actions of individuals diagnosed with Anorexia Nervosa should be responded to. Rather it examines whether in practice the distinction between capacity and wisdom is maintained.

In response to difficulties in achieving compliance with the prescriptive aspirations of the MCA, the paper calls for greater transparency and a change in the language used in relation to capacity. The contention that action can and should be differentiated in to categories of capacitous and incapacitous action is itself a value judgement. How differentiating regimes such as the MCA chose to identify action as incapacitous is a further value judgement. Through changing the way capacity is spoken about, the values that first underpin the concept of capacity and the values that permeate capacity determinations may be brought to the fore, allowing for a better understanding of how we differentiate action and how would be assessors are to act in accordance with the MCA.

2. What Is Capacity?

The term capacity, as well as variants such as mental capacity and legal capacity, offers an approach for the categorisation of action and by extension persons. Legal capacity references the power an individual is afforded in a specific legal context ([4], note 6). Where a person is considered able to make decisions and is permitted by other to make such decisions, they hold legal capacity. Accordingly, the presence of legal capacity entitles a person to personal freedom, to script their engagement with others in legal relationships ([5], p. 10; [6], p. 3). A distinction can be observed between the passive capacity to have legal rights and the active capacity to exercise such rights. Legal capacity as such is the lens through which people are differently permitted to act in the world. Mental capacity in contrast, commonly refers to the ability, which individuals may or may not have, to make decisions. How mental capacity is defined is varied, reflecting diverging attempts to define what makes up the decision-making process. The concepts of mental capacity and legal capacity can be linked to each other as seen in cases where mental capacity is a prerequisite for legal capacity [7]. The understanding of mental capacity and legal capacity endorsed in any jurisdiction influences how the actions of persons can be categorised.

In 1989, the existing approach to categorising action in England and Wales was found to be lacking, leading to a period of debate addressing the nature of capacity. Although distinctions could be made between capacitous and incapacitous action, only where an incapacitous decision related to therapy, or property and analogous affairs, could others make a decision. The case of *Re F (Mental Patient: Sterilisation)* demonstrated this legal lacunae stemming from the passing of the Mental Health Act 1983, after which there was no mechanism for deciding what should be done where a patient is incapacitated and the issue in question is non-therapeutic [8]. In response to a perceived gap in the law [9], the Law Commission of England and Wales (hereafter, Law Commission) initiated an investigation into how legal procedures relating to incapacity could be reformed [10]. In considering three approaches to defining capacity, the Law Commission examined how the relation between mental and legal capacity should be understood.

A status approach allows for legal capacity to be determined on the basis of whether a particular characteristic can be attributed to a person. This approach holds either a correlation between the presence of a characteristic and decision-making ability: *i.e.*, the presence of a certain characteristic impairs or compromises decision-making ability. Alternatively, it holds that the presence of a characteristic should exclude persons from applying their decision-making ability: *i.e.*, people with that particular characteristic are not permitted to make decisions, regardless of whether they have the ability or not. The first relies on a link holding between mental capacity (as status) and legal capacity, the second on a link between status and legal capacity, disregarding mental capacity. A practical difficulty for such an approach lies in the determination of which characteristics should be associated with incapacity. Examples of a status approach would be the direct association of characteristics such as gender, sexuality, religious faith, race or disability with incapacity. The Law Commission in its 1995 document "Mental Incapacity", however, demonstrated opposition to a status approach on that basis that it failed to recognise capacity as decision specific. A status approach would be considered "out of tune with the policy aim of enabling and encouraging people to take for themselves any decision which they have capacity to take" ([10], para. 3.3).

An outcome approach allows for a determination of legal capacity on the basis of the decision made. What a person chooses to do in a situation can be assessed in terms of its appropriateness or acceptability. Such an approach is constrained in a similar way to the status approach, in that a framework is required to govern the evaluation of the appropriateness or acceptability of actions. The approach, as distinct from one based on status as legal capacity, hinges on what others think of the action and not what others think about the actor performing the action. A refusal to adopt an outcome approach is found in *Re C (Adult: Refusal of Medical Treatment)* [11], where the diagnosis of schizophrenia and the decision to forego medically advised treatment were not equated with a lack of capacity. The Law Commission in principle expressed opposition to this approach as it "penalises individuality and demands conformity at the expense of personal autonomy" ([10], para. 3.4).

