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DECISION MAKING FOR INCOMPETENT PATIENTS: WHO DECIDES AND BY WHAT STANDARDS?

I. INTRODUCTION

Patients must possess the mental, legal, and emotional capacity to participate in decisions that affect their health care. A person’s competence will have implications on whether or not a person decides on a particular type of treatment, whether treatment is to be discontinued, and whether medical professionals are subject to civil or criminal liability. Theoretically, persons who suffer from a mental disorder or disability are afforded the same rights and guarantees as others in society, but practically the law has found it necessary to define circumstances under which key decisions may be taken away from the individual seemingly for their own benefit. Individuals who are labeled incompetent rarely perceive the situation in this way.

Competency may refer to at least thirty different kinds of legal questions, each with its own tests and standards. Patient self-determination, autonomy, and beneficence are all factors that affect competency and decision making. There are several different methods of determining capacity for health care decision making and because there are different methods as well as interpretations by the courts, there is inherent inconsistency in rendering a patient competent to make medical care decisions. This Comment addresses the weaknesses and possible dangers of applying unequal standards for assessing competency for medical decisionmaking and suggests a movement toward a more uniform standard. The difficulty rests on the lack of agreement and the result may be exploitation or misdirected intervention.

Section I deals with the different definitions of capacity, the roles of patient autonomy, and the concept of beneficence. In this section, informed consent is discussed as well as the physician’s role in a capacity determination of a patient. Then Section II will discuss the major tests used to determine patient capacity for health care decision making. The capacity tests include the following: (1) the Loren H. Roth, Alan Meisel and Charles W. Litz Formulation; (2) the President’s Commission Study; (3) the Sliding Scale Model; and (4) the MacArthur Treatment Competence Study. Section III will explore and analyze state definitions of competency. The case law and legislation in the area of competency determination for health care decisionmaking shows the inconsistency in applying many combinations of tests to determine competency. There is some confusion over the terminology with respect to clinical and legal capacity. In this Comment, the terms competency and capacity are used interchangeably.
II. DECISION MAKING CAPACITY AND PATIENT AUTONOMY

A. What is Incompetency?

Medicine, law, psychiatry, philosophy, and other disciplines have led to competing theories of what defines competence. Some patients clearly possess capacity while others clearly do not. Examples of those individuals without decisionmaking capacity include infants, young children, comatose patients, the severely mentally handicapped and the severely mentally ill. However, in many situations, the patient's capacity to make health care decisions is not as obvious.

Incompetency is a legal term that describes persons who are found unable to properly exercise certain individual rights and legal prerogatives due to mental incapacity. Both the vagueness and extensive legal literature on the subject make competency determinations susceptible to arbitrariness and pose a threat to individual liberty. Incompetency provisions are usually justified by the notion that the patient does not act effectively in their best interest, so society must intervene. Many times, declaring a patient incompetent to make health care decisions can be more intrusive and liberty depriving than a criminal conviction.

The distinction between general and specific competence is significant. An individual is presumed to have capacity unless proven otherwise. When a capacity determination is questionable, the courts have traditionally viewed competence in general terms. The more recent view is that a person may have competence to decide some issues but not others. For example, specific competence for health care decision making would render a patient competent to decide what would be done medically to the body, but incompetent of becoming a guardian for another


2. See ROBERT G. MEYER, ET AL., LAW FOR THE PSYCHOTHERAPIST, 89-113 (1988); see also BLACK'S LAW DICTIONARY 522 (6th ed. 1991) “The quality or state of being incapable, want of capacity, lack of physical or intellectual power, or of natural or legal qualification; inability, incapability, disability, incompetence.” E.g., Peter Margulies, Access, Connection and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity, 62 FORDHAM L. REV. 1073, 1093 (1994) (discussing the lawyer's role and ethical considerations of having an incapacitated client); Robert W. White, Motivation Reconsidered: The Concept of Competence, 66 PSYCHOLOGICAL REV. 297, 333 (1959) (arguing that the motivation needed to attain competence cannot be completely from sources of energy-like drives or instincts).


4. See MEYER, supra note 2, at 89.

5. See id.


8. See Margolis, supra note 6, at 921; see also William M. Altman et al., Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives, 37 VILL. L. REV. 1671, 1678 (1992) (stating that decisional capacity is viewed along a continuum as a matter of degree, not an all-or-nothing phenomenon).
Lastly, decisionmaking capacity is not an immutable characteristic that a person has or does not have. Competence is a continuum concept. One commentator states,

Because no one factor can distinguish those with decisionmaking capacity from those without, an artificial line must be drawn so that only those patients judged to perform at or above this threshold are deemed to have decisionmaking capacity and, consequently, will be treated as “competent” to make health care decisions.10

B. Competency Assessment and Beneficence

A competency assessment is also correlated to the concept of beneficence or do no harm. The term beneficence conjures up ideas of mercy, kindness, and charity.11 Some believe that there is a need for clearer reasoning to deal with the potential conflicts that can arise between the principal of beneficence and autonomy at the moment of the medical decision.12 A key question to is “which should be the dominant principal—the patient’s freedom to choose what he or she thinks is good, or the doctor’s freedom to intervene when, in his or her opinion, the patient has made a harmful or dangerous choice?”13 It is assumed that these interventions are on the patient’s behalf.

There are several problems with this assumption. First, the patient’s values are at the mercy of the physician’s own subjective values.14 Second, there is the presumption that beneficence is synonymous with strong or weak paternalism.15 Larger goals of beneficence would allow the physician’s intervention to restore quality of life in some cases.16 The flip-side of beneficence is the concept of

10. See Margolis, supra note 6, at 922.
11. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 209 (3d. ed. 1989). Throughout history, the health profession’s codes and writings on ethics have been understood in terms of beneficence. In the Hippocratic works, beneficence has been the most celebrated expression as the core principal of medicine. Id.
14. See FADEN & BEAUCHAMP, supra note 12, at 156; see also, e.g., SILBERFELD & FISH, supra note 9, at 51-52 (explaining that when a patient imprudently refuses medical treatment, the distinction between medical care and competency assessment breaks down).
15. See id. Competency assessments presume that when a patient disagrees with the physician, “beneficence” requires that patient autonomy be violated.
16. See id. at 157. Three rules are advanced to justify the necessity of medical paternalism: weak form, intermediate form, and hard form. The weak form states that the doctor should always intervene to reverse potentially reversible conditions impairing competence. The intermediate form articulates that the physician should always act to reverse trauma or illness despite objections to the contrary, or unless the patient’s wishes were set forth before the questioned capacity. The hard form of the rule applies particularly to psychiatry. See id. at 157-
C. Respecting the Value of Patient Autonomy

The theory behind decisional capacity serves many social principals that include autonomy. Autonomy has come to mean the patient's right to choose the treatment he or she believes is best. The interest of protecting autonomy in treatment decisions is twofold. First, protection of autonomy is a reflection of a value placed on liberty. Second, safeguarding patient autonomy serves to restore the balance in the physician/patient relationship by humanizing it. One commentator states that autonomy is the "responsible use of freedom and is therefore diminished whenever one ignores, evades, or slight one's responsibilities."

