

# Reasoning and Reversibility in Capacity Law

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**Abstract**—A key objective of the law in the assessment of decision-making capacity in clinical settings is to allow clinicians and judges to avoid making value judgements about the reasons that patients use to refuse treatment. This paper advances two lines of argument in respect of this objective. The first is that authorities cannot rationally avoid significant evaluative judgements in the assessment of a patient's own assessment of the facts of their case. The take-home message is that assessing reasoning is unavoidable value-laden. Yet the underlying motivation behind clinicians' and the law's value-neutral aims, i.e., the avoidance of undue paternalism, is worth preserving. That being so, the second line of argument will try to show that that underlying motivation is better served in a limited range of cases by embedding a 'reversibility standard' in the assessment process so that the patient can, if they wish, and in due course, bring about the consequences that they were prevented from realising as a result of a determination of incapacity.

**Keywords:** reasons, values, capacity, paternalism, reversibility standard

## 1. *Introduction*

Throughout the common law, judges have often remarked that it is not the business of doctors or the courts to thwart the wishes of patients who refuse treatment, regardless of whether the patients' reasons are 'rational, unknown or even non-existent'.<sup>[1](para.3)</sup> Supported by this 'reason-neutrality' view, the right of choice has accordingly been regarded as the determinative legal principle whenever patients are presumed, as they always are, to have the capacity to make their own decisions. However, when the presumption of capacity is rebutted on account of an assessed impairment or disturbance of the mind, decisions are then made for patients on the basis of what would be in their 'best interests' as they would, in part, be determined by the patient themselves if they had capacity.<sup>i, [2],[3],[4]</sup> The move from a presumption of capacity to a determination of

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<sup>i</sup> e.g., England and Wales' Mental Capacity Act 2005 (MCA), s 4 and Ontario's Health Care Consent Act 1996 (HCCA), c. 2, sched. A, s. 21 (2) (HCCA). If the court finds that a patient has capacity,

incapacity is structured by assessment processes which have attempted to retain the ‘reason neutrality’ framework in the guise of what is frequently described as ‘value neutrality’. The key ambition with this latter kind of neutrality has been that, even if the justifications for having a particular capacity assessment process are value-laden (e.g., promoting patient wellbeing when the patient cannot promote it themselves), the assessment itself should remain neutral about the values reflected in the patient’s decision to refuse treatment.

Yet the value neutrality just outlined is illusory. I offer an explanation of why this is so by focussing in section 2 on the ‘use or weigh’ test, sometimes called the ‘ability to reason’ test, that features in capacity statutes.<sup>5,6</sup> The key argument of that section is that any clinical or judicial judgment pertaining to the soundness of a patient’s reasons for refusing treatment conceptually requires a value-based assessment of those reasons.<sup>ii,7,8</sup> I follow in section 3 by developing a ‘reversibility standard’ for capacity assessments, the purpose of which is to retain, in some cases, and as much as it is rationally possible to do so, the value neutrality ambitions of capacity laws. Where it is not possible to retain those ambitions, clinicians and judges must recognise that it is a question of *when* not *if* capacity laws are unavoidably and profoundly paternalistic—or so I will conclude in section 4.

## 2. Reasoning as Valuing

### A. Case Law

Capacity laws typically feature some version of what has come to be known as the four abilities model of capacity assessments.<sup>9</sup> The model holds that a patient is presumed to have decision-making capacity unless they are, or become, unable: (a) to understand the facts relevant to the treatment decision; (b) to appreciate, across time, that those facts apply to them;<sup>iii, [10](para.37),[11]</sup> (c) to weigh

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there is no question of determining best interests (e.g., in *Re MB* [2](para. 30)). If, on the other hand, a patient is found to lack capacity, their subjective views of their best interests remain essential to, though not determinative for, the court’s determination of such interests, as we saw in *Wye Valley NHS Trust v Mr B* [3] (paras. 5 and 6) and in *Aintree University Hospitals NHS Foundation Trust v James* [4], especially Lady Hale at paras. 44–45.