A functional approach breaks from both status and outcome approaches, by placing mental capacity as central to any determination of legal capacity. Accordingly, capacity hinges not on the outcome or who has made the decision, but on the individual's action being preceded or accompanied by a set of tasks. Defining which tasks make up functional capacity vary from a focus on cognitive tasks such as expressing, understanding, appreciating and reasoning, to approaches focused on practical rationality [12]. The benefit of a functional approach lies in establishing a complex threshold before individuals can be found to lack capacity. In understanding cognitive or rational processes as indicators of capacitous action, functional approaches attempt to move away from determining capacity based on external factors (status and outcome) to an approach based on what is discrete to the individual, to what has been referred to as an individual's "actual functioning" ([13], p. 170).

3. The Mental Capacity Act 2005

The understanding of capacity adopted in the MCA proposes a fusion of functional and status approaches, whilst also rejecting approaches based on status or outcome alone. In Section 1, principles are set out underpinning the use of the Act, which reflect principles already established in common law. Principle 2 holds that all persons over 16 are held to have capacity until it has been established that they lack capacity. Principle 4 reads a person "is not to be treated as unable to make a decision merely because he makes an unwise decision". This principle suggests that a conferral of a lack of capacity must be based to a degree on an aspect that is not related to a judgement about the perceived wisdom of the decision.

In Section 2 a diagnostic requirement is established as a condition for any determination of a lack of capacity. For a person to lack capacity in relation to an issue, at a material time, they must be unable to make a decision "because of an impairment of, or a disturbance in the functioning of, the mind or brain" ([1], Part 1, Section 2). In limiting the possible attribution of a lack of capacity to individuals who meet the diagnostic threshold, the MCA contributes to the understanding that capacity or its lack is a property or feature of a person, as opposed to a judgment of an individual's actions by others. Where an individual fails to meet this diagnostic criterion, they may not be considered to lack capacity.

Section 3(1) clarifies the impact that a disability must have on decision-making ability. A person is considered unable to make a decision if they are unable to perform the following functions:

(a) to understand the information relevant to the decision;
(b) to retain that information;

(c) to use or weigh that information as part of the process of making the decision; or
(d) to communicate his decision (whether by talking, using sign language, or any other means) ([1], Part 1, Section 3(1)).

For a person to be found to lack capacity under the MCA they must be unable to perform one or more of the functional tasks of understanding, retention, use of or weighing, or communicating. Furthermore this inability must be caused by an impairment of their mind or brain [1]. The requirement of a causal link reflects the view of the Law Commission in 1995 that a diagnostic threshold would prevent a large number of people being found to lack capacity under a functional approach alone ([10], para. 3.8).

In addition to adopting a functional-status approach the MCA also rejects an outcome approach to capacity, echoing the position at common law that individuals may not be found to lack capacity simply on the basis of making an unwise decision [2]. This rejection demonstrates a recommitment to the distinction in law between the mental capacity of the decision maker and the wisdom of the decision made [14,15]. Section 2(3) of the MCA reinforces Principle 4, prohibiting value judgements that associate particular characteristics with a lack of capacity. Accordingly a person may not be found to lack capacity simply on the basis of age, appearance, a condition, or an aspect of behaviour ([1], Part 1, Section 2(3)). As stipulated in the MCA, any judgement about capacity on the basis of a status or behaviour alone "might lead them [assessor] to make unjustified assumptions about capacity" ([1], Section 2(3)).

The process for categorising action contained within the MCA can be viewed as comprised of prescriptive and prohibitive aspirations. Admirably, the MCA seeks to prohibit the labelling of individuals as lacking in capacity on the basis of status or outcome alone. Therein the MCA seeks to move capacity legislation away from practices in which individuals could have their actions interfered with on the basis of the wishes or interests of others. In contrast the practice prescribed for determining capacity in the MCA is not as easily discernible. A lack of capacity is not to be conferred on a person's actions simply by reference to the perceived wisdom of the action, or the person's age, appearance, condition, or behaviour. In the explanatory notes to Section 2(3) this demand is clarified, placing significant constraints on any would be assessors: "Any preconceptions and prejudicial assumptions held by a person making the assessment of capacity must therefore have no input into the assessment of capacity" ([3], para. 23). From here on in, the paper considers whether the prescriptive aspirations of the MCA are achievable.