Two individuals have shaped the development of the principal of autonomy--Immanuel Kant and John Stuart Mill. According to Mill, there is a moral demand for non-interference. Kant's view lends itself to respect for persons and concluded that human dignity rests in our ability to preserve our autonomy to achieve the kinds of lives or treatments we want for ourselves.

Competence and autonomy are closely related, but not identical concepts. Autonomy means self-governance while competence is the ability to perform a task. For example, incompetent patients may act autonomously while some competent patients can retain their faculties in some situations but not in others. Internal factors such as fear, neurotic compulsions or drug addictions can impair both autonomy and competence. In the medical arena, the reluctance to promote total patient self-determination could be due to the influences of the traditional...
medical model. An example of this idea is given in the following case.

In the case, In re Martin, a patient, Michael Martin, lacked capacity to give informed consent to treatment after a car/train accident. As a result, the probate and appellate courts wrongfully disregarded evidence of Martin’s awareness of his environment and willingness to cooperate with his caregivers as indications of his desire to live. The court required Martin to satisfy a strict standard before allowing him to choose life, and destroyed his autonomy and his interest in life without vindication.

When dealing with medical treatment decisions, the legal counterpart to autonomy is informed consent. In the last two decades, protection of autonomy has been primarily justified by informed consent provisions. When a patient cannot exercise the right of self-determination for himself, a surrogate may be appointed to decide on medical treatment. The surrogate may be the physician or the patient’s family. Some commentators have stated that a determination or suspicion of incompetence can be used to justify paternalism by physicians and family members.

Studies indicate that many physicians claim that they obtain “informed consent” from their patients prior to medical procedures. However, the evidence that establishes “informed consent” differs among physicians as to their subjective perception. One potential problem stems from physicians focusing more on the informing aspect rather than on the consent aspect of the doctrine. Some physicians take the informed consent obligation earnestly. However, in general, the doctrine of informed consent has done little to change the traditional relationship between the physician and the patient.

D. Informed Consent and the Role of Capacity

Capacity is inherently intertwined with the notion of informed consent. Decisionmaking capacity is a threshold element of informed consent. The
informed consent doctrine traces its origins to the notion that all competent patients have the right to determine what shall be done with their own bodies. 39

The doctrine of informed consent requires that a patient be given information that will cognitively influence his or her decision. 40 This information includes the condition, proposed treatment, risks and benefits, and alternatives. 41 Consent must be given by someone who is competent to be binding in the decision. 42 The doctrine of informed consent acknowledges that the consequences of a physician’s explanation may be a patient’s refusal of medical treatment and assumption of the risk of the consequences of the decision. 43 It is important to assess the patient’s capability to understand and appreciate the disclosed information, so that the physicians can be confident that it is the patient’s decision. 44

In regards to the incompetent patient, surrogate decisionmaking provides an alternative. 45 Comatose patients and infants are clear examples of individuals who are not capable of making decisions for themselves. 46 An incompetent patient creates an obligation for a surrogate decisionmaker to be found. A surrogate must be identified and provide a basis for the physician to defer the medical decision to them. 47

Additionally, there are many patients that are borderline cases with regard to competency. 48 This situation may create a clear conflict for the physician. The physician aims to honor the patient’s wishes and respect their autonomy while not

39. See Pollock, supra note 21, at 506; Schloendorff v. New York Hosp., 105 N.E. 92, 93 (1914) (stating that a surgeon who performs an operation without the consent of the patient will be liable for damages); see also Union Pacific Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (holding that an order to examine the patient will not be enforced due to lack of consent); Note, Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Prehersence, 64 NOTRE DAME L. REV. 394, 398 (1989) (discussing the common law right of bodily self determination); cf. In re Farrell, 529 A.2d 404, 410 (1987) (holding state interests are not compelling enough in the context of a competent, terminally ill adult patient living at home to withdraw a life-sustaining respirator); In re Conroy, 486 A.2d 1209, 1221 (1985) (holding an elderly nursing home patient somewhat conscious of her surroundings did not have the right to refuse nasogastric feeding tubes).

40. See Annas & Densberger, supra note 3, at 568.
41. See id.
42. See Pollock, supra note 21, at 507; see also Annas & Densberger, supra note 3, at 568 (explaining that the most meaningful way to test for competence in a situation is to determine if the patient actually understood the information necessary to provide “informed” consent).


44. See Annas & Densberger, supra note 3, at 568.
45. See Pollock, supra note 21, at 507. Decisions for incompetent patients are often made by the following individuals: spouse, child, a more distant relative, or a close friend. A detailed discussion of surrogate decision making is beyond the scope of this Comment.
46. See Annas & Densberger, supra note 3, at 568.
47. See James F. Drane, The Many Faces of Competency, HASTINGS CENTER REP., Apr. 1985, at 17. See generally Thomas J. Marzec, Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach, 1 ISSUE & MED. 293, 301-313 (explaining in detail how surrogates are appointed along with the procedural and theoretical difficulties of surrogate decisionmaking).
48. See Annas & Densberger, supra note 3, at 568-69.
jeopardizing the deliverance of good medical care. In all of the capacity cases, the issue lies in the freedom of the patient to exercise a decision and accepting the responsibility of the consequences of the decision. To better understand this issue, we must consider the procedure of determining patient competency determination.

E. Procedure for Competency Determinations

Patient capacity is initially called into question by the physician in most cases. Doctors routinely make competency determinations during the course of their practice that are rarely reviewed. Often, this assessment takes place without the party’s awareness. Only a small number of physicians are aware that the law requires an adult person to be presumed competent unless otherwise declared by a court. When there is no question of the patient’s incapacity, an expensive judicial process is a non-issue. However, when the patient’s capacity is questionable, it is the physician who, almost always, makes a legal determination regarding decisionmaking capacity.

There are several contexts in which a physician is likely to question a patient’s competency. First, a person may refuse treatment that is prescribed. Second, if a person of questionable certainty is to undergo a major medical procedure, a physician may seek consultation to ensure that the person is able to give informed consent. Third, a competency evaluation may be sought when a patient who is de jure incompetent for most purposes, may give consent in a limited context.