<sup>ii</sup> For complementary lines of argument, see [7] and [8].

<sup>iii</sup> Strictly speaking, the MCA makes no mention of the ability to appreciate facts across time, opting instead for the ability to retain information that is relevant to the decision under question (MCA

or use, i.e., reason with, those facts; or (d) to communicate their decision.<sup>iv</sup> These conditions are necessary for decision-making capacity; a finding of inability in respect of any of them is sufficient for a determination of incapacity as long as the inability in question is due to an impairment or disturbance of the mind.<sup>[12](para.32)</sup>

Of the four conditions, the ability to weigh or use has been recognised by the courts as being ‘the most difficult’ criterion to assess.<sup>[8]</sup> In *Kings College Hospital NHS Foundation Trust v C & V*,<sup>[12]</sup> the court remarked that this difficulty stemmed from the ‘degree of subjective judgment involved’ in the assessment of the patient’s weighing and using of the relevant considerations. In that case, the judge went on to disagree with ‘two very experienced psychiatrists’ who determined that C lacked capacity on account of what they assessed as C’s inability to weigh and use certain key considerations.<sup>v, 13(pp83, 100)</sup> On the court’s view, however, there was a range of ‘reasonable interpretations’ available in respect of those considerations, and that the psychiatrists’ thresholds for the ability to reason were insufficiently accommodating. In other cases, the court would caution against setting the bar for what counts as the ability to reason too low. In *NHS Trust v Ms T*, the patient refused a blood transfusion as part of her treatment because she believed that her blood was evil and any blood given through transfusion, by mixing with hers, would also become evil: ‘[t]herefore’, she would say, ‘the volume of evil blood in my body will have increased and likewise the danger of committing acts of evil.’<sup>[14](para.8)</sup> The court decided that her ‘misconception of reality’ was to be treated as evidence of impairment,<sup>vi, [10](para. 61)</sup> and that ‘no weight’ should be accorded to this particular reason for refusing the transfusion.<sup>[10](para. 66)</sup> Similar reasoning was deployed by the court in *Oxford University Hospitals NHS Foundation Trust v Z*,<sup>15</sup> where the patient, a young woman with a mild learning disability, was found to lack capacity to refuse an intrauterine contraceptive device because, in part, her reasoning failed to adequately incorporate the complex risks which would be entailed by her refusal both for her own life and of any future infant. Sometimes, even, what occupies the court is a patient’s instrumental rationality, that is to

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pt. 1 s. 3(1)(b)). The case law around the MCA, however, reveals that judges continue to rely on the ability to appreciate as part of their capacity determinations. See, e.g., [10] and [11].

<sup>iv</sup> See, e.g., MCA pt. 1 s. 3.

<sup>v</sup> For discussion, see [13].

<sup>vi</sup> This is not to say, however, that Ms T’s ‘misconception of reality’ was the sole determinant of the court’s view that she was falling short of the relevant standard of reasoning.

say, the adoption of means that are, if not conducive to, then at least not antithetical to one's own stated ends.<sup>[16]</sup> In *A Mental Health Trust v ER & Anor*, for example, a patient with severe and enduring anorexia nervosa reported that she had 'no desire to die' and that she wished 'to take steps in order to avoid that [outcome]'.<sup>[17](paras.20–21)</sup> The court recognised that the patient was 'articulate and clear in her views, but, most importantly, insightful into her condition'.<sup>[13](para.32)</sup> Nevertheless, she evaded meals as part of her treatment, engaged in 'behaviours to appear higher in weight, in order to "trick" staff' at her clinic, and at times attempted to justify her 'drive for thinness' by relying on distorted beliefs about her weight.<sup>[13](para.20)</sup> The severity of the disconnect between her stated ends and adopted means constituted evidence of what the court called 'unrealistic thinking' and an inability to 'act rationally' in respect of her treatment options, as a result of which she was found to lack capacity.<sup>[13](paras.33–34)</sup>

## B. Soundness

In these and other cases,<sup>[18](para.27),[19](para.13)</sup> the question before the court pertained not to the existence or non-existence of the patients' reasons in refusing treatment but, instead, on their quality. More specifically, the concern was for the soundness of the reasoning on offer. Soundness is a feature of deductive reasoning that is valid, i.e., where the conclusions follow from the premises, and where all of the premises involved are, in fact, true. No factually false conclusions are permissible in sound reasoning, and I will need to get my facts right in order for my reasoning to count as sound. I have also said that any judgment of the soundness of a patient's reasoning for refusing treatment conceptually requires a value-based assessment of those reasons. But why is the assessment value-based and not, say, merely factual?

