University of Essex

EAP
Essex Autonomy Project

Mental Capacity in the Absence of Belief

An Open Letter to the President of the Court of Protection and of the Family Division of the High Court

Prof Wayne Martin, Director
The Autonomy Project
University of Essex

Summary: A recent judgment in the Court of Protection brings into sharp focus a fundamental question that now urgently requires resolution. Can someone satisfy the functional test for decision-making ability without believing the information that has been provided to them concerning the decision that needs to be made? A longstanding precedent of the High Court answers this question in negative. According to the MM Dicta, a person who does not believe a particular piece of information does not, in truth, understand it, nor can it be said that they are able to use and weigh it. Invoking the MM Dicta, Roberts J recently ruled that ST, a 19 year-old woman with a degenerative mitochondrial illness, lacked the capacity to make her own care and treatment decisions because she did not believe the information provided to her about her prognosis. The author of this open letter calls upon the courts to review the MM Dicta as a matter of urgency. He argues that the Dicta are substantially false, legally incorrect, and dangerous in practice. As regards a person like ST, the legally significant question is not whether she believes or disbelieves the information provided to her, but whether she is able to understand, use and weigh that information in making a decision. The author concludes that some of the reasoning in the ST judgment is fallacious, but that Roberts J also points us towards a promising alternative approach in cases like that of ST. On this alternative approach, the focus is not on belief or disbelief, but on the person's ability to contemplate alternate possibilities relevant to the decision. The Open Letter does not take a position on the question of whether ST herself had or lacked capacity to make her own care and treatment decisions. The focus is rather on the reasoning used by the court in answering this question, and on the framework assessors use in doing so.

About the Author: Wayne Martin is Professor of Philosophy at the University of Essex, where he directs the Essex Autonomy Project, a multi-disciplinary research and public policy initiative focusing on the ideal of self-determination (autonomy) in care settings. Areas of research expertise include: judgement and decision-making, the *Mental Capacity Act 2005* (MCA), the assessment of decision-making capacity, insight, human rights in the context of disability. From 2014 to 2016 he led a multi-disciplinary team providing research support to the Ministry of Justice on the question of whether the MCA complies with United Nations Convention on the Rights of Persons with Disability. In 2019 he provided Judicial College training on MCA s.1(3) to district judges of the Court of Protection. He works closely with the National Mental Capacity Forum in providing MCA training to frontline capacity professionals. Further information about the Autonomy Project can be found on the project website: http://autonomy.essex.ac.uk.

University of Essex

EAP
Essex Autonomy Project

Sir Andrew MacFarlane
President of the Court of Protection and of the Family Division of the High Court

8 Oct., 2023

Dear Sir Andrew MacFarlane,

My name is Wayne Martin; I am Professor of Philosophy at the University of Essex, where, for the past thirteen years, I have directed the Essex Autonomy Project. The Autonomy Project is a multi-disciplinary research and public policy initiative focusing on the ideal of self-determination (autonomy) in care settings. One major focus of our research is decision-making capacity and its assessment.

I am writing now in connection with the recent judgment in the Court of Protection in the matter of ST.[1] The question before the Court concerned the capacity of ST, a 19-year old woman, (a) to litigate and (b) to make her own decisions in relation to future medical treatment. The finding of the Court was that ST lacked capacity to litigate without a litigation friend, and that she lacked capacity in relation to future medical decisions.

It is not my intention in this letter to offer an opinion on the question of ST's capacity. I propose to focus instead on the reasoning that was used by the Court in reaching its conclusion, and on certain substantive premises upon which the Court relied in its ruling. To anticipate my conclusion: I shall argue here that some of that reasoning was flawed, and that some of those substantive premises are false. However I shall also argue that there are fruitful indicators within the ruling that point us toward an alternative approach to the assessment of capacity in cases like that of ST.

The significance of the matters upon which I focus is not confined to this case alone. Indeed the judge in the case was following a longstanding precedent. I argue in what follows that the precedent needs to be revisited, and that the time has come for the courts to reject it.

My discussion in what follows focuses on two questions. Firstly, can someone satisfy the legal standard for mental capacity without believing information that has been provided to them concerning the decision that needs to be made? Secondly, how should those tasked with the assessment of decision-making capacity take into account evidence that the person being assessed does not believe critical information that has been provided to them?

I proceed as follows. I start (§1) by revisiting a case that was decided in the High Court very shortly before the MCA came into effect in 2007 – the so-called MM case.[2] My focus is what I shall refer to as *the MM Dicta*: two general principles enunciated in that case by Mr Justice Munby (as he then was). In §2 I turn to the recent ruling by Mrs Justice Roberts in the ST case, and consider the role played in that judgment by the MM Dicta. In §3 I set out to rebut the MM Dicta, which I argue are substantially incorrect, and which license a fallacious inferential shortcut in the assessment of a person's decision-making ability. In §4, which is the longest section, I formulate and respond to a number of objections. In the final section (§5) I propose a positive alternative to the MM Dicta for thinking through questions about capacity in cases like that of ST.

[1] *A NHS Trust and ST* [2023] EWCOP 40.
[2] *Local Authority X v MM* [2007] EWHC 2689 (Fam).

§1 The MM Dicta

In *re MM*, Mr Justice Munby ruled in the High Court that MM, a woman suffering from paranoid schizophrenia, lacked capacity to make her own decisions in a variety of matters. What matters for our purposes here is not so much the particulars of MM's situation, but the broad principles that Mr Justice Munby articulated as a framework for addressing them.

Munby J's ruling in MM came at a pregnant moment. The Mental Capacity Act had received royal assent in 2005, including within it the now-familiar functional analysis of decision-making capacity as comprising four abilities:

> (a) to understand the information relevant to the decision;
>
> (b) to retain that information;
>
> (c) to use/weigh that information as part of the process of making the decision, and
>
> (d) to communicate the decision.[3]

At the time of the ruling in MM, the new statute had not yet come into effect, so Munby J's judgment was formally reached under the then-prevailing common law standards for incapacity, while at the same time taking account of the new standard that had recently been adopted by Parliament.