The treating physician may be uncertain about the patient’s emotional and cognitive abilities. A doctor would likely request the opinion of other professionals who are presumed to have knowledge and experience in capacity assessment. Ordinarily, there should be more than one examination before a patient is deemed...
to be incompetent for health care decisionmaking. Further, a physician may wish to respect a family’s decision about a particular treatment but may be concerned that a family member or another may blame the physician for withholding or withdrawing the intervention.

A correct competency assessment aims at eliminating two types of errors: (1) preventing competent persons from deciding about treatments and (2) failing to protect incompetent persons from the damaging effects of a bad decision. When a physician believes that there may be a significant impairment to decisionmaking ability, they must estimate the probability that a court would find the patient incompetent on the basis of what is demonstrated. Also, the physician must assess the cause of the patient’s limitation, and the recommendation for treatment if it is feasible. If the physician believes that the patient is incompetent, mechanisms, such as a court order, can be undertaken to obtain an alternate decision on the patient’s behalf. A physician must exercise careful judgement regarding the acceptability of allowing the patient’s family members to make medical decisions on the patient’s behalf.

III. TESTS FOR DECISIONAL CAPACITY

Many current assessment tools are inefficient and difficult to administer. Some tests are too lenient while others prove to be too stringent. There has been a desire to have a more universally accepted method to determine capacity. An extensive analysis of all of the instruments developed to determine capacity over the past twenty years is beyond the scope of this Comment. The following tests are

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60. See Appelbaum, supra note 6, at 1638. If there is reason to suspect that the impairment is caused by specific circumstances, such a administration of medicine or time of day, at least one evaluation should take place when these conditions are not present. Cf David M. Eddy, Practice Policies-What Are They?, 263 JAMA 877, 877 (1990) (discusses how practice policies can present powerful tools to deal with the complexity of medical decisions).

61. See id.; see also Jeffrey Blustein, The Family in Medical Decisionmaking, HASTINGS CENTER REP. May-June 1993, at 6, 13 (discusses family involvement and its implications on patient autonomy). But see, Harwig, supra note 17, at 5 (stressing that the prevalent ethic of patient autonomy ignores family interest in medical treatment decisions).

62. See Drane, supra note 47, at 17.

63. See Appelbaum, supra note 6, at 1638. This prediction should be based on the examiner's experience is their jurisdiction.

64. See id. The most difficult problem associated with this assessment is when the patient refuses to cooperate. See R.H. Lockwood, Annotation, Mental Competency of Patient to Consent to Surgical Operations or Medical Consent, 25 A.L.R. 3d 1439 (1970).

65. See Lockwood, supra note 63, at 1439. This may require a judicial hearing in some states. The practice in most states is to accept the substituted decision by family members. See discussion infra pp.14-15 (noting that the President's Commission endorses this approach as a means of not overloading the judiciary).

66. See Appelbaum, supra note 6, at 1635.

67. See Lockwood, supra note 64, at 1439.

68. One test focuses on the role of neurobehavioral deficits in patients that have experienced stroke, head injury, Alzheimer's disease, and multi-infarct dementia. The emphasis of the test is developing guidelines for the assessing specific forms of cognitive impairment not general guidelines. See Morris Freedman et al., Assessment of Competency: The Role of Neurobehavioural Deficits, 115 ANNALS OF INTERNAL MED. 203, 205 (1991); see generally Daniel C, Marson et al., Neuropsychologic Predictors of Competency in Alzheimer's Disease Using a
the most commonly cited and discussed ways of determining capacity for health care decision making: (1) the Roth, Meisel & Litz Formulation; (2) the President’s Commission Study; (3) the Sliding Scale Model, and (4) the MacArthur Treatment Competence Study.

A. The Roth, Meisel, & Lidz Formulation

Some scholars have attempted to categorize the possible tests for capacity that could be applied to patients whose capacity was in question.69 One of the tests was developed by a psychiatrist, a lawyer, and a sociologist.70 This particular test involves five categories: (1) evidencing a choice; (2) “reasonable” outcome of choice”; (3) choice based on “rational” reasons; (4) ability to understand; and (5) actual understanding.71 Each approach balances patient autonomy against social goals in different ways.72

1. Evidencing a Choice

This test is the most respectful of patient autonomy for health care decision making.73 According to this test, a patient is competent if he or she evidences a preference for or against treatment.74 Only the patient who does not evidence a choice is considered incompetent to make health care decisions. This test


69. See FURROW, supra note 23, at 246. Other known capacity assessment instruments that are available include the following:
- Mini-Mental State Examination (MMSE)
- MacArthur Group’s Understanding of Treatment Disclosure and Thinking Rationally About Treatment
- Edelstein’s Hopemont Capacity Assessment Inventory
- Neurobehavioral Cognitive Status Examination
- Wechsler Adult Intelligence Scale
- Short Psychiatric Evaluation Schedule
- Brief Cognitive Rating Score
- Mental Status Questionnaire
- Kapp, supra note 32, at 79-80.

70. See Loren H. Roth et al., Tests of Competency to Consent to Treatment, 134 AM. J. PSYCHIATRY 279, 283 (1977) [hereinafter Roth].

71. See id. A majority of commentators suggest that the legal standard for determining competency fall into one or more of the scholarly categories. See Appelbaum, supra note 6, at 1635.


73. See id.

74. See Roth, supra note 70, at 280. This preference may be a yes, a no, or even a desire that the physician make the decision for the patient. Additionally, this test may be what a court had in mind when it ruled that even legally incompetent and possibly non-comprehending residents of state schools may not be sterilized unless they have formed a genuine desire to undergo the procedure. See Wyatt v. Aderholt, 368 F. Supp. 1383, 1385 (D. Ala. 1974); see also Wolff, supra note 72, at 743. By focusing on purely behavioral evidence, this test is very reliable. However, this test does not function well for ascertaining competency for medical refusal cases. All consents or refusals constitute a choice—only a non-decision would be considered incompetent.
encompasses the unconscious patient at a minimum.\textsuperscript{75} The following case example shows the use of the test of evidencing a choice:

A 41-year-old depressed woman was interviewed in the admission unit. She rarely answered yes or no to direct questions. Admission was proposed; she said and did nothing but looked apprehensive. When asked about admission she did not sign herself into the hospital, protest or walk away. She was guided to the outpatient ward by her husband and her doctor after being given the opportunity to walk the other way.\textsuperscript{76}

Further, strict defenders of individual autonomy have agreed that patients who do not formulate and express a choice are incompetent. Szasz stated,