4. The MCA's Challenge

Whilst considerable political focus has been placed on assessing the implementation of the MCA [16], it is argued here that any such considerations must be informed by an examination of whether compliance with the MCA is possible. The characterisation of some professionals or bodies as failing to comply with the MCA is of little significance, if compliance itself is impossible. The

[1] Although temporary impairments of the mind or brain, such as the result of alcohol or drug use, are sufficient to meet the diagnostic requirement, Principle 3 and subsection 3 require that where capacity is likely to be regained in the future then the decision can be delayed if doing so would be in the individual's best interests.

approach adopted in the MCA places demands on any assessors of capacity to view capacity as a time specific judgement, referring to a person's functional ability at a given time in regard to a specific decision. Would be assessors of capacity are required to act free from preconceptions or prejudicial assumptions they may hold.

In this context of competing demands any would be assessor seems confronted with a double bind. In the first they are tasked with upholding the MCA's understanding of capacity as a time specific, functional assessment of an individual who meets the diagnostic requirement. In the second, as clarified in the explanatory notes, an assessor must not only put to one side prejudicial assumptions, which might take in personal values, but also preconceptions. We may assume that such a bind is not intended; as to do so would make the implementation of the MCA impractical. Accordingly then what is covered by the term preconceptions must exclude the conceptions central to the MCA itself. If this charitable interpretation is to be maintained, then the MCA seeks to distinguish between types of preconceptions, those endorsed in the MCA and those which must be put to one side and have no bearing on the assessment process. What initially appears to be a double bind imposed on assessors is in fact a call for a distinction between types of preconceptions.

The task confronting assessors of capacity can be examined by drawing on values-based medicine. The requirement that a distinction is maintained between sanctioned and unsanctioned preconceptions can be viewed as akin to the distinction between wide and narrow descriptive criteria.

4.1. A Values-Based Medicine Perspective

Bill Fulford [17,18] proposes a framework for making sense of values in medicine. In response to attempts to distinguish between objective bodily illness and value-laden mental illness [19,20], Fulford proposes that all concepts in medicine rest on a set of values. Differences between medical concepts vary by the relative acceptance or credence afforded to values. On the one hand, where there is general acceptance of values a definition has "narrow descriptive criteria" ([18], p. 123). On the other, where there is considerable disagreement about the values underpinning a definition, there is "wide descriptive criteria" ([18], p. 123). Such a differentiating framework allows for differences in the relative acceptance of medical concepts to be recognised while acknowledging that all concepts rest on a set of values.

The approach for differentiating between values outlined by Fulford can be applied to the distinctions maintained between preconceptions in the MCA. The MCA is both expressive of and reliant on sets of preconceptions that have been afforded significance. At the outset the definition of mental capacity endorsed in the MCA is a product of a series of consultations led by the Law Commission, which itself relied on the preconception that action should be distinguished into capacitous and incapacitous action. In practice the application of the MCA relies on the preconceptions or values of medicine at various stages in the assessment process. Both these sets of preconceptions can be read as corresponding to "narrow descriptive criteria" for the MCA, representing that which is taken as generally accepted or factual. Outside of these sanctioned preconceptions are those that the MCA seeks to curtail and remove from the assessment process. An assessor's preconceptions and prejudicial assumptions correspond to the "wide descriptive criteria". The aim to remove contested values, such as religious perspectives, from the assessment process, is a laudable endeavour in seeking to prevent a healthcare professional imposing their will on a patient.

4.2. The MCA's Challenge: Overview

In advocating that mental capacity is not to be determined by a simple evaluation of the relative wisdom of the decision, the MCA requires an additional component on which assessments can be based on. This additional component is provided in the MCA by a two-stage understanding of mental capacity, which requires the presence of impairment in mental functioning, which contributes to an individual's inability at a specific time to perform certain cognitive tasks. As proposed here, the two-stage process of assessing mental capacity is itself a sanctioned preconception drawn from medical, psychiatric and legal discourses. The difficulty for the MCA in evaluating an action from the perspective of sanctioned preconceptions is to do so in a way that is clearly distinct from a judgement by others about the wisdom of a decision.

5. Anorexia Nervosa and Mental Capacity Assessment

The cases of Ms E [21] and Ms L [22], respectively, considered whether two young women diagnosed with severe Anorexia Nervosa had the capacity to make decisions relating to their care. At the time of her hearing in late May 2012 Ms E, aged 32, was diagnosed as suffering from unstable personality disorder, alcohol dependence syndrome, opiate dependence and debilitating and lifelong physical consequences of long-term malnutrition. Jackson J identified two questions regarding capacity to be addressed by the court. Firstly, did Ms E, at the time of the hearing, have the mental capacity to make decisions about her treatment and secondly, whether Ms E had capacity when she made an advance directive in October 2011. At the time of her hearing in August 2012, Ms L, aged 29, weighed almost three stone, was diagnosed with end stage organ damage and was generally expected to die in a matter of weeks regardless of what actions were carried out. King J considered whether Ms L had capacity in relation to decisions about serious medical treatment, including nutrition and hydration and dextrose in the event of hypoglycaemic episodes.