One of the points that occupied Munby J's attention in MM was an apparent divergence between one of the common law elaborations of decision-making capacity and the new statutory definition thereof. Under the so-called Eastman Test, enunciated in 1994 in *re C*,

> [T]here are three stages to the decision: (1) to take in and retain treatment information, (2) *to believe it*, and (3) to weigh that information, balancing risks and needs.[4]

What drew Munby J's attention in MM was the inclusion, under the Eastman Test, of an element that is not found on the face of the then-new statutory definition in the MCA. The first element in the Eastman Test maps more-or-less straightforwardly onto the first two elements in the statutory definition in the MCA; the third element corresponds to the third element in the MCA definition. But what should we make of the absence of any mention of belief in the MCA standard adopted by Parliament?

In his ruling in MM, Munby noted the absence, but argued that this apparent divergence between the Eastman Test and the MCA test was merely superficial. Why? Because, Munby reasoned, a requirement of belief is itself implicit in other abilities that do figure in the statutory definition:

> If one does not 'believe' a particular piece of information then one does not, in truth, 'comprehend' or 'understand' it, nor can it be said that one is able to 'use' or 'weigh' it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information.[5]

---

[3] MCA s.3(1).

[4] *Re C (An Adult: Refusal of Treatment)* [1994] 2 FCR 151; emphasis added. The judge is here citing the testimony of Dr. Nigel Eastman, who was an expert psychiatric witness in the case, and whose name became associated with the standard he enunciated.

[5] *Local Authority X v MM* [2007] EWHC 2689 (Fam).; para 81.

Elaborating upon this point, Munby J claimed that the MCA Test and the Eastman Test rest on the same "general theory of what is meant by 'understanding' a problem and having the capacity to decide what to do about it." This general theory, Munby J holds, applies to "all 'problems' and all 'decisions.'"[6]

These claims in MM cry out for critical assessment. In undertaking that assessment, I propose to distinguish what are in fact two distinct propositions.

> Dictum A: If one does not believe a particular piece of information then one does not, in truth, understand it.
>
> Dictum B: If one does not believe a particular piece of information then it cannot be said that one is able to use or weigh it.

§2: The MM Dicta in the ST Ruling

In her ruling in the ST case, Mrs Justice Roberts cites the MM Dicta verbatim at para. 81, reiterating their significance at para 83:

> Whilst it is clear that the strict terms of the MCA 2005 omitted a 'belief' requirement from the wording of ss.2 and 3, it is clear from *Local Authority X v MM* that the approach taken by Munby J subsumes the requirement for belief within the statutory limbs of understanding, using and weighing as part of the decision-making process.

In the balance of the ruling, Mrs Justice Roberts repeatedly invokes ST's disbelief of (or 'refusal to accept') relevant information pertaining to her medical condition. "She does not *believe* that her doctors are giving her true or reliable information when they tell her that she may have only days or weeks to live."[7] "[S]he does not believe what her doctors are telling her about the trajectory of her disease and her likely life expectancy."[8] "Because she does not fully understand the progressive effects of her disease and is unwilling or unable to believe the prognosis offered by her doctors, she regards treatment overseas as her only chance or option."[9]

When Roberts J finally announces her conclusion regarding ST's capacity, she explicitly warrants her finding based on the evidence concerning ST's disbelief:

> In my judgment … ST is unable to make a decision for herself in relation to her future medical treatment, including the proposed move to palliative care, because she does not believe the information she has been given by her doctors. Absent that belief, she cannot use or weigh that information as part of the process of making the decision.[10]

Roberts J reemphasises this rationale in the following paragraph:

> In my judgment in this case, as the evidence demonstrates, ST's fundamental distrust in, and refusal to accept, the information she is given by her doctors as to the likely timescales of her deterioration, do not simply operate to impair her ability to make a decision. They prevent her from understanding, using and

[6] *Local Authority X v MM* [2007] EWHC 2689 (Fam).; para 72 and 73.
[7] *A NHS Trust and ST* [2023] EWCOP 40, para. 84; emphasis original.
[8] *ibid*., para. 86.
[9] *ibid*., para. 91.
[10] *ibid*., para. 93.

weighing the information in the context of the options available to her in terms of future care planning.[11]

§3 An Initial Rebuttal of the MM Dicta

My principal aim in this letter, Sir Andrew, is to convince you that the MM Dicta are substantively and demonstrably false.

Allow me to begin to make my case by using the technique of *reductio ad absurdum*. Let's suppose for the sake of argument that the MM Dicta were true. What would follow?

Scenario 1: The Juror

You are a potential juror in a criminal trial. In the process of jury selection, you are asked whether you understand the indictment that has been read out in court. You answer affirmatively.

If the MM Dicta were correct, then we could immediately conclude that you also believe the indictment to be true – prior to hearing any evidence or argument in the case! You understand the indictment. If one does not believe information then (according to the MM Dicta) one does not, in truth, understand it. So it must be the case that you believe the indictment to be true – even before the opening arguments have begun.

Scenario 2: The Scientist

You are a scientist employed to test a hypothesis. Your supervisor asks you whether you understand the hypothesis that you are being asked to test. You answer affirmatively.

If the MM Dicta were correct, then we could immediately conclude that you also believe the hypothesis to be true – prior to conducting any experiments! You *understand* the indictment. If one does not *believe* information then (according to the MM Dicta) one does not, in truth, understand it. So it must be the case that you believe the hypothesis to be true – even before the experiment begins.

The conclusions warranted by the MM Dicta in Scenario 1 and Scenario 2 are manifestly absurd. It is obviously possible to understand the information in a criminal indictment or a scientific hypothesis without believing that information to be true. It follows that something is badly wrong in the MM Dicta themselves.

Let's now add a third *reductio* argument – one that brings us closer to the core issues before the court in the ST case.

Scenario 3: The Second-Opinion Consultant

You are an experienced clinician who has been asked to provide a second medical opinion in a complex case. You review the medical records and make arrangements to examine the patient. Already at that first encounter, you are confident that the original diagnosis is incorrect. You order a new set of tests that subsequently disprove it. You *understand* the original diagnosis, but you never believed it.