Suppose A warns B that a lorry is approaching at speed and that if B wants to cross the road, B should be careful not to step into the lorry's path. B thanks A for the warning but protests that A's understanding of how our bodies fare in high-speed human-lorry interactions is mistaken. 'There is nothing to fear', says B to A. Unfortunately for B, A was right. In stepping into the path of the lorry, B is fatally struck. Looking back, we might say that B ought to have listened to A. We might also say that B ought to have had working knowledge of the physics behind high-speed human-lorry collisions. But is it true that these *oughts* are *evaluative*, that is to say, do they rely on *values* for their rational

force?<sup>vii, [20]</sup> Contingently, the answer is a clear Yes: if B valued their life, and other things being equal, then they ought to have listened to A. Or, if B valued their life, they ought to have understood the relevant facts correctly. Now you might wonder if this is not just a sort of value-pumping—inserting into the story the value of self-preservation, which B may or may not have endorsed for themselves, and then proclaiming that, by its light, B reasoned in error. No doubt that is a valid objection if one is on the fence about the presumption that B signed up to the value of self-preservation. Yet the answer to the question of whether the *oughts* involved are evaluative or not is a clear Yes even non-contingently: B ought to have relied on true rather than false premises concerning human-lorry interactions because that is on the cards, analytically, in what it means to reason correctly.<sup>viii</sup> What we learn from B's demise is that understanding the facts of one's circumstances involves correctly reasoning, one component of which, namely, soundness, is biased in favour of and assessed with reference to what is in fact true.

What I have said so far is a conceptual explanation for the court's view that 'unrealistic thinking' or a 'misconception of reality', understood as a sufficiently inadequate understanding of the relevant facts, is sufficient for determining that a patient lacks the ability to reason and, by extension, lacks capacity.<sup>[14](para.61)</sup> Insofar as that determination entails an assessment of soundness, it is an assessment of the patient's reasoning with reference to external standards which, at the minimum, will include standards of correct reasoning. In engaging this assessment process, it is clear that neither clinicians nor judges can rationally avoid the evaluative exercise of holding up the patient's reasoning to the bar of what is regarded as counting as (i) true or (ii) false but reasonably so.<sup>ix</sup> Accordingly, the common view that what the courts are doing in capacity assessment cases is agnostic about the wisdom of the reasons that patients use to refuse treatment is decidedly false. The courts clearly have limits in respect of what they will tolerate as false reasons—and, as we have seen, <sup>[14](para.61),[21](para.31)</sup> the lower boundary of how demanding these limits are will be

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<sup>vii</sup> Some philosophers, notably John Broome, distinguish between *oughts* and *reasons*. Nothing will turn on that distinction here, for we may also ask whether B's *reasons* were inadequate from an evaluative point of view. See [16].

<sup>viii</sup> Is the aim of reasoning correct reasoning? And is it analytically true that to reason correctly is, in part, to rely on true rather than false premises? If your answer to these questions is No, then the answer to the question of whether the *oughts* involved in B's story are evaluative remains only contingently true. Addressing this form of scepticism, however, is beyond the scope of this paper.