As both cases adhered to the MCA's two-stage approach to capacity assessment they allow for an examination of how Principle 4 and Section 2(3) are complied with. Two questions guide this examination. What are the sanctioned preconceptions at play in the assessment of capacity? Is the assessment of functional capacity distinct from an evaluation of the action from the perspective of sanctioned preconceptions? Of ethical importance here is the identification of what preconceptions are central in the assessment process thus allowing for the actions of some individuals to be interfered with. These questions raise the issue of what role judgements about the wisdom of a decision should play in the assessment process. Wisdom is a second order expression that is underpinned by a set of values and made from a particular standpoint. Therein when an action is considered wise or unwise the evaluation is underpinned by a set of values. An action can, however, be considered from a particular perspective of values without the evaluation taking the form of a wisdom judgement. One such alternative would involve evaluating an action in relation to its compliance or adherence with the values of a particular perspective.

The first step of the assessment process, the diagnostic threshold, requires that an individual have an "impairment in the functioning of the mind or brain". The inclusion of this requirement for any finding of incapacity reflects the upholding of a proposal from the Law Commission in 1995 [10]. In the cases

of Ms E and Ms L the diagnosis of severe Anorexia Nervosa achieved compliance with the diagnostic threshold. The understanding that somatic and psychiatric disorders meet the diagnostic requirement does not negate the reliance such disorder categories have on values [23–26]. The evaluation of whether individuals meet the diagnostic requirement simply demonstrates the deference to and sanctioning of medical and psychiatric descriptions.

Turning to the functional definition of capacity, the second of the two-stage approach, we find a further resource for identifying sanctioned preconceptions in the determination of capacity. The fourth requirement of the functional test, the ability "to communicate his decision" is understood in the MCA as external to the decision-making process and capacity per se, representing the simple requirement that the decisions can be expressed and acknowledged. Communication is considered a conduit through which a decision can pass but is not itself considered a critical aspect of the decision-making process. Its relevance is clarified in the explanatory notes where the requirement is considered a "residual category and will only affect a small number of persons" ([3], para. 27). Where it is possible that an individual can communicate their decisions Principle 3 requires that "all practicable steps to help him to do so have been taken". The communicative abilities of an individual should thus not limit the recognition of their actions as capacitous but in fact place a requirement on assessors to tailor their communication styles to the individual ([27], para. 2.7). The requirement that practitioners exhaust all practicable communication styles coupled with the notion that communicative ability provides a conduit for a decision to be passed, are both sanctioned preconceptions for the MCA.

The first requirement of the MCA's functional definition, understanding, relates to the individual's understanding of the information relevant to decision they are tasked with making. Although the decision the individual is tasked with making is the central issue on which capacity determinations are based, there is insufficient guidance provided on what decisions individuals can have their capacity assessed in relation to [2]. In both cases, Ms E and Ms L were assessed in regard to their understanding of the information relevant to the specific decisions that were put to them. What the requirement of understanding explicitly requires is unclear. One approach suggests that understanding refers to tacit acknowledgment of the information. Accordingly one can be held to understand information, without believing the information ([30], p. 180). An alternative interpretation as set out by Munby J in *Local Authority X v MM & KM* (2007) holds that understanding, in the context of decision-making requires a subjective endorsement ([31], para. 81). As such, belief is a precondition of understanding.

Shifting back to the cases, both Ms E and Ms L were found to demonstrate an understanding of information and Ms E a subsequent retention of the relevant information. Jackson J found that Ms E could clearly understand and retain information and also held the external ability to communicate her decisions with others ([21], para. 48). In the case of Ms L medical professionals disagreed as to the scope and depth of Ms L's understanding. For one doctor Ms L lacked "deep understanding" ([22],

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[2] This seeming oversight suggests that the decisions put to individuals within a healthcare context are not problematic, however a recent case concerning male sterilisation might draw attention to the issue. See A *NHS Trust and DE (Appearing by his Litigation Friend the Official Solicitor)* [28] and *FG & JK and C Local Authority and B Partnership Trust*, [2013] EWHC 2562 (Fam) [29]. If therapeutic interventions are offered to certain groups of people and not to others, such as the intervention of sterilisation to a recent father who have a mental disability and not to fathers generally, there is a risk that the MCA could support the offering of particular interventions if capacity is used to facilitate the intervention to take place.