[11] *ibid*., para. 94.

> If the MM Dicta were correct, both the process and the outcome would be impossible. It would *never* be possible to *understand and yet disagree* with a medical diagnosis. Why? Well, if you *disagree* with a diagnosis or prognosis, that means that you *do not believe* it to be true. And if you don't believe it to be true then, according to the MM Dicta, you also don't understand it.

Once again here we have arrived at an *absurdum*.

I want to return below to consider where exactly the MM Dicta went wrong, and also to consider and reply to some possible objections. But before doing so I want to advance and defend a further claim: *The MM Dicta are not only false; they are dangerous*. Why? Because they license an *inferential shortcut* in capacity assessments.

> Scenario 4: The Harried Assessor
>
> You are clinical professional working in the NHS. Perhaps you are a clinical psychologist or a speech and language therapist or a GP. You have a relentless workload and you are keenly aware that your team is operating with a huge backlog. Your supervisor asks you to conduct a mental capacity assessment to determine whether a patient is able to make their own care and treatment decisions. You review the notes and discover that the patient rejects the diagnosis (or the prognosis, or both). You conduct a quick interview, confirming that the patient does indeed reject their diagnosis. Being aware of the ST case and the MM Dicta, you immediately conclude that the patient fails the functional test and so, under MCA s.3(1), is *unable to make a decision for himself*. Without wasting precious time gathering any further information, you tick the relevant box in the electronic paperwork. In the free text field you cite the MM Dicta: 'Patient does not believe the diagnostic information therefore *it cannot be said that they are able to use or weigh that information.*'

What has happened here? The MM Dicta have in effect given the harried frontline professional a license to take an inferential shortcut. Let's call it *The MM Shortcut*. The inferential shortcut takes us directly from evidence about what a person *believes* to a conclusion about that person's *ability to understand, use or weigh*. No direct evidence about their actual ability to understand or to use or weigh information needs to be gathered before concluding that the person fails the functional leg of the statutory test for capacity.

Already in light of our findings so far we should be able to recognise the MM Shortcut for what it is: *a fallacy*. In order to conduct any minimally adequate assessment of capacity, the assessor needs to investigate what the person is actually able to understand about the information that has been provided to them. They need to probe the patient's ability to use and weigh that information. But if the MM Dicta were true, none of that would be necessary in applying the functional leg of the statutory test in a case where the patient does not believe the diagnosis or prognosis.

Up to this point I have been trafficking in fictional scenarios. Even those fictional scenarios should suffice to prove my main point, viz., that there is an urgent need for the courts to review the MM Dicta. But let's not rely on fictional scenarios alone. I turn now to consider two real (anonymised) cases. The first case was reported to me by a speech and language therapist during group work at an MCA training setting that I delivered. The second derives from an observational study of clinical decision-making in mental health settings; I was the principal investigator.

Real Case 1: The Coffee Drinker

> Charles (not his real name) is a man in his 90s who has recently suffered a major stroke. He is being cared for in a nursing home. As a result of the stroke, Charles has cognitive and mobility impairments, can only communicate in writing, and is unable to swallow. The medical instructions on his chart say 'nil by mouth,' and since the stroke, Charles has taken no food or liquid orally. But recently, Charles has persistently been asking the staff for coffee. Charles himself insists that his swallowing difficulties have been resolved. The medical diagnosis indicates that the swallowing difficulties have not been resolved and that drinking could be fatal for Charles. When a speech and language therapist conducts an interview to assess Charles's capacity to make a decision about drinking, he writes on his tablet: 'I understand that I might die.'

Here is the key question that I would like you to consider: Given what we know so far about Charles, is there anything that he could do or say that might convince you that he has the ability to make the decision about whether or not to drink coffee? Or better yet: suppose that *you* are Charles. Is there anything that *you* could say or do that ought to convince the assessor that the presumption of capacity has not been discharged?

If the MM Dicta were correct, then the answer to these questions would have to be no. No further evidence could possibly show that Charles passes the functional test once we know that he rejects the information provided to him by the medical team. If he doesn't believe the information then he doesn't understand it. If he doesn't understand information that is clearly relevant to his decision then he fails the functional test.

But now suppose that Charles continues to press for the coffee. He writes on his tablet and shows it to the assessors:

> *I am an old man. I have had a good long innings. This stroke has really knocked me back. I know that the medical team is convinced that I cannot swallow. I have heard their diagnosis and recommendations. They think that drinking will be very dangerous for me. Maybe they are right. But I think that they are wrong about that. They are the experts, but I know my own body. And I am willing to take the risk. It's on me. If drinking a cup of coffee turns out to be my final act on this earth, then so be it. And if it is not, then I'll be able to enjoy my remaining days more than I am enjoying myself now. What do you say? Are you really going to stop me?*

If indeed Charles were to respond in that way then we would need to take seriously the possibility that he does indeed have the ability to make his own decision about the coffee. We would need to probe further, to be sure. We might press him to say something about what dying might be like for him if he goes ahead with his plan. We might invite him to 'give the other side of the argument,' explaining in his own words why it is that his family and the clinical team are so concerned about his taking anything by mouth. But here is the crucial point: *if the MM Dicta were correct, none of that would be relevant.* Charles disbelieves the diagnosis; he therefore fails the functional test. Such is the fallacious logic of the MM Shortcut.

Real Case 2: Nelson[12]

> Nelson is a male in his late forties. He has a longstanding diagnosis of schizophrenia, which he has never accepted. He is an in-patient under s.3 of the Mental Health Act on a male acute ward, where he has been cooperating in treatment, and is on a pathway towards a near-term discharge. The pathway involves progressively giving Nelson more leave (escorted, then unescorted, then extended …) and increased responsibility for his own care. The consensus of the MDT is that Nelson is still in need of psychiatric treatment, but that he is effectively ready for discharge. There is a delay while a suitable form of supported accommodation and community mental health support is put in place. At his weekly ward rounds, Nelson requests that he be 'made informal.'

