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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.¹ 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.² Both the vagueness and extensive legal literature on the subject make competency determinations susceptible to arbitrariness and pose a threat to individual liberty.³ Incompetency provisions are usually justified by the notion that the patient does not act effectively in their best interest, so society must intervene.⁴ Many times, declaring a patient incompetent to make health care decisions can be more intrusive and liberty depriving than a criminal conviction.⁵

The distinction between general and specific competence is significant. An individual is presumed to have capacity unless proven otherwise.⁶ When a capacity determination is questionable, the courts have traditionally viewed competence in general terms.⁷ The more recent view is that a person may have competence to decide some issues but not others.⁸ 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

1. Benjamin Freedman, *Competence, Marginal and Otherwise*, 4 Int'l J.L. & Psychiatry 53, 55-55 (1981) (describing the main groupings of the marginally incompetent).

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).

3. See George J. Annas & Joan E. Densberger, *Competence to Refuse Medical Treatment: Autonomy Versus Paternalism*, 15 TOLEDO L. REV. 561, 562 (1984).

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

5. See *id.*

6. See Wendy M. Margolis, *The Doctor Knows Best: Patient Capacity for Health Care Decisionmaking*, 71 OR. L. REV. 909 (1992). See, e.g., *Lotman v. Security Mutual Life Ins. Co.*, 748 F.2d 868 (3d Cir. 1973); *Saunders v. State*, 492 N.Y.S. 2d 510 (N.Y. Sup. Ct. 1985); *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978); Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 N. ENG. J. MED. 1635, 1635 (1988) [hereinafter Appelbaum].

7. See Bernard Lo, *Assessing Decision-Making Capacity*, 18 L. MED. & HEALTH CARE 193, 194 (1990).

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).

individual.⁹

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 physicians's intervention to restore quality of life in some cases.¹⁶ The flip-side of beneficence is the concept of

9. See generally THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY & THE LAW 217-220 (1982) (discussing specific and general competency in depth); MICHEL SILBERFELD & ARTHUR FISH, WHEN THE MIND FAILS: A GUIDE TO DEALING WITH INCOMPETENCY 45-48 (1994) (discussing task-specific competency and general incompetency).

10. See Margolis, *supra* note 6, at 922.

11. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPALS 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.*

12. See RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 100 (1986).

13. See *id.*; see also EDMUND D. PELLEGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD 157-159 (1988) (describing three forms of beneficence as it relates to clinical intervention: weak form, intermediate form, and hard form).

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 impeding 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-

autonomy.

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.¹⁷ The interest of protecting autonomy in treatment decisions is twofold. First, protection of autonomy is a reflection of a value placed on liberty.¹⁸ Second, safeguarding patient autonomy serves to restore the balance in the physician/patient relationship by humanizing it.¹⁹ One commentator states that autonomy is the "responsible use of freedom and is therefore diminished whenever one ignores, evades, or slights one's responsibilities."²⁰

Two individuals have shaped the development of the principal of autonomy