It is quite obvious, that I make this abundantly clear, that I have no objection to medical intervention vis-a-vis persons who are not protesting, . . . [for example,] somebody who is lying in bed catatonic and the mother wants to get him to the hospital and the ambulance shows up and he just lies there.\textsuperscript{77}

2. "Reasonable" Outcome of Choice

This test entails evaluating the patient's capacity to reach the "reasonable," the "right," or the "responsible" decision.\textsuperscript{78} The emphasis on this test is the outcome rather than on whether a decision has been reached in the first place.\textsuperscript{79} This test emphasizes social goals over patient autonomy.\textsuperscript{80}

The "reasonable" outcome of choice test requires the evaluator to agree with the patient in their decision.\textsuperscript{81} If that is not the case, then the patient's decision is overridden.\textsuperscript{82} For example, under this standard, a mentally ill person who decides to forego medical treatment despite a substantial risk to his or her mental well being may be labeled incompetent and denied the right to self-determination.\textsuperscript{83} The reasonableness of a result is based on a balancing test of complex factors and is likely to be subjective rather than objective.\textsuperscript{84}

Given the medical profession's tendency to preserve life, the patient is most likely to be considered incompetent if there is disagreement between the doctor and

\textsuperscript{75} See Roth, supra note 70, at 280. In psychiatry, this test encompassed the mute patient who cannot or will not express an opinion.
\textsuperscript{76} See id.
\textsuperscript{77} See M.C. McDonald, And Things Get Rough, PSYCHIATRIC NEWS, Nov. 5, 1975, at 13-14.
\textsuperscript{78} See Roth, supra note 70, at 280.
\textsuperscript{79} See id.
\textsuperscript{80} See id.; see generally Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1149, 225 Cal. Rptr. 297, 308 (1986); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 426-27 (1977) (holding that state interest to protect individuals was a significant issue).
\textsuperscript{81} See Wolff, supra note 72, at 743.
\textsuperscript{82} See id.; see also Freedman, supra note 1, at 58-60.
\textsuperscript{83} See Paul R. Friedman, Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons, 17 ARIZONA L. REV. 39, 77 (1975).
\textsuperscript{84} See id.
the patient. In medicine, there is a common presumption of patient incompetence in that the physician knows best. Medical scepticism of patient’s decisional capacities can be traced back to the time of Hippocrates. Hippocrates advised his fellow practitioner to:

Perform [these duties] calmly and adroitly, concealing most things from the patient while you are attending him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient’s future or present condition.

This notion was reflected in early professional codes of the early nineteenth and twentieth centuries and continue on into the medical practice of today. A modern example of this idea is the case United States v. Charters. In Charters, a psychiatric patient refused antipsychotic drugs that were prescribed by a physician to make him competent to stand trial. This refusal was used as a basis of his adjudged incompetency.

Lastly, this test is used more often than might be admitted by both physician and the courts. When life is at stake, a court may focus on the smallest ambiguity to cast doubt on the patient’s competency to make medical decisions. For example, in one case, a judge ordered the amputation of the leg of an elderly dying man even though the man had told his daughter before this physical deterioration not to permit the surgery.

3. Choice Based on “Rational” Reasons

This test evaluates whether the patient’s decision is due to a mental illness. Parallels can be drawn between this test and the previous test—“reasonable” outcome of choice. If the patient decides the “right” way, then the issue of competency will probably not come up. In this test, the quality of the patient’s thinking is what is important.

The rational reasons test has many shortcomings. An obvious problem is

85. PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL RESEARCH, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT 126-36 (1982).
86. See Annas & Densberger, supra note 3, at 576.
87. See id.
88. See id. Hippocrates recommended this position to physicians because he doubted patient’s capacity for self-determination. Id.
89. See id.
91. See id.
92. See Roth, supra note 70, at 281. Judicial decisions overriding patient’s desires with certain religious beliefs not to receive blood transfusions may rest in part on the court’s view that the individual’s decisions was unreasonable. See N.L. Cantor, A Patient’s Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 RUTGERS L. REV. 228-264 (1973).
93. See Roth, supra note 70, at 281.
94. See id.
95. See id.
deciding what is a rational decision and what is not a rational decision. The test may express a value preference for a certain type of thinking. Any attempt to assess the quality of reasoning runs the risk of the competency evaluator to substitute their own manner of thinking. Another problematic area is proving the causal link between the irrational decision and the patient’s incompetence. Conditions such as phobia, panic and depression can lead to an irrational decision but do not necessarily equate with incompetence.

4. The Ability to Understand

The ability of a patient to understand is consistent with the law of informed consent. Under the informed consent doctrine, patients may make treatment decisions only when those decisions are informed, voluntary, and competent. The traditional method for administering this test is the following: (1) the patient is given the information necessary to make a informed decision; (2) the patient’s decision is made; and (3) the patient is then asked for the information that was considered relevant in making the decision.

There are several limitations of this particular test. One limitation of this test is that the patient may understand the risks but not the benefits of a particular decision. Another problem with this test is that it does not gauge how sophisticated the understanding must be to in order for the patient to be viewed competent. One last shortcoming of this test is that its application depends on evaluating mental processes rather than concrete and observable elements of behavior.

96. See id.; see also Wolff, supra note 72, at 745. The subjective evaluation can infringe on patient autonomy and does not allow personal peculiarity responses from a rational decision maker.

97. See Friedman, supra note 83, at 78. There is a line between genius and madness; many sound decisions have been made on the basis of unconscious or preconscious thought. These decisions may be characterized as irrational or intuitive. Id.

98. See id.

99. See Freedman, supra note 1, at 64.

100. See Wolff, supra note 72, at 745. One proposed solution to this problem is to limit the responses that fail under this test to those premised under known falsities. See also Roth, supra note 69, at 281. For example, a delusional patient may refuse ECT not because he or she is delusional but because he or she is afraid of it, which is considered a normal reaction.

101. See Roth, supra note 70, at 281.

102. See Freedman, supra note 1, at 63. The tests of competency are almost the same as the “informed” and “voluntary” requirements of informed consent.

103. See Wolff, supra note 72, at 745; The following is an example of how the test of the ability to understand is used:

A 44-year-old woman who was diagnosed as having chronic schizophrenia refused amputation for her frostbite. She was nonpsychotic. Although her conditional was evaluated psychiatrically as manifesting extreme denial, she understood what was proposed and that there was some risk of infection without the surgery. Nevertheless, she declined. She stated, “You want to take my toes off; I want to keep them.” Her decision was respected. She agreed to return to the hospital if things got worse. A month later she returned, having suffered an auto-amputation of the toes. There was no infection; she was rebandaged and sent home.