At the time of this episode, Nelson was being treated under the Mental *Health* Act. So one might think that the MM Dicta (which pertain to the Mental *Capacity* Act) are simply irrelevant to his situation. But this would be a legal mistake. In asking to be 'made informal,' Nelson is asking that his Mental Health Act section be removed while he continues to receive treatment. Without the section, the legal basis for continuing treatment would be *Nelson's consent*. But Nelson's consent is legally valid only if Nelson himself has the *mental capacity* to make his own decision concerning continued treatment. So the MCA standard for decision-making ability *is* directly relevant to the decision about whether Nelson should be 'made informal.'

I include as an Appendix to this letter an excerpt from the verbatim transcript of the ward round at which Nelson's request to be 'made informal' was considered by Nelson's multi-disciplinary team. The transcript shows (spoiler alert!) that the decision was indeed taken to make Nelson informal. In doing so the team was in effect taking Nelson's consent to continuing psychiatric treatment on the ward, despite ample evidence that Nelson did not accept (i.e., did not *believe*) the diagnosis of schizophrenia.

Nelson's case is by no means an isolated one. And it proves a vital point. *Actual medical practice is flatly inconsistent with the MM Dicta.* In practice, clinicians accept consent for treatment from patients who *understand but do not believe* diagnostic information that has been provided by authoritative sources. In doing so clinicians recognise that decision-making capacity is sometimes present even in the absence of belief.

§4 Objections and Replies

I hope that the arguments in the preceding section have convinced you that there is a problem with the MM Dicta, and that they are urgently in need of review by the courts. In this section my aim is to buttress those convictions by formulating and replying to some possible objections. In addition to bolstering my rebuttal of the MM Dicta, answering these objections will have two added advantages. It will help explain why the MM Dicta may initially have seemed plausible, despite what we have seen to be their absurd and dangerous

[12] The data presented here regarding Nelson (not his real name) was gathered as part of an observational study conducted during ward rounds on in-patient psychiatric wards in an NHS psychiatric hospital. Written consent to reproduce excerpts from the transcripts of the ward round was provided by all participants. Ethics approval for the study was provided by London - Camberwell St Giles Research Ethics Committee (IRAS ID: 255485: *Clinical Assessment of Insight in Psychiatric Ward Rounds: An Observational Study*). Funding for the study was provided by the Wellcome Trust (Grant Number 203376/Z/16/Z).

consequences. And they will point us in the direction of a more defensible framework for capacity assessment in cases like that of ST.

I consider four objections:

> Objection 1: The *reductio* arguments against the MM Dicta rely on an unduly narrow construal of the notion of *understanding* at work in MCA s.3(1).
>
> Objection 2: The *reductio* arguments against the MM Dicta may be sufficient to refute Dictum A, but they fail against Dictum B.
>
> Objection 3: In practice, the absurd and dangerous consequences of the MM Dicta can be avoided through a rigorous application of the so-called 'diagnostic threshold.'
>
> Objection 4: In order to appreciate the force of the MM Dicta, we need to take into account the fact that the functional test is a test of *abilities*.

Objection 1:

The first objection appeals to variation in the meaning and usage of the verb 'to understand':

> Let's concede that there are contexts where an attribution of understanding does not imply belief. (There is no contradiction in saying 'I understand what you are saying but I disagree with you.') Nonetheless, there are other uses of 'to understand' which follow a different logic. Munby's ruling in MM arguably includes one example. Recall that he appeals there to a "general theory" of "what is meant by '*understanding' a problem*."[13] If someone is aptly described as *understanding a problem*, then it is plausible to conclude that the person *believes that there is a problem*. So perhaps, after all, the requirement of understanding does subsume a requirement of belief.[14]

Reply:

The linguistic observation on which the first objection relies is sound, but it does not vindicate the MM Dicta. At most it serves to shift the question. For the task must now be to consider which among the various meanings of the term 'to understand' is at work in the specific context that concerns us: the legal articulation of a functional standard for mental (in)capacity. Here, all the indicators point to a sense of 'understand' that does not imply belief. Consider:

- The functional definition in MCA s.3(1) refers to the ability "to understand *the information* relevant to the decision" (emphasis added). That is, the object of understanding (its grammatical accusative, so to speak) is *information*. This was a point of emphasis in the Law Commission report that paved the way for the statutory definition: "Whilst we agree that it is the person's understanding which should be assessed, we think that it is the person's ability *to understand information,* …, which is the real point."[15] Understanding *a problem* may indeed involve believing that there is a problem, but *understanding information* is conceptually and practically distinct from believing it.

[13] *Local Authority X v MM* [2007] EWHC 2689 (Fam), para. 72.
[14] I am grateful to Fabian Freyenhagen and Scott Kim for pressing this objection.
[15] The Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* (London: HMSO, 1993); LC128, para 3.20; emphasis added.

- Internationally, one of the most widely used instruments for the assessment of mental capacity is the Mac-CAT(T). The Mac-CAT(T), which was designed to articulate US standards of competence, does include a qualified requirement that a patient believe information relevant to the decision that needs to be made. Crucially, however, the Mac-CAT(T) treats this as a separate requirement, *over and above the requirement of understanding*. Indeed in introducing the further requirement, the authors of the instrument appeal to an example of a woman "who appears fully to grasp the meaning of what has been disclosed to her. But she appears not to believe that what she has been told applies to her condition." [16]

- In the UK, we find the same pattern of usage in the Eastman Test. As we have seen, the Eastman test includes a belief standard, but explicitly treats "believing information" as a distinct stage in the decision-making process, *over and above* the initial stages of "taking in" and "retaining" the information.

- In their classic survey of *The History and Theory of Informed Consent*, Faden and Beauchamp offer a subtle commentary on the variety of meanings of the notion of understanding, distinguishing three broad forms of understanding, which they refer to as (i) *understanding how* (i.e., understanding how to do something); (ii) *understanding that* (i.e., understanding that something is true); and (iii) *understanding what* (i.e., understanding what has been asserted). They conclude that "the typical pattern of understanding in informed consent settings is for patients or subjects to come to understand *that* they must consent to or refuse a particular proposal by understanding *what* is communicated in an informational exchange with a professional." Elaborating on the relevant sense of *understanding what*, they go on to add: "one does not have to *believe* information in order to understand it."[17]

So while it is true that there are some contexts in which understanding implies belief, there is ample evidence that MCA s.3(1) is not such a context.