para. 49), whereas for the treating psychiatrist Ms L demonstrated understanding but lacked "motivation" ([22], para. 48). What is significant about the assessment of understanding and retention is that individuals are being evaluated against the preconceptions of medicine and psychiatry, respectively. The two individuals in question were required to demonstrate an understanding of and subsequent retention of information in regard to a decision that was put to them by others. The permissibility of putting decisions to an individual and the identification of information that is relevant to such a decision demonstrates the MCA's sanctioning of specific approaches in care and in regard to what information is significant.

A finding that an individual fails to meet the requirements of understanding and retention would seem to demonstrate compliance with Principle 4. Individuals are not found to lack capacity simply because they make an unwise decision. Rather they lack capacity on the basis of a failure to endorse, accept, or remember a set of sanctioned preconceptions endorsed by the MCA. What is assessed is an individual's compliance or adherence to the perceived wisdom of medicine and psychiatry that have been sanctioned as relevant in such considerations.

5.1. Preconceptions and the Assessment of the Ability to Use or Weigh Information

The third requirement of the MCA's functional approach, "to use or weigh information" is the final stage of the process where capacity determinations may be capable of complying with Principle 4. To restate, Principle 4 holds that an individual is "not to be treated as unable to make a decision merely because he makes an unwise decision". In both the case of Ms E and Ms L the inability to use or weigh information provides the basis on which a lack of capacity determination is reached. For Ms E, Jackson J holds "there is strong evidence that E's obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way" ([21], para. 44). Ms E is considered to lack the ability to weigh up information as her "need not to gain weight overpowers all other thoughts" ([21], para. 49). In regard to the advance directive made by Ms E in October 2011, as that directive was made without a simultaneous assessment of Ms E's capacity, sufficient doubt can be raised as to whether she had capacity at the time ([21], para. 65). In the case of Ms L, King J drawing on the views offered by Ms L's treating doctors as well as consultant psychiatrists, holds that she lacks capacity in relation to treatment decisions "on the basis that she is unable to weigh up the risks and benefits" ([22], para. 52). Ms L's "profound and illogical fear of weight gain" ([22], para. 53) is considered to impinge on her ability to critically evaluate information relating to eating.

Any determination that an individual is unable to use or weigh up information in relation to a specific decision, however, requires a method by which executive and deliberative faculties can be assessed. It is argued here that there are two possible approaches that can be taken to this assessment. Either an individual's values and beliefs, as that which guide and influence action, are considered to have a direct impact on the ability to use or weigh up information or they do not. In the case of Ms E, Jackson J adopts the former approach and is echoed in the case of Ms L, where King J maintains that the values and beliefs characteristic of an individual suffering from Anorexia Nervosa cause a "deficit in capacity specific to issues relating to food and weight gain" ([22], para. 54).

Two concerns can be raised in response to the approach taken. First, while this assessment of the ability to weigh or use information may appear to reject an outcome approach, as it is the inability to

perform such actions rather than the decision made which is significant, the distinction is less clear on examination. If there is a presence of an irrational belief which prevents any decision being made which would be inconsistent with the belief, then the presence of the belief will invariably determine the outcome of an action. Observing this connection Jackson J notes Ms E is in a "catch 22 situation concerning capacity: namely, that by deciding not to eat, she proves that she lacks capacity to decide at all" ([21], para. 53). While the focus is on the process that underpins the decision and not the decision itself, Jackson J acknowledges the presence of the obsessive fear, which is held to impair deliberation, can only be surmised from the decision made by the individual. This is not to suggest that an outcome approach of sorts is being applied, or that obsessive fears should not be held to be incompatible with deliberation but rather that the ability to assess deliberative processes in these cases seems weakened by the need to include the outcome.

Tim Thornton proposes that this inability to separate the outcome from the process is a feature of the MCA's appeal to the notion of a mental mechanism [32]. While intuitively it might be appealing to infer two distinct mental processes underpin two differing attempts at a similar act, for example between a native speaker reading a text and a student learning the language, reading the same text, Thornton holds that the idea is limited in its application. Drawing on Wittgenstein's observation that mechanisms are only hypotheses developed in response to what is observed, Thornton argues that the outcomes of the action observed influences the explanatory force we attribute to mental mechanisms ([32], p. 130). The inability to remove a consideration of the outcome from the assessment of the process leads Thornton to claim that the assessment of weighing and use of information is in practice the assessment of "an ability generally to make the right decision relative to that information" ([32], pp. 131–32).