<sup>ix</sup> For related discussion, see [3].

set by reasons that produce a conception of reality that is sufficiently and materially unwise or unrealistic.<sup>x</sup> So, the ability to reason, as far as the law is concerned, is the ability to reason according to an evaluative conception, however implicit or unacknowledged, of what the court recognises or treats as reasoning well enough to pass the bar of, at the very least, not constituting a misconception of reality. And once the court has explicitly or otherwise selected a standard of the ability to reason, it has expressed itself as valuing that standard over others—this, as I have argued elsewhere, is just part of the logic of selecting between alternative possibilities.<sup>[22](p.411)</sup> But once capacity courts, guided by best-interests considerations, get into the business of enforcing that standard notwithstanding the contrary wishes of the individuals who appear before it, what we have is paternalism.<sup>xi</sup> That result, by itself, is arguably neither a good nor bad thing, for the justifiability of the paternalism in question is to be decided partially on the extent to which, and the durability of, the law’s intrusion on a person’s autonomy. The question of *durability*, in particular, will take us to section 3. But before I get to that question, let me address a point of scepticism which may be lurking in the minds of some readers about my arguments regarding the nature of the evaluative commitments at play in the reasoning of capacity courts.

The sceptic might claim that the arguments thus far just show that the courts have evaluative commitments insofar as epistemic matters are concerned. That is, the courts value (a) what is true or, at the minimum, (b) what is false but reasonably so over and above (c) what is so false as to be a misconception of reality. Yet the sceptic might say that that kind of evaluative hierarchy in epistemic matters (e.g., soundness in reasoning) is a long way away from the kind of ethical commitments that would entail the court telling people how to live their lives. Indeed, much of the jurisprudence in capacity courts across common law jurisdictions is emphatically concerned with making a point of *not* telling people how to live their lives.<sup>xii,[23],[24]</sup> So, even if it is true that the courts

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<sup>x</sup> Neil Levy pointed out to me that one exception to the demandingness of these boundaries are views of reality that are sufficiently widely shared in one’s cultural context, such as one’s religious community. This exception is mirrored in the DSM-5’s entry on delusions, which likewise excepts religiosity that is not what it cryptically refers to as ‘elevated’.

<sup>xi</sup> To be clear, just because the evaluative commitments of capacity law implicate, as I will suggest, the perennial tension between autonomy and paternalism, that is not to say that other tensions and other values are not at play. Capacity law has many evaluative commitments but this article focuses on a narrow albeit significant subset of them.

<sup>xii</sup> e.g., *Re J* [23]; *Fleming v Reid* [24].

have the kind of epistemic evaluative commitments I have described, the spirit of the value-neutrality ambitions of the four abilities model is not aimed at those commitments. The aim, instead, is to require the court to be neutral in respect of the ethical values reflected in a person's decision-making, and not letting those values determine the court's findings in respect of their capacity. That story, in any case, is roughly what a sceptic might tell—and adding, for good measure, the important though often overlooked insight that not every evaluative commitment entails an ethical one.<sup>xiii</sup>

Yet whatever one's views might be on the complex question of whether epistemic norms of reasoning constitute ethical values, it is a fact that, in favouring a particular kind of reasoning—i.e., reasoning that is reasonable in its view—the court is favouring particular kinds of outcomes.<sup>xiv</sup> If every possible outcome were reachable through reasonability, it would be irrational for the court to favour reasonability. What a standard of reasonability does is place a minimum threshold of acceptability on possible outcomes. And that minimum threshold is highly unlikely be ethically inert, for it will entail significant consequences for the lives of the parties involved and for anyone else who may one day be subject to the precedent.<sup>[25](p.174)</sup> A minimum threshold that is not ethically inert is ethically salient and, as such, the business of enforcing it against the wishes of persons will, assuming beneficence, involve some kind of paternalism. As I say, the extent to which that is an objectionable outcome will depend on the durability of the measures the court adopts, which is our topic in the next section.

### 3. *Reversibility Standard*

The underlying motivation of both the law's reason-neutrality approach in capacity settings and value-neutrality ambitions in capacity settings is the avoidance of undue paternalism and the safeguarding of personal autonomy.<sup>[26](paras.6–11),[27](para.33)</sup> As far as the latter ambition is concerned, I have claimed that evaluative judgment is a rational requirement of any assessment process. This has not been to suggest that the underlying motivation to safeguard personal autonomy should be abandoned. Far from it. Indeed, that

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<sup>xiii</sup> Forcing a draw in a game of chess you cannot win is an evaluative commitment because it entails valuing a draw over a loss. But that value, by itself, is ethically inert.