Roth, supra note 70, at 282.

104. See id.

105. See id.

106. See id.
5. Actual Understanding

The fifth prong to this test requires that the patient actually cognitively evaluates the costs, benefits, alternatives of the treatment, and be able to apply these thoughts to the situation at hand. This test obligates the physician to educate the patient and directly ascertain whether the patient has actually understood. It is important for patients to have an understanding as to what the significance of what is being said as well as being aware that they have a critical part to play in the decision-making process. This test articulates a potentially high level of competency thereby being difficult to achieve. Further, this test amplifies the subjectivity problem found in the ability to understand test because the focus is on whether the patient actually understands.

Despite these problems, a court has held that this test can be the most exacting standard to determine competency for a patient. In the case, In re Farrell, a patient suffering from Lou Gehrig’s Disease was adjudged competent based on a psychologist’s examination rather on the application of the actual understanding test.

All of the elements of the tests are combined when the enumerated test is applied. Most importantly, one authors stress that “the circumstances in which competency becomes an issue determine which elements of which tests are stressed and underplayed.” In theory, competency is supposed to be an independent variable that determines who will make health care decisions. In practice, there appears to be an interplay of two additional variables: the risk/benefit treatment ratio and whether the patient consents or refuses treatment.

B. The President’s Commission Study

Another major test for determining capacity for health care decision making was conducted by the President’s Commission for the Study of Ethical Problems in

107. See Wolff, supra note 72, at 749.
108. See Roth, supra note 70, at 282. Physicians must make sure that the patient understands what is being told and encourage active participation in the selection of treatments.
109. See Appelbaum, supra note 6, at 1636. Authors suggests that to test patient’s understanding, it is better for the physician to ask the patient to paraphrase the information. A physician may ask a patient to interpret statistical statements such as “There is a fifty percent chance that the operation will be successful.” Patient’s awareness of their role can be ascertained by the physician asking whether or not they understand the purpose of informed consent and their role as a patient. Id.
110. See Roth, supra note 70, at 282.
111. See Wolff, supra note 72, at 749.
113. See id. at 412; see generally In re Conroy, 486 A.2d 1209 (holding that a competent patient has a clear understanding of his or her illness and prognosis, and of the risks and benefits of the proposed treatment, and has the capacity to reason and make judgements about that information).
114. See Roth, supra note 70, at 282.
115. Id.
116. See id.
Biomedical and Behavioral Research. The President’s Commission sought to develop clear policies to assess incompetence. In the Commission’s view, decisionmaking capacity is specific to a person’s actual functioning in situations in which a health care decision is made rather than the person’s status. Decisionmaking capacity primarily requires three elements: (1) possession of a set of values and goals; (2) the ability to communicate and understand information; and (3) the ability to reason and deliberate about one’s own choices.

First, a framework of values must be ascertained and stable. The patient must be able to make reasonable consistent choices so that a course of therapy could be initiated with some prospect of being completed. Second, the patient must have the ability to give and receive information. The Commission stipulates that the these abilities can be evaluated only as they relate to the decision at hand. Using this ability, a person also needs to have sufficient life experience to appreciate the meaning of the different alternatives. Third, the patient must have the ability to compare the impact of the alternatives on personal goals and life plans.

The measurement of these abilities can be very complex. In the context of informed consent, it is critical that a the patient make a specific medical decision. A problematic aspect to this test is that the standard does nothing to prevent the occurrence of a defect or mistake in the patient’s reasoning process. Another criticism of the model is that the Commission ranks the question of assessment second to creation of ways of making decisions on behalf of those patient’s believed to be incompetent.

C. The Sliding Scale Model

Some suggest a sliding scale model or a risk-benefit analysis for assessing
capacity for medical decision making. Under this analysis, the amount of capacity required should depend somewhat on the seriousness of the medical decision at hand. When the decision approaches a life or death situation, the courts may require a greater capacity for the individual. One commentator states that it is one thing for a patient to refuse chemotherapy or a respirator when it is known that the treatments or technologies would do nothing little to prohibit inevitable death, but it is another thing for a patient to refuse insulin that would enable him or her to live indefinitely, or antibiotics that would cure an otherwise fatal infection.

The sliding scale model had three general categories of medical situations: (1) easy, effective treatments; (2) less certain treatments; and (3) dangerous treatments. Within each category, as the consequences of the person’s decision become more serious, the more stringent the standard. Three major assumptions underlie this model. First, the content of the decision should be considered so the competency determination is linked to the particular decision. Second, the concept of reasonableness is found at every level within the model. Third, the reasonableness assumption justifies some paternalistic behavior.

There are several objections to the sliding scale model for determining competency for health care decision making. Libertarian thinkers view the model as a way of justifying physician paternalism and diminishing a patient’s right to make medical choices. Significantly, the least stringent category of the model establishes the rationality of the decision with the competency of the decision maker. Regarding the most stringent standard, objections are raised because every patient must thoroughly understand and render a rational decision to be competent. In that situation, many people would be deemed incompetent. Additionally, the medical delivery system would be overrun with surrogate decision making.

128. See Altman, supra note 8, at 1680; See John H. Hess, Looking for Traction on the Slippery Slope: A Discussion of the Michael Martin Case, 11 Issues in LAW & MED. 105, 117 (1995). With the presumption in favor of life, a sliding scale capacity standard should be applied when faced with the risk of allowing a person to die in error. Id.; see generally In re Martin, 504 N.W.2d 917, 924 (Mich. App. 1992) (enumerating a four-part test for assessing capacity).
129. See Drane, supra note 47, at 17-21; see also Appelbaum, supra note 6, at 1638 (explaining that courts have not explicitly adopted the sliding scale model).
130. See Drane, supra note 47, at 17-21.
131. See Marzen, supra note 47, at 300-301.
132. See Drane, supra note 47, at 18-21.
133. See id. at 18.
134. See id.
135. See id. For example, when two people play chess, there are certain expectations even though no particular decisions are required. If, the player makes an unusual move, the other player may wonder whether the player is competent or knows what he is doing. Id.
136. See id.
137. See id. at 21. The author believes that the model safeguards patient autonomy while balancing the autonomy with well-being. But see In re President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1010 (authorizing a hospital to administer blood transfusions to a patient who objects on religious grounds is proper when the patient will die as a consequence).
138. See Drane, supra note 47, at 18. The President’s Commission rejects any standard based on the outcome of the decision itself. If that were the case, competence would boil down to what the doctor believes is best for the patient.
139. See id.
makers depriving patients of self-determination. Lastly, in the context of right to die cases, some argue that the sliding scale model prefers maintaining the status quo by choosing life instead of death.