Second, the reliance on the description of the beliefs of an individual diagnosed with severe Anorexia Nervosa as irrational introduces an additional sanctioned preconception. Clarification is required as to whether the deliberative and executive faculties are being assessed here and if so how, or whether the preconception that irrational beliefs prevent deliberation in cases of severe Anorexia Nervosa is being endorsed and applied. There is a difference between a philosophical view that irrational fears obscure the ability to reason and the interpretation or claim that an individual diagnosed with severe Anorexia Nervosa has an irrational fear that prevents deliberation. The basis on which the later claim is endorsed is critical. If the sanctioned preconception is being applied because the individual decides not to eat and is diagnosed with severe Anorexia Nervosa then the question can be asked if anyone in such a situation would have the sanctioned preconception applied? If it is possible for an individual diagnosed with severe Anorexia nervosa who refused to eat to be found to have capacity then the question can be asked as to when is the sanctioned preconception to be applied?

The second approach to understanding the relationship between values and beliefs and the ability to weigh information maintains that a person's values and beliefs do not impact on the use or weighing up of information. In this situation the proposed mental mechanism would weigh information free from the individual's values and beliefs, although the information being weighed might be done so against the individual's values and beliefs. While this approach is not adopted in either cases discussed, if it were to be adopted similar difficulties would exist. For such an approach to be coherent, as Thornton claims, it would have to be possible to demonstrate the difference between a weighing of information that guides decision-making and a weighing of information which although performed does not influence the decision made ([32], p. 129). Furthermore this approach to mental mechanisms would be confronted

by the inability to separate a consideration of the mechanism or process from the outcome. How these difficulties would be overcome in practice would seem to require a series of sanctioned preconceptions, as was the case in the first approach to evaluating capacity.

The two approaches to assessing the ability to weigh and use information present difficulties for the assessor. The limitations of assessing the process alone require a coupling of process and outcome. Where this difficulty is overcome in practice by appeal to sanctioned preconceptions, questions remain as to the basis on which these preconceptions are applied. If the alternative approach to the relationship between values and a mental mechanism were adopted, similar problems would emerge.

5.2. Preconceptions and the Assessment of Capacity: Overview

The requirement that capacity determinations rest on an "other than wisdom" component is achieved by way of a reliance on sanctioned preconceptions. These preconceptions provide the framework against which individual decisions are evaluated for adherence. This demonstrates a reversal from an approach that evaluates the wisdom of a decision, as gone is a set of preconceptions structuring the appraisal of a decision and in place a decision is considered against a set of preconceptions. These sanctioned preconceptions, as that which allow for compliance with Principle 4, however remain evaluative judgements or perspectives. As such the achievement of compliance with Principle 4 demonstrates an "other than wisdom" component where this component is achieved through accepting and privileging certain evaluative judgements.

As it has yet to be shown how the assessment of capacity can achieve a separation of the process of weighing and using information from the outcome, an understanding of an appropriate or acceptable relation between process and outcome is necessary for the process to be assessed. What constitutes or fails to constitute these appropriate relations represents further sanctioned preconceptions. One such sanctioned preconception is drawn on in the cases of Ms E and Ms L where the values and beliefs of an individuals diagnosed with severe Anorexia Nervosa are considered to impair deliberation in relation to matters concerning weight gain and nutrition. The issue in practice for any assessor is to ascertain which sanctioned preconceptions are to be applied, on what basis and more fundamentally from where are these preconceptions derived from or stored.

In line with Section 2(3) assessors of capacity must maintain a distinction between sanctioned and unsanctioned preconceptions so that they may assess capacity in the absence of preconceptions and prejudicial assumptions. As the cases examined above demonstrate the array of preconceptions permitted in the assessment process, it is reasonable to suggest that the examination of other cases would yield further sanctioned preconceptions. Quite how would be assessors are to assess capacity in the absence of preconceptions and prejudicial assumptions requires clarification. Which preconceptions specifically are to have no bearing on the assessment process and subsequently how are these preconceptions to be put into abstention? Furthermore, is there a process by which a prejudicial assumption can come to be accepted as a sanctioned preconception and thus be permitted in determining capacity?