Application to the Reasoning in ST:

Once we are attuned to these contextual differences in the use of the verb 'understand,' we can begin to see what may have gone wrong in the reasoning in ST, making the MM Dicta appear more plausible than they really are. Consider this passage near the culmination of Roberts' ruling:

> In this case I accept that ST is aware of the nature of her disease in terms of it being a mitochondrial depletion syndrome which is rare. She knows that she is one of few people in the world to have the disease. I further accept that she knows the disease by its nature is progressive and she recognises that, at some point in the future, she may succumb to its effects and die. *What she fails to understand, or acknowledge, is the precariousness of her current prognosis*.[18]

One thing that is striking in this passage is the extent of the knowledge (and hence *understanding*!) that Roberts does attribute to ST. So how can this be made to fit with the conclusion that ST lacks the understanding required to make a decision? A clue can be found

[16] Grisso, T., & Appelbaum, P., *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (Oxford: Oxford University Press, 1998), 43.
[17] Faden, R & Beauchamp, T., *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986), 248-255; see in particular 250.
[18] *A NHS Trust and ST* [2023] EWCOP 40, para. 84; emphasis added.

in the last sentence, which runs together two quite different things: *understanding one's prognosis* and *acknowledging one's precariousness*.

A medical prognosis provides a patient with information. *Understanding that prognosis* in no way implies believing it. (Note that if it did, then the second-opinion consultant in our Scenario 3 could never understand a prognosis with which he disagreed!) But *acknowledging the precariousness of one's situation* is something quite different, and one could reasonably conclude that it (like Munby's 'understanding a problem') entails belief.

In another passage Roberts uses "understand" interchangeably with "fully comprehend,"[19] then goes on to write that ST "does not *fully* understand the progressive effects of her disease."[20]

What we can see here is that the reasoning in ST turns on a *double fallacy of equivocation* – an equivocation between 'understand' and 'fully comprehend,' and an equivocation between 'understanding information' and 'acknowledging precarity.' The statutory question is whether ST *understands the information* that was provided to her by the doctors. The question that Judge Roberts ultimately answered was whether ST *fully understands the effects of her disease*. Plausibly, the latter might require ST to believe the information provided to her by her doctors. Manifestly, the former does not.[21]

Objection 2:

The second objection treats Dictum A and Dictum B separately:

> Let's concede that the *reductio* arguments cut against Dictum A. The juror understands the indictment without believing it; the scientist understands the hypothesis before forming a view about whether it is true; the second-opinion consultant understands a diagnosis which he never believed. So it is indeed a fallacy to infer lack of *understanding* from the absence of belief. But Dictum B concerns not understanding, but the *ability to use and weigh*. So the *reductio* arguments against Dictum A leave Dictum B intact. And Dictum B has independent plausibility, regardless of the fate of Dictum A. The idea that you could disbelieve information and still use and weigh it in the balance is just plain wrong.[22]

Reply:

The second objection raises important issues that will be helpful in pointing us towards a better framework for capacity assessment in cases like that of ST. But the first step must be to remind ourselves that we are in fact perfectly capable of using and weighing information without believing that information to be true.

> Scenario 5: Another Juror
>
> You are a member of a jury. The defendant testifies that he never met the victim. But you then hear evidence from multiple credible sources who provide both

[19] *A NHS Trust and ST* [2023] EWCOP 40, para. 86.
[20] *ibid.*, para. 91; emphasis added.
[21] It is worth pausing to consider just what a high standard Roberts finally applies to ST. What 19 year old could possibly have a *full understanding* of the progressive effects of mitochondrial depletion syndrome? Who has a *full comprehension* of the significance of their own mortality? With good reason, Parliament required *understanding*, not *full understanding* – whatever that would mean.
[22] I am grateful to **** for pressing a version of this point.

testamentary and documentary evidence that the defendant was in fact personally acquainted with the victim. Faced with this contradicting evidence, you conclude that the defendant is an untrustworthy witness and resolve to treat all of his testimony with suspicion.

Scenario 6: The Engineer

You are an engineer in the control room at a power station. In the control room are meters and screens that provide readouts from different sensors that are distributed around the facility. There are readouts of temperature, levels in various tanks, flow rates through various conduits, radiation levels, etc., as well as various video monitors from CCTV feeds. The engineer from the last shift made a note in the log that one of the thermal monitors (H743a) has been giving erratic readings and may need to be replaced. H743a is located in a tank that is currently full, so it would be costly and disruptive to replace it immediately. Besides, there are other thermal monitors nearby (H743b and H743c) as part of the redundancy systems at the plant. Midway through your shift you note that the readout from thermal monitor H743a indicates -20º C. That is well below the temperature at which the contents of that tank would be frozen solid. But the flow monitors indicate that the flow in and out of that tank is normal, which would be impossible if the contents were frozen. Moreover, H743b and H743c are both giving temperature readouts that are well above the freezing point of the contents of the tank. You put in a work order to replace thermal monitor H743a.

Scenarios 5 and 6 share a logic that is common in decision-making situations: the person who needs to make the decision is faced with *contradictory information*. In navigating such circumstances, the decision-maker uses and weighs the available information, drawing inferences, perhaps forming and testing hypotheses, before finally deciding which information to believe and which information to reject. The juror uses and weighs the information provided by the various witnesses (including the defendant) as part of a process of making a decision about which witnesses to trust. The engineer uses and weighs the information displayed on the various meters (including H743a) in deciding which meter to replace. Such operations are common in rational decision-making in the messy real world of often contradictory information, but they would be strictly impossible if Dictum B were true. So Dictum B is false.

Scenarios 5 and 6 once again involve fictional scenarios. Even those fictional scenarios suffice to demonstrate that Dictum B is false. *The courts should therefore renounce it.* And since Dictum B is false, the direct inference from disbelief to inability to use or weigh is fallacious. *Assessors should avoid it.* But perhaps it is best not to rely on fictional scenarios alone. So let's once again supplement the fictional scenarios with a real case that is closer to the matter at hand.

Real Case 3: The Judge

You are a judge in the Court of Protection. Your task is to determine whether ST has capacity to make medical decisions. One consultant psychiatrist (Dr D) submits a report concluding that ST passes the functional test for mental capacity;[23] a second consultant psychiatrist (Dr C) submits a report concluding

[23] *A NHS Trust and ST* [2023] EWCOP 40, para. 43: "[Dr D] confirmed that in his view [ST] does not fail the functional test under the MCA."

> that ST fails the functional test.[24] Keeping an open mind, you use and weigh the information in both reports before finally concluding that ST fails the functional test. You report that you are unable to accept Dr D's view to the contrary.[25]
>
> If Dictum B were true, Roberts J's own decision-making in the ST ruling would be impossible. If Dictum B were true, the very fact that Judge Roberts used and weighed the information in Dr D's report would entail that she believed it to be true. Since Roberts' manifestly did use and weigh Dr D's report without agreeing with it, Dictum B must be false.

Application to the Reasoning in ST:

It is clear that Dictum B plays a significant role in Roberts J's ruling in ST. She claims that "the heart of the current dispute in relation to capacity [pertains to] ST's ability to *use and weigh* the information she has been given[.]"[26] In reaching her conclusion on this question, she relies on the evidence provided by Dr C, whose "report set out his conclusion that [ST] was *unable to weigh* the consequences of her decision … *because she was fundamentally unable to accept* [sic!] that her condition was progressive[.]"[27]

It is therefore worth considering why Dictum B might be tempting, despite its evident conflict with the familiar experience of deliberating with information that is inconsistent or whose reliability is uncertain.

I suspect that the answer may be that the metaphor of *weighing* makes Dictum B seem more plausible than it really is. Judges in particular are everywhere confronted with the image – and the metaphor – of the scales of justice. Judicial rulings themselves regularly appeal to the idea of 'weighing in the balance' as a trope for deliberation. Following out the implication of this metaphor, it is tempting to conclude that one must *believe* information before one *weighs* it against other information. After all, if one does not believe it, one will assign it zero weight, so the prospect of weighing it seems to become incoherent.

If the metaphor of the scales helps us understand the appeal of Dictum B, critical reflection upon that metaphor should also help dispel the illusion. Here we need to remind ourselves that the scales of justice are indeed a *metaphor*. Information does not literally have a weight, whether one believes it or not. And one does not actually use information by placing it on a balance scale.

A safer approach in this zone is to think of using and weighing information as an involving a mix of *reasoning* and *imagination*. We use and weigh information by *considering its consequences*, by *deploying it in inferences* (including *reductio* inferences!), and by *using our imagination* to consider how the information fits (or fails to fit) with other available information. Crucially, these are all activities that can be conducted using information that one believes, disbelieves, or over which one has no opinion one way or the other. I return to this approach in §5 in proposing an alternative to the MM Dicta for assessing capacity in cases like that of ST.

---

[24] *A NHS Trust and ST* [2023] EWCOP 40, para. 50: "[Dr C] considers that [ST] does not meet all aspects of the functional test[.]"
[25] *ibid.*, para. 92: "I am unable to accept [sic!] Dr D's evidence that ST passes the functional test[.]"
[26] *ibid.*, para. 76; emphasis added.
[27] *ibid.*, para. 64; emphasis added; see also para 92.

Objection 3:

The third objection concedes that the MM Dicta are not strictly and universally true, but rejects the conclusion that they have dangerous or absurd consequences in practice. This objection relies on the distinction between *decision-making ability* and *mental capacity*:

> Strictly speaking, the functional test in MCA s.3(1) is a test for decision-making ability: if I lack one of the four statutory abilities then, under the MCA, I lack the ability to make a decision for myself in the matter at hand. In order rebut the presumption of capacity, however, an additional condition must be met. It must be established that I lack decision-making ability "*because of* an impairment of, or disturbance in the functioning of, the mind or brain."[28] In practice, this second leg of the statutory test for incapacity provides a safeguard against the dangerous and absurd consequences alleged in the *reductio* arguments. Notably, the scenarios used to rebut the MM Dicta rely on cases where there is no suggestion of impairment of or dysfunction in the mind or brain. So even if the MM Shortcut were used to conclude that the jurors (or the second-opinion consultant or the engineer or the judge …) were unable to understand, use or weigh the relevant information, they would not be found to be lacking in mental capacity if that inability was not caused by an impairment or dysfunction of the mind or brain. No harm, no foul.

Reply:

This defence of the MM Dicta smacks of desperation. If the dicta are not true, then the courts need to say so, to say so *soon*, and to say so *clearly*. What *is* correct, and important, is that the fallacious MM Shortcut licences *at most* a finding of lack of decision-making ability. So even the most harried frontline assessor could not stop there; they would need to go on to consider the causes of the alleged inability. But this damage-limitation approach is inconsistent with what the courts have said with increasing clarity about the conduct of capacity assessments. Both the Court of Appeal and the Supreme Court have made clear that a capacity assessment is a two-step process, and that the application of the functional test must come first.[29] So if there is no evidence that the person lacks one or more of the statutory inabilities, *questions about impairments and dysfunctions of the mind or brain should not even arise*. In licencing an illicit inference from lack of belief to lack of decision-making ability, the MM Dicta not only fallaciously warrant a finding of lack of decision-making ability; they also expose the person to questions about impairments in the functioning of their mind or brain – question which, under the circumstances, should not be asked at all.

Application to ST Ruling:

Although the third objection does nothing to vindicate the MM Dicta, it does offer a different lens with which to read some of the most contentious passages in the ST ruling. As we have seen, both Roberts J and Dr C explicitly claim that ST fails the functional test *because* she does not believe the information provided to her.[30] At this point I hope that we can agree that this is inadequate if interpreted as a *justification* of the finding of decision-making inability. Again and again we have seen (not least in Judge Roberts' own deliberations) that it is eminently possible to understand, use and weigh information which one does not believe and

[28] *Mental Capacity Act* s.2(1).
[29] *A Local Authority v JB* [2021] UKSC 52; para. 78 and 79; see also *PC and the City of York* [2013] EWCA Civ 478, para. 58.
[30] *A NHS Trust and ST* [2023] EWCOP 40, paras. 92 (for Dr C) and 93 (for Roberts).

cannot accept. So evidence of disbelief does not in and of itself provide evidence of decision-making inability.

But as we have seen in considering the third objection, a capacity assessment cannot simply *document* an inability to understand, use or weigh relevant information; it must also probe the *causes* of those inabilities. So perhaps Judge Roberts' 'because' is best understood as a claim about those *causes*. Could it be that a particular kind of disbelief, or a particular pattern or modality of disbelieving, *causes* decision-making inability? Or perhaps there are cases where disbelief and the decision-making inability *themselves have a common cause*.

Objection 4:

The fourth objection appeals to the fact that the MCA standard for incapacity is articulated in terms of *abilities*:

> Strictly speaking, the functional test does not require *actual understanding* of the relevant information; it requires only the *ability to understand* that information. It does not require the person *actually* to use and weigh the relevant information; it requires only that the person is *able* to use and weigh the information at the time the decision needs to be made. This feature of the MCA standard can be challenging in practice. (How does one determine whether a person has an ability that they are not presently exercising?) But it also casts the MM Dicta in a different light. The *reductio* arguments demonstrate that one can understand, use and weigh information without believing it. But an *inability to believe* is something different; perhaps *that* really is incapacitating.

Reply

I will argue in the next section that there is an important kernel of truth in the fourth objection, but as a defence of the MM Dicta it is unconvincing. We need to note, first, that the statutory language of the MCA (i.e., the language actually adopted by Parliament) makes no mention of an ability to believe – no more than it makes mention of actual belief. So the objection only sticks if we are convinced that the abilities that *are* enunciated in statute somehow *imply* or *presuppose* an ability to believe. But does the ability to understand information imply an ability to believe it? Does my capacity to use or weigh information presuppose that I am able to accept that it is true?

The answer to both questions is *no*.

The most direct way to demonstrate this is to consider cases where we make use of information that we know to be false. Suppose an informant gives me information that I know to be incorrect. In that situation I do not have the ability to believe the information. (Try it! Are you able to believe that Elizabeth II remains Queen of England?) But I can nonetheless *make use* of that information, and weigh it in making a decision – most notably by using the false information to discredit the source. This is exactly what the engineer does with the information from the faulty thermal monitor. Given all the other things that the engineer knows, he knows that the information from H743a is false. It is, quite literally, *unbeliev-able*. But the engineer nonetheless uses and weighs that information, grasping its meaning (i.e., understanding it), and then deploying his reasoning and his imagination to conclude that the monitor producing the unbelievable information is faulty.

Application to the ST Ruling:

In key passages of the ST ruling, Roberts J broaches the idea that ST is *unable* to believe or *unable* to accept the prognostic information provided to her.[31] Indeed one might justifiably complain that the ruling moves rather too freely between claims about what ST *does not* believe and what she is *incapable* of believing. As we have now seen, neither an absence of belief nor an inability to believe can suffice to demonstrate an inability to understand, use and weigh information. Nonetheless, it is worth exploring the possibility that certain forms of inability to believe may themselves be the effect of something that is indeed incapacitating.

§5 Conclusion: An Alternative to the MM Dicta

I am aware of the risk that I may by now have belaboured my point. But perhaps this is one of those circumstances where a bit of belabouring is in order.

I have endeavoured to prove that the MM Dicta are false and that the MM Shortcut is fallacious. I have tried to consider every possible avenue by which the Dicta might be defended. None survive scrutiny. I have also argued that at least some of the reasoning in ST is fallacious. The ruling relies on the indefensible MM Dicta, which are made to seem plausible only in virtue of a double equivocation – between 'understand' and 'fully comprehend,' and between 'understanding information' and 'acknowledging precarity.' And I have demonstrated that the ruling itself provides an illustration of precisely what it denies, viz., that it is indeed possible to understand, use and weigh information that one does not believe to be true.

If these conclusions are correct, then there is indeed an urgent need for the courts to review the MM Dicta, and to be clear that they should not be relied upon – whether in future rulings in the Court of Protection or in any of the capacity assessments that take place on a daily basis across the land.

Many of my conclusions in this letter have been negative, but I propose to conclude by pointing toward a positive lesson that we might take from the ST ruling. Although the main line of reasoning in Roberts J's judgment fails to survive criticism, there is a subsidiary line of analysis that points towards a fruitful alternative approach.

In order to bring this out, it is worth beginning from a passage in which Roberts J responds to the Official Solicitor:

> In relation to the concerns raised by the Official Solicitor in this context, I can accept the proposition that an individual who expresses hope that they will survive, or even a belief based on that hope, does not, *without more*, become incapacitous simply because they disagree with the medical advice they are given.[32]

Roberts J's main point here is one with which we should heartily agree. Rejecting medical advice must never be the basis for a finding of incapacity. Indeed we should go further: it should never be the basis for a finding of decision-making inability either. But what does Roberts J signal with the two words that I have emphasised: *without more*?

In several passages in the ruling it is reported that ST is *unable to contemplate possibilities* that conflict with her convictions. Dr A reports that ST "is unable to contemplate an outcome

[31] *A NHS Trust and ST* [2023] EWCOP 40, para. 64, 91.
[32] *ibid.*, para. 94; emphasis added.

which is inconsistent with her conviction that she can, and will recover."[33] Roberts describes "ST's complete inability to … contemplate the possibility that her doctors may be giving her accurate information."[34] I have argued at length in this letter that neither *believing* information nor being *able* to believe information is required in order to understand, use and weigh that information. *But the ability to project oneself imaginatively into different possibilities is something different.*

Three points are significant here.

Firstly, it is important to realise that contemplating (or 'entertaining') possibilities is itself a distinctive psychological activity, one at which human beings notoriously excel, and one that is quite distinct from belief. (I can contemplate the possibility of life on Mars without believing, or being able to believe, that there is life on Mars!) It follows that the *ability* to contemplate possibilities is itself distinct from the *ability* to believe.

Secondly, there are many circumstances in which the ability to contemplate possibilities, *including possibilities that one does not believe*, plays an essential role in decision-making. We can see how this works in a number of the scenarios surveyed above. The plant engineer sees the anomalous reading on H743a. This leads him to *consider the possibility* that the temperature in the tank is -20ºC, and to *think through what such a possibility would entail* (the contents of the tank would be frozen; there would be no flow in the output conduit, etc.). In this way, the engineer's ability to contemplate a possibility that he does not believe to be actual plays a role in his decision-making process. If in fact the engineer were *unable even to contemplate the possibility* that the temperature was -20ºC, none of this imaginative and deliberative work could get going.

In short, *contemplating possibilities* is a core activity in deliberation, and at least in some contexts plays an essential role in the ability to use and weigh information in the process of making a decision.

Thirdly, the capacity for contemplating possibilities is intrinsically finite, and can be compromised under conditions of impairment. No one can contemplate all the possible moves in a game of chess; someone with a brain injury or dementia (for example) may not be able to contemplate more than one or two. Crucially, the contemplation of possibilities also requires a degree of cognitive openness (or cognitive flexibility): the ability to imagine things as being other than they seem to be. It can therefore be *compromised by cognitive rigidity*. A mind that has become too rigid can thereby lose the ability to contemplate possibilities, and with it the ability to engage in meaningful deliberation.[35]

What does any of this have to do with the issues at stake in ST? Ultimately, I submit, ST's disbelief of the prognosis is not the decisive issue pertaining to her capacity. Disbelieving the information provided in one's prognosis is perfectly compatible with using and weighing that information in making a decision. Even an *inability* to believe is not, as we have seen, in and of itself incapacitating. *But it can be an effect of an underlying cause that itself incapacitates*. Contemplating or entertaining possibilities is core to the ability to use and weigh information. Arguably it is a component of *understanding* that information as well.

---

[33] *ibid.*, para. 100.

[34] *ibid.*, para. 103.

[35] A classic representation of this latter phenomenon can be found in Henry Fonda's 1957 film, *Twelve Angry Men*. Juror #3 (Lee J Cobb) is the final holdout on that famous fictional jury, insisting that the defendant is guilty. Again and again, Juror #3 is challenged to contemplate possibilities that would cast doubt on the prosecution's case. Again and again he shows himself incapable of doing so ("Isn't it *possible* …?" "It's not possible!") – for reasons that finally become clear at the end of the film.

So if one cannot even *contemplate the possibility* that is presented in a prognosis, that might explain one's inability to believe it. More importantly: it might prevent one from using and weighing it as well.

So how should an assessor proceed when confronted with a person who, like ST, does not believe authoritative information pertaining to the decision they face? If what I have argued here is correct, two key negative lessons follow. Do not rely on the MM Dicta. Do not take the MM Shortcut. Positively, this means that the assessor should remain alive to the possibility that the person is able to understand, use and weigh information that they do not believe. In practice, this will mean probing positively the person's understanding of the relevant information (whether or not they believe it), and determining whether and how they are able to factor that information into their deliberations. Where the person's disbelief of authoritative information seems to be a key obstacle in the decision-making process, probe for the underlying *causes* of that disbelief, and be alert for forms of extreme cognitive rigidity that may preclude the possibility of even contemplating possibilities that conflict with the person's convictions.

Sincerely,

Prof Wayne Martin, Director
The Autonomy Project
University of Essex

Appendix: Pseudonymised Ward Round Transcript

The discussion begins with Nelson out of the room.

Consultant:	So what does Nelson want?
Nurse:	Either more leave or to be made informal.
Consultant:	What leave does he have now?
Nurse:	30 minutes.
Consultant:	Do we have a wish list?
Nurse:	Leave is the main thing.
Consultant:	Are you concerned?
Nurse:	He has been using his leave well.
Consultant:	We could increase to 4x 30 minute leaves a day. It would be unescorted, so not a drain on staff time.
Ward Manager:	It will be a drain on staff time to sign him out four times. He has been irritable.
Ward Doctor 1:	He was initially agitated, but he has settled – after the first 48 hours.
Consultant:	What was the reason for admission?
Ward Doctor 2:	He was evicted from his accommodation, and lived on the streets for a period of weeks. During that time he stopped taking his meds.
Consultant:	What was the reason for the section?
Ward Doctor 2:	He became very agitated after taking some drugs that he had been given by someone on the streets.
Consultant:	OK. Let's meet with him.

There is a break while a member of the team invites Nelson to join.

Consultant:	Things seem to have gone better with this admission. Why do you think things have gone better this time?
Nelson:	Last time I was not taking my meds. I was not compliant last time.
Ward Manager:	You are right!
Consultant:	Why are you taking your meds this time?
Nelson:	I did not like the [Drug 1] last time; it made me zombie. This time, with the [Drug 2], it is OK.
Consultant:	Why are you taking it?
Nelson:	It is a nice level.
Consultant:	It keeps you on an even keel? Why do you think we prescribe it?
Nelson:	The [name of drug]?
Consultant:	Yes. Why do you think the doctors prescribed it for you to take?
Nelson:	[turning the question around:] Why *did* you prescribe it?
Consultant:	[to Ward Doctor] Dr *, do you want to explain?
Ward Doctor:	In the past, Nelson, did you have strange symptoms?
Nelson:	No.
Ward Doctor:	Hear voices?
Nelson:	No.
Ward Doctor:	Did you ever have unclear thoughts?
Nelson:	No. It is because of the diagnosis that they gave me: paranoid schizophrenia. That is why you prescribe it.
Consultant:	You don't agree with that diagnosis, do you?
Nelson:	No.
Consultant:	So why do you take the medication?
Nelson:	It is the only way that I can get out of this place. And with my temper and everything, my aggression. It helps.
Consultant:	So Nelson, what do you think we decided?
Nelson:	That you would make me informal.
Consultant:	Laughs. Yes.