D. The MacArthur Treatment Competence Study

The MacArthur Treatment Competence Study was formulated by a psychologist, Tom Grisso, and a psychiatrist, Paul Appelbaum, to address clinical and policy questions associated with person’s abilities to make medical decisions. The MacArthur Treatment Competency Study formulated instruments in an attempt to utilize the current body of law that has developed around treatment refusal, rather than treatment acceptance. The instruments were developed to establish measures of decisionmaking abilities related to the components enumerated by Roth, Meizel and Litz.

The MacArthur Treatment Competency research group surveyed the various standards of competency that have developed through case law, judicial discretion, and legislation. Some commentators state that the MacArthur group “has potentially elevated the State definitions to the ‘gold standard’ for competency determinations.” The MacArthur Study investigated decisionmaking capacities by developing instruments to study individuals and then comparing patient’s that were ill with person’s who were not ill. The thrust of the study was to analyze a patient’s level of understanding, appreciation, and rational manipulation or

140. See id.
141. See Hess, supra note 128, at 121; see also Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 283 (1990) (explaining that there are procedural mechanisms in place to balance the risk of erroneously keeping those persons alive who want to die against taking the lives of those who want to live).
143. See Trudi Kirk & Donald N. Bersoff, How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study, 2 PSYCHOL. PUB. POL’Y & L 47- 48 (1996). The data available regarding who accepts and who refuses mental health treatment shows that the great majority of mental health consumers accept treatment, even when involuntarily committed to hospitals. Only a minority of patient refuse treatment and an even smaller number of patients persistently refuse treatment. Id.
144. See Berg, supra note 142, at 363-366. The following six criteria were used to guide the development of the measures:
1st The functions being assessed needed to have close conceptual relationships with the appropriate legal standards of competence.
2nd The content of the instruments needed to be relevant to the decision being studied. Since the specific concern was whether or not to proceed with treatment, the instruments needed to reflect this goal
3rd The content of the instruments needed to be meaningful to the persons being studied.
4th The content of the instruments needed to be sufficiently standardized so that comparisons within and across subject groups were possible.
5th Measurements had to have objective criteria for scoring that could be applied in a equitable fashion.
6th The instruments had to be practical for use in a research setting and potentially adaptable for clinical use. Most importantly, the instruments had to be able to be administered in one sitting and by interviewers without extensive clinical training. Id.
145. See Kirk & Bersoff, supra note 143, at 51.
146. See Berg, supra note 142, at 368.
reasoning. There were three main findings of the MacArthur Study. First, patients who are hospitalized with depression or schizophrenia showed deficits in their decisionmaking compared to hospitalized medically ill patients and non-patient groups. Second, the majority of the patients with schizophrenia performed in the unimpaired range on each of the measures that were tested: standing, appreciation and reasoning. Last, patients who experienced more severe psychiatric symptoms, particularly thought disturbances, tended to manifest deficits in understanding and reasoning.

There are both positive and negative aspects for the MacArthur Study. The important strength of the model is that it measures and defines a range within which the person moves from having decisional capacity to lacking decisional capacity. The group's findings may help clinicians better evaluate different types of decisionmaking impairments. Additionally, judges and health professionals have statistically reliable and potentially valid instruments available that are specifically designed for the measurement of competency to make treatment decisions.

There are also many inherent problems with the MacArthur Treatment Competence Study. One difficulty is that the tests make measurements on a continuous scale, while the concept of incapacity is categorical. Another difficulty is that several different cognitive processes form the basis for decisional capacity. One commentator states, "it is unclear whether all must be impaired, whether some are more crucial than others, and at what level each individual capacity must be impaired before the general capacity of decision making is absent." Lastly, some advance the position that the MacArthur instruments may not comply with the Fourteenth Amendment's requirements of substantive and procedural due process.

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147. See Kirk & Bersoff, supra note 143, at 62-65. Cf. Kapp, supra note 53, at 75. Grisso and Appelbaum warn that the MacArthur group's measures of decisional capacity "should not be interpreted as though they provide determinations of legal incompetence to consent to treatment." Id. Grisso and Appelbaum argue that because legal determinations of capacity vary across jurisdiction and that the scores of the competence test may be skewed for various reasons, a single national capacity test would lack meaning. But see Kapp, supra note 53, at 76 (stressing that instead of making more attempts to develop or perfect a "capacimeter", we should devote attention to development and dissemination of clinical practice parameters in the area of competence determination).

148. See Berg, supra note 142, at 371. It should be noted that most of the differential was due to the patient group with schizophrenia.

149. See id.

150. See id. at 374.

151. See id.

152. Kapp, supra note 53, at 75. Authors suggest that the MacArthur study could assist medical care givers to devise more effective therapeutic strategies and explain to courts how psychiatric and psychological findings relate to resolution of legal issues.


155. See id.

156. See id.

157. Kirk & Bersoff, supra note 143, at 45 (arguing that the standards for treatment competency may become even more stringent, threatening the autonomy of treatment refusers).
E. Other Considerations in Applying Capacity Tests

Efforts should be made to help ensure that the capacity test has been applied as accurately as possible. One author explains, "[b]ecause depriving patients of their decision-making rights is a serious infringement of liberty, every effort should be made to help each patient perform best."\(^{158}\) The examiner should attempt to adequately educate the patient if the patient is having difficulty understanding.\(^{159}\) In addition, the patient may respond better and feel more comfortable when the examiner is of the same cultural background.\(^{160}\) Further, patients that are from lower socioeconomic backgrounds and educational levels may need more attention due to culturally determined ideas about illnesses that may be interpreted as a lack of understanding or possibly delusional.\(^{161}\)

IV. STATE DEFINITIONS OF CAPACITY

A. Overview

Legally, competence is viewed as a question of fact.\(^{162}\) Courts have been reluctant to articulate a standard to determine competency for health care decision making.\(^{163}\) Instead of using a particular standard, courts are more likely to let physicians, psychiatrists in particular, to testify about the capacity of the patient. Practically, courts rarely are involved in formal capacity assessments of medical decisional competence.\(^{164}\)

In the conservator and guardianship areas of the law, courts often defined competency as a term with all or nothing consequences.\(^{165}\) Modernly, the law presumes competency rather than incompetency and sanity rather than insanity.\(^{166}\) All proceedings to determine the capacity of a person begins with a presumption of competence until the contrary can be shown. With the advent of medical technologies to sustain life, the issue of competence has become more critical.
because the stakes in decisionmaking are higher. Subjects that have been commonly litigated include ventilator refusals by patients and their surrogates, cancer chemotherapy, kidney dialysis, surgery, and nasogastric feeding tubes.