The examination of two cases before the court of protection helps demonstrate considerable procedural difficulties affecting any would be assessor. At each stage of the two-stage assessment process are sanctioned preconceptions that determine how the actions of individuals are to be assessed. While Principle 4 fails to call for a value neutral account of capacity, it does require that a determination

of capacity rest on something other than a judgement about the perceived wisdom of the decision. In achieving this through a distinction between sanctioned and unsanctioned preconceptions further difficulties arise. The requirement that assessors carry out their assessments free from preconceptions and prejudicial assumptions, when preconceptions are central to the assessment process itself, seems problematic. What the MCA requires an assessor to bring to the assessment process is decidedly vague.

6. Classificatory Problems

In seeking to ground the determination of capacity on an "other than wisdom" component, the MCA relies on the privileging of certain preconceptions. The significance afforded sanctioned preconceptions and declined to other preconceptions and prejudicial assumptions structures the categorisation of action. Examining the cases of Ms E and Ms L allows for three features that flow from this distinction to be highlighted: medical deference, unobservable mental procedures, and selective pathologising.

As the preconceptions of medicine are present at multiple stages in determining whether an individual has capacity, the MCA can be read as deferential to medicine. The requirements that individuals meet the diagnostic threshold, understand and retain the proposed relevant information, and articulate a decision in regard to a proposed intervention, each reference the role medicine plays in establishing the context for a capacity assessment but also contribute to the substance of the assessment process. This deference is reaffirmed in the Code of Practice's support for a distinction between a doctor's ability to assess capacity and the ability of other assessors. Doctors are identified as having "more skill then somebody without medical training" ([27], para. 4.46) for the purpose of capacity assessment. As the assessment process draws on sanctioned preconceptions from medicine the notion that doctors have greater skill may simply refer to a greater familiarity and understanding of what the sanctioned preconceptions in any case are.

The four part functional understanding of capacity assessment, in which a failure in any one element may be indicative of a lack of capacity, contributes to the idea that the ability to "use or weigh information" is a key aspect of the decision-making process. Although the separation of capacity assessment into four aspects may be considered to add clarity by breaking down component parts of the process, the assessment of the deliberative faculty alone is problematic. That sanctioned preconceptions scaffold the assessment of capacity reveals the presence of a prior understanding of what decisions follow from the performance of the functional process in a specific context. The process against which the decisions individuals are considered and the assessment of that process rely on already established accounts of the relationship between a process and outcome. This practical reliance on preconceptions, however, is not clearly outlined in the MCA. Principle 4, which calls for an "other than wisdom" component to underpin capacity assessments, fails to identify from where that component is derived. Principle 4 could be amended to acknowledge the role other values and preconceptions play instead and read "A person is not to be treated as unable to make a decision merely because he makes an unwise decisions. However an examination of the decision against an established understanding of the process and outcome of a decision, alongside repeated unwise decisions may be sufficient for a finding of an inability to make a decision".

The third issue, selective pathologising, draws on the first, namely that the MCA is deferent to medical opinion. This deference allows for specific preconceptions to influence and shape the potential

use of the MCA. In relying on the insights of psychiatry to provide accounts of impairments of the mind or brain, the MCA coalesces with the biases of psychiatry more generally. That the MCA supports a discipline, which selectively pathologises the behaviour of some individuals, in this case two young women with Anorexia Nervosa, while not identifying the behaviours of others as pathological, is problematic. The decision of elderly patients to refuse food, of victims of domestic violence to stay in violent relationships, or of individuals to engage in dangerous sporting activities could potentially be understood similarly to how Ms E and Ms L's respective views about weight gain were considered. For example might the decision of a woman in a violent relationship who is committed to staying in the relationship at all costs, such that she is incapable of acting in anyway incommensurate with that belief, be considered irrational or obsessive? Similar arguments can be developed about elderly patients who avoid food or individuals who engage in risky sporting endeavours. The scope of the MCA's ability to be applied to individual action is limited to the conditions within medicine and psychiatry that are held to result in impairment in the mind or brain. Any affording of power to other professionals such as social workers or psychologists, as able to confer on individual's a diagnosis of an impairment of mind or brain, although perhaps welcomed, would not remove the role of values within the assessment process.

7. Moving Forward

The question of how the role of values and preconceptions within the MCA and the assessment process may be responded to, it is argued here, can be both forward looking and historical. Two approaches can guide such a response, a call for greater transparency and a change in the language used to discuss capacity. Two questions can direct the call for greater transparency. Firstly, what are the sanctioned preconceptions of the MCA and capacity assessment and on what basis are these preconceptions to be applied in specific cases? Secondly, how are sanctioned preconceptions derived or established and following from this, is it possible for new sanctioned preconceptions to be established?