<sup>xiv</sup> I have addressed a version of the foregoing objection in [8].

motivation can be effectively serviced in a limited number of capacity cases by embedding a ‘reversibility standard’ in the assessment process, the purpose of which would be to allow the patient, if they wish, to eventually bring about the consequences that they were prevented from realising on account of a determination of incapacity. What would such a standard look like? And how would such a standard help the courts in capacity cases? Let me take these questions in turn.

If a patient wishes to forego some treatment and thereby realise a certain outcome but is unable to do so because of a finding of incapacity, they have been doubly frustrated. First, assuming that they are subsequently treated, their wish not to undergo treatment will have been thwarted. The clock cannot be turned back on that count and the potentially transformative experience of having treatment forced upon them will remain an indelible and possibly traumatic part of their lives. And second, the treatment will have thwarted their plans, such as they were, to endeavour towards and possibly bring about certain ends. For the patient, this latter frustration can sometimes be rectified. Once the patient is released from involuntary care, for instance, they can commence or recommence efforts to do what they were initially stopped from doing. Treatment that permanently precludes the patient from rectifying the second frustration is accordingly more intrusive, from the patient’s first-person point of view, for their personal autonomy.<sup>xv,[28](p.299)</sup> But in the absence of that permanence, it is sometimes possible for the patient to reverse, as it were, the outcome-specific component of an intervention and place themselves, so far as possible, in the position they would have been if it were not for the treatment. This intuitive idea, adapted from the law of tort,<sup>[29](paras.129–33),[30](para.39)</sup> is worth developing into a practicable standard for capacity cases if for no other reason than the fact that it counts in favour of the view that paternalism, though it is a persistent feature of incapacity determinations, ought to be attenuated by promoting, from the patient’s point of view, their ability to self-legislate across time.<sup>31(p.440)</sup>

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<sup>xv</sup> Why specifically from the patient’s first-person rather an all-things-considered point of view? Because, as Neil Levy has convincingly argued, it is sometimes possible to increase autonomy by constraining it—specifically, by limiting a patient’s capacity to act upon cognitive illusions and/or temporarily impaired states of mind which we know diminish reasoning and, *a fortiori*, autonomy.



Table 1: *Reversibility Standard*

The proposed treatment:

- a. does not prevent the patient, with *reasonable effort*, encompassing considerations of time, cost-effectiveness, and other factors specific to their case, to realise the wishes they are expressing; and
- b. falls below a relevant case-specific threshold of *durability*, over which its effects are to be regarded as virtually permanent.

No doubt the utility of the standard is constrained by its limited scope (Table 1). For one thing, it is irrelevant to settings where the proposed treatment practically prevents the possibility of the patient placing themselves in the pre-treatment position or where the proposed treatment potentially entails a personally transformative experience.<sup>[32],[33]</sup> Where it is a possibility,<sup>[34],[35],[36]</sup> however, reversibility has a few autonomy-enhancing uses.

First, when the standard is used to tilt the balance of considerations in favour of reversible treatment decisions,<sup>xvi</sup> clinicians and judges are less likely to make what are called ‘serious prudential mistakes’.<sup>37</sup> These are errors in decision-making that are (i) virtually irreversible and which (ii) leave patients seriously worse off than (iii) alternative outcomes that were (iv) relatively easy to bring about (think, for example, of decisions to discharge patients with substance use disorders who have life-threatening but easily treatable infections).<sup>38</sup>

Secondly, satisfying the reversibility standard can be a useful psychological incentive, for it can be put to a patient who is anxious about the proposed treatment,<sup>39</sup> reassuring them that if they don’t like the outcome, they can reverse course later on. This may also count as an incentive for clinicians and judges in the assessment of a patient’s best interests, for if there is doubt about the prospects of success of the available treatment options, the fact that one of the options allows for a reversal of course is a consideration that counts in favour of that option provided that it doesn’t impact the feasibility of the others.