The case, Bouvia v. County of Riverside, exemplifies some of the difficulties encountered in determining competence. Elizabeth Bouvia was a twenty-six year old victim of cerebral palsy that has afflicted her since birth. She was admitted to the hospital as a potential suicide and asked the staff to assist her in removing feeding tubes so that she would die. Bouvia sought a restraining order against the hospital due to the staff force feeding her. Ironically, all of the physicians found her competent but stressed that due to recent events in her life, she wished to die. The events included the recent separation from her husband, inability to find employment, and inability to have a child. The trial judge ruled that Bouvia was competent but did not permit the removal of the feeding tubes because of the profound effect it would have on the doctors. Bouvia demonstrates the confusion of when a competence determination is appropriate and considers the consequences flowing from the medical decision.

B. Evolution of Statutory Standards

Medical decisionmaking capacity is guided by legal standards that have evolved on a state-by-state and case-by-case basis. Most of these legal standards are codified in the state’s guardianship statutes. These standards usually contain vague and confusing criteria. Some states have formally defined competency and the elements that are included for healthcare decisionmaking by legislation and case law. The state legislature provided a more explicit set of standards for deciding when a particular state’s parens patriae authority should be drawn on to impose a

167. See id. at 564.
168. See id. at 564-565. A discussion of right to die and suicide issues are beyond the scope of this Comment.
170. See id. at 1135.
171. See id. at 1136.
172. See id. at 1135.
173. See id.
174. See id.; see also CHARLES P. SABATINO, COMPETENCY: REFINDING OUR LEGAL FICTIONS 1-28 (Michael Smyer et al. eds., 1996) (tracing the evolution of medical decision making capacity enumerated in guardianship statutes). During the past quarter century, almost every state legislature has enacted changes in is guardianship statutes. ld.
175. See id.
176. See id. at 564.
177. See id.
178. See Kapp, supra note 53, at 76.
In 1993, the Uniform Health-Care Decisions Act was approved by the National Conference of Commissioners on Uniform State Laws. The Uniform Health-Care Decisions Act states, "capacity means an individual's to understand the significant benefits, risks, and alternatives to proposed health care, and to make and communicate a health care decision." This enactment reflects a widely accepted view that capacity to make health care decisions is a matter of a person's ability to make reasoned decisions. However, in the realm of health care decision making, competency is still a legal battlefield for balancing patient's rights and state interests.

C. Varying Approaches to Determine Competency

Case law standards for decisionmaking are highly sensitive to the facts in the given case, resulting in uncertainty as to what standards could be applied in another situation. Courts have used various approaches in deciding on the issue of medical decisionmaking competency. Under the medical competency approach, a patient's competence to consent is a factual issue. Other courts have suggested that the standard for determining health care decisionmaking capacity is the same for a person entering into a contract. Under this contract approach, if a patient makes a choice based on irrational reasons, the physician must honor the decision if the patient understands the information that the physician has provided.

The contract approach was applied in Miller v. Rhode Island Hospital. In Miller, the court stated that it was appropriate to apply the contract standard especially because the case involved an intoxicated patient's understanding of the risks and consequences of surgery. There are several criticisms of the contract approach. Some stress that the contract approach does not fully balance an

180. See Kapp, supra note 53, at 76.
181. UNIFORM HEALTH-CARE DECISION ACT § 1(3), 9 U.L.A. 148 (1999), reprinted in SABATINO, supra note 177, at 14
182. See id.
183. See SABATINO, supra note 177, at 14.
184. See Bouvia v. Superior Court, 179 Cal. App. 3d 1127 (1986) (preserving life, preventing suicide, protecting innocent third parties, and maintaining ethical standards of the medical profession are the state’s primary interests).
185. See Berg, supra note 142, at 375.
186. See In re Schiller, 373 A.2d 360, 363 (1977) (stating that the question of competency is a matter for the trier of fact); Grannum v. Berard, 422 P.2d 812, 814 (1967) (stating that the trier of fact determines the issues of competency from the circumstances of the individual case).
187. See Miller v. Rhode Island Hospital, 625 A.2d 778 (1993) (adopting the contract standard for an intoxicated patient's understanding of the risks and consequences of surgery); Schiller, 372 A.2d at 367 (suggesting mental capacity is the same for entering into a contract); In re Yetter, 62 Pa. D. & C.2d 619, 624 (1973) (applying the contract standard for to determine capacity to consent to medical treatment); Grannum, 422 P.2d at 814 (applying contract law to test mental capacity to consent to medical treatment).
188. See Walkow, supra note 43, at 771. See Yetter, 62 Pa. D. & C.2d at 624 (holding that the patient has a right to refuse a breast biopsy despite her irrational fear of death); Freedman, supra note 1, at 62-63 (explaining a hypothetical that involved a patient who needed an appendectomy but refused the procedure because he feared the procedure would cause impotence).
189. 625 A.2d at 786.
190. See id.
individual’s freedom with good medical care.\(^\text{191}\)

**D. Legal Trends in the Courts**

Several important trends have emerged over the last three decades. The law increasingly recognizes that decisional capacity is viewed along a continuum rather than an all or nothing phenomenon.\(^\text{192}\) Numerous courts have held that a patient may have capacity to make some health care decisions but not others.\(^\text{193}\) Another trend has emerged enumerating explicit, function-centered, substantive standards for use in capacity assessment for use in medical decision making.\(^\text{194}\) Courts also recognize that competence can change from day to day.\(^\text{195}\) Additionally, some statutes have defined decisionmaking capacity as a patient who can understand and appreciate the consequences of a proposed medical treatment and communicate a choice about their preferences despite lacking complete capacity.\(^\text{196}\)

When defining mental competency, most courts evaluate a patient’s capacity to make medical decisions based on the standards for medical competency as opposed to standards for legal competency.\(^\text{197}\) Importantly, a patient who fluctuates between capacity and incapacity cannot be denied the opportunity to make health care decisions, including life-sustaining medical care.\(^\text{198}\)

**E. Legal Standards of Competence**

Judges inherently use a specific competency test, but their opinions rarely document which test is used or what factors let them to the patient’s passing or failing the test.\(^\text{199}\) Courts apply different standards of medical competency to...
determine a patient's competence to make medical decisions. The components formulated by Roth, Meizel and Litz have reflected and continue to be drawn upon today. However, the combinations of those standards used by the courts are endless and without rhyme or reason.

1. Ability to Communicate a Choice

Many courts use the element of being able to communicate a choice as a threshold determination of competence. Those patients who are comatose or in a persistent vegetative state are rendered incompetent. In the case, In re Estate of Loungeway, the court explicitly stated that "[o]bviously, a patient who is irreversibly comatose or in a vegetative state will be incompetent, unable to communicate his intent." Other courts have implicitly adopted this standard by holding that a patient who is unable to communicate cannot be competent. It should be noted that demonstration of this ability alone does not render a questionably competent individual competent. As a result, many courts and legislatures combine this standard with others when evaluating competence.

2. Ability to Understand the Relevant Information

The ability to understand the relevant information is the most common standard cited in both the legislatures and the courts. Despite the fact that courts and legislatures include an understanding standard in assessing competency, often they fail to define the term. Statutes commonly include language such as "understand the nature and consequences" and could be interpreted to include an understanding and an appreciation standard.

200. See Freedman, supra note 1, at 59-60.
201. See In re Department of Veteran's Affairs Medical Ctr., 749 F. Supp. 495, 497(S.D.N.Y. 1990) (patient was delirious, semi-conscious, and unable to participate in meaningful conversation); In re R.H., 622 N.E.2d 1071, 1073 (Mass. App. Ct. 1993) (mentally retarded patient had limited communication skills).
202. See Berg, supra note 142, at 353.
205. See Berg, supra note 142, at 353.
207. See Berg, supra note 142, at 354.
208. See id.; see also, e.g., MD. CODE ANN., HEALTH-GEN.§ 5-601 (I)(1) (1994 & Supp. 1999 ) (defining capability to give informed consent as ability to understand the nature and consequences of a decision and evaluate the risks and benefits); In re Schiller, 372 A.2d 360, 367 (N.J. Super. Ct. Ch. Div. 1977) (holding that the standard is whether the person in question possesses sufficient mind to understand, in a reasonable manner, the nature, extent, character, and effect of the act).
3. Ability to Appreciate the Nature and of the Situation and its Likely Consequences

This criterion requires that the patient be able to apply information that is understood to his or her own situation. In the case, In re Roe, the court held that a patient suffering from schizophrenia was incompetent because the patient refused to take his medication and the patient did not believe he was mentally ill. However, the following case evidences a situation where a court did not indicate that a patient was incompetent after refusal of potentially life-saving treatment.

A Massachusetts Court of Appeals in Lane v. Candura, involved a 77-year old widow who was suffering from gangrene in her right foot and lower leg as a result of her diabetes. Mrs. Candura had undergone two amputations on a toe and portion of her left foot. Following the surgeries, her physician recommended that the leg be amputated without delay. She refused.

The Court of Appeals concentrated on her ability to understand and her actual understanding of her situation and the alternatives. The court reversed the trial court’s decision and stated that “Mrs. Candura’s decision may be regarded by as most unfortunate but on the record in this case it is not the uninformed decision of a person incapable of appreciating the nature and consequences of her act.” The court stated that it is clear that Mrs. Candura does not wish to have any more surgeries even those this decision will likely lead to her death. The Candura decision is also noteworthy because the court acknowledges that a patient may be declared incompetent in a guardianship but rendered competent to decide whether or not to have a leg amputated.

Other courts have used the appreciation criterion to evaluate competency for healthcare decisionmaking. For example, In re Milton, a patient refused treatment for her uterine cancer because she believed that in faith healing and that the faith healer was her husband. The court held that the patient was competent and believed that she had accepted the fact that she was ill and without treatment she would die.

4. Ability to Manipulate Information Rationally

The criterion, the ability to manipulate information rationally, is concerned

209. See Berg, supra note 142, at 355. An example of this situation is a patient who accepts that their physician believes that they are ill, but deny that there is a problem in the face of objective evidence to the contrary. Id.
212. See id. at 1233.
213. See Annas & Densberger, supra note 3, at 570-571.
214. Candura, 376 N.E.2d at 1236. The court noted that until she withdrew her consent for her leg to be amputated, her competence was not questioned. The doctors readily accepted her consent in the two previous surgeries, but questioned it when her decision did not agree with the physicians’ opinions. Id. at 1235.
215. See id.
216. See Altman, supra note 8, at 1678.
218. See id.
with the patient's decisionmaking process not the outcome of the decision. This criterion is never found alone and as a result, courts compound this criterion with other criterion to decide competency. In *Reise v. St. Mary's Hospital*, the court held that the patient must understand the information as well as demonstrate the ability to knowingly and intelligently evaluate the information and participate in the decision by means of a rational thought process.

**F. Other Compounded Standards**

Both case law and statutes exemplify a variety of combinations of different standards to decide competency for healthcare decisionmaking. A problem is presented when cases and statutes enumerate some standards but then use broader or vague language that may include other elements. For example, in the case, *Thor v. Superior Court*, the court stated that a competent patient must possess: (1) the capacity to reason and make judgements; (2) a clear understanding of the risks and benefits of the proposed treatment alternatives; and (3) a full understanding of the nature of the disease and the prognosis. In this instance, it is unclear whether appreciation is part of the competency assessment or whether the court wanted to stress the understanding requirement of the standard.

**G. Overall Problems and Considerations**

There are many substantive and procedural shortcomings of the elements and standards articulated by the courts and legislatures to determine competency for healthcare decisionmaking. First, clarification of the terms and how they are used must be accomplished within the courts. Also, more reliable evidence must be produced regarding how accurately the standards are being applied. Last, there needs to be more information to be able to comment on the relative procedures and their value for determining competence.

**V. CONCLUSION**

There are many types of decision making capacities including consenting to medical treatment, managing financial affairs, power of attorney, and executing a
will. Several competency standards for medical decision making have been debated over the years and there is no consensus on the issue. Some patients cannot be determined competent to make health care decisions under any circumstances. Most adequately functioning people cannot be deemed incompetent due to some selective test for competency. There can be no universal definition to determine capacity. However, a widely accepted standard has not emerged. There must be greater uniformity among numerous competency standards, their spotty application, and unarticulated standards used by the courts.

The competency tests for health care decisionmaking can be easily biased by the evaluator—whether that be in a courtroom or a hospital. One author comments, “the goal in choosing a standard is, on one hand, to enhance self-autonomy and guard against paternalism and, on the other to provide for vicarious judgement in the best interests of patients when necessary.” The law continues to search for a workable application of competency determination while at the same time avoiding inappropriate denial of decisional capacity and intervening on behalf of those persons who cannot make decisions for themselves.

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228. Friedman, supra note 83, at 76.