That values and preconceptions are inherent in notion of mental and legal capacity, the MCA and the assessment process, can be acknowledged. A statement in regard to what the sanctioned preconceptions are and when they are to be applied could provide clarity as to how assessors are to comply with Section 2(3) but also aid the population at large in understanding from what perspective their actions can potentially be evaluated. Where certain behaviours and actions are to be associated with a lack of capacity, such as the decisions relating to weight gain made by individuals diagnosed with severe Anorexia Nervosa, this understanding could be made explicitly clear to individuals and practitioners. This association would have to be supplemented with guidance concerning the timing of doubting. As demonstrated in the cases of Ms E and Ms L, the Court of Protection supports the equating of severe Anorexia Nervosa with an inability to make decisions concerning weight gain, however further guidance is required addressing when individuals diagnosed with severe Anorexia Nervosa should be assessed. The furnishing of normative guidance would allow would be assessors of capacity to account for their actions related to capacity, by appeal to criteria, as opposed to ideals of acting outside of preconceptions.

Greater transparency in regard to why and how certain preconceptions are afforded significance while others are not could provide further clarity for both practitioners and the public. The continued

privileging of particular medical perspectives as the perspective from which actions are evaluated means that where an individual's values, actions and decisions correspond to that which has been considered symptomatic of a mental disorder, they risk having their individuality penalised. Conversely, individuals whose values and behaviours have not been considered symptomatic of mental disorder are permitted under the MCA to continue making decisions. The engagement in dangerous sports, the decision to stay in a relationship where one is a victim of violence and the decision to radically curtail calorific intake can each be considered unwise to a degree, however the degree to which these decisions are pathologised and institutionally responded to is different. Consequently the opportunity for any individual engaged in such activities coming under the remit of the MCA is reliant on the association of their behaviour with a disorder of the mind or brain.

Additionally, the acknowledgement that sets of values inform any conferral of incapacity could provide an opportunity to discuss what types of behaviours or actions should be interfered with, but might also inform the more fundamental question of why we differentiate between the actions of people in the first place. Debate could be opened up around why some unwise decisions are considered irrational or obsessive and impacting on the decision-making ability, while others are not. Such a process might provide a counter practice to the reliance on medical opinion in capacity determinations and assist in developing a process for differentiating individuals who need support to exercise their legal capacity and those who do not.

The recognition of the role sanctioned preconceptions play at various stages of capacity assessment can be seen to contribute to the call for a change in how capacity is theorised and understood. One such change has been proposed here to the wording of Principle 4 of the MCA such that greater recognition is giving to the role established preconceptions play in the assessment process. This change in language echoes the call of Gerard Quinn for a "new vocabulary" ([5], p. 5) in relation to mental capacity. The language and way capacity is discussed can move to acknowledge the role others play more explicitly. A focus on the proposed cognitive features of decision-making exclusively can be at the expense of an acknowledgement of the role others play and have played in scaffolding the practice of categorising action as capacitous or incapacitous. The language used to talk about capacity can be altered to acknowledge the role-sanctioned preconceptions play and in doing so highlight the context in which capacity determinations take place.

A movement towards greater transparency and a change in the language used in relation to capacity could provide not only a resource for present and future understanding and practice. It may provide the basis on which previous determinations of capacity as well as decisions not to use capacity legislation may be examined.

8. Conclusions

This paper raises the complexities in adherence to Principle 4 and Section 2(3) of the MCA in an effort to ascertain the grounds on which capacity determinations are made. It is argued that fundamental to the MCA is the idea that capacity determinations can rest on an "other than wisdom" component. This is achieved in practice by evaluating actions against a set of sanctioned preconceptions concerning functional processes. The identification that preconceptions scaffold the assessment process raises further questions. What these sanctioned preconceptions are, when they are to be applied, and from

where they are derived, remain unspecified. As such the basis on which individuals are found to lack capacity, as well as the grounds on which such determinations can be challenged, is somewhat obscured. In the cases of Ms E and Ms L these issues are highlighted in the inability to assess the process of decision-making without reference to the outcome and the application of the sanctioned preconception that individuals with severe Anorexia Nervosa who refuse to eat lack the ability to make decisions about nutrition. The paper suggests that for classification of action in accordance with the MCA to be practiced and understood requires greater transparency and a more nuanced use of language.

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Conflicts of Interest

The author declares no conflict of interest.

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