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<sup>xvi</sup> Tilting the balance of considerations in this way is not just about deciding between alternative treatments, but sometimes about deciding between providing a treatment and not doing so.

And finally, for judges in particular, the standard is one further instrument of satisfying the doctrine, which appears in most capacity statutes,<sup>xvii</sup> that amongst the available treatment options the least restrictive and intrusive should prevail.<sup>[40](para.42),[41](para.,58),[42](pp.124)</sup> For, as I explained earlier, the durability of a treatment outcome partly specifies its intrusiveness on a person's autonomy: the greater the durability, the greater the intrusion across time. From the point of view of the person whose autonomy is the subject of the intrusion, the reversibility standard is a kind of get-out clause since it disqualifies those treatments that effectively prevent them from changing course.

#### 4. *Paternalism: When Not If*

Let me conclude by tying the two main threads of this paper together a bit more firmly. I have tried to persuade you that assessing soundness is a rational requirement of assessing a person's ability to reason. When reasoning is unsound, the courts are compelled to determine just how far they are willing to go in accommodating reasoning that gets the facts wrong. They need to determine, in other words, what counts as a reasonably false view of the facts which nevertheless remains above the bar of what in *Ms T* was held to be a 'misconception of reality' severe enough to constitute evidence of a disorder of the mind.<sup>[14]</sup> Assessing a person's reasoning with reference to a selected standard in that way is straightforwardly evaluative. And, as I have put it, that also happens to be straightforwardly paternalistic once the court starts issuing orders to enforce its findings. But why paternalistic?

Paternalism, no matter the variety, ultimately boils down to two key ingredients—it involves (i) an act intended to be beneficent by one party that is (ii) contrary to the wishes of another party.<sup>xviii</sup> In a basic sense, it is pretty clear that all law is paternalistic. When I receive a parking ticket, it is typically contrary to my wishes; and one justification that is very popular amongst legal philosophers for why, from the law's point of view, I ought to obey the rules is that they get me to conform to *reasons that I already have*, e.g., normative reasons

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<sup>xvii</sup> e.g., UK: MCA pt. 1 s. 6; Canada: Substitute Decisions Act 1992 s. 66(9); US: Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (UGPPA) (2017) Art. 3, s. 301(a)(1)(A) & (B).

<sup>xviii</sup> And so, to be clear, the fact a best-interests decision promotes autonomy over time does not, therefore, make it non-paternalistic.

not to be inconsiderate to other road-users, etc.<sup>43</sup> The law, on that account, is both beneficent in its concern for my faithfulness to the reasons that apply to me and, by dint of its coercive ways, mostly insensitive to my wishes.<sup>xix</sup> So, let there be no talk of *if* legal rules, including the assessment rules that constitute capacity law, are paternalistic. The question is instead about *when* they are paternalistic. And the answer to that question, as I have hoped to clarify, is that they are paternalistic *all the time*.

The rules of capacity law, of course, are no traffic laws. Capacity law comes into direct contact with people's basic first-person conceptions of what it means to be autonomous. Determinations of incapacity often entail life-altering restrictions and their implications, legal and otherwise, have been compared to falling off a 'cliff edge'.<sup>[13](ch.2)</sup> It is against this backdrop—that of law's basic paternalism and of the gravity of a finding of incapacity—that the autonomy-enhancing ambitions of the reversibility standard or the least restrictive doctrine are to be appreciated. But where those ambitions cannot be realised, no one should be under any illusion that what remains is a profoundly thorough form of paternalism. The justification of that result will not, as I say, turn on the fact that we have paternalism but, instead, on the extent to which a person's autonomy is promoted over time.

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- <sup>4</sup> *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.
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<sup>xix</sup> You might object that it may not always be good for me, or in my interests, to conform to the normative reasons that apply to me. If that is your view, we may have a basic disagreement about the value of rationality—and, needless to say, this is not the place to try and resolve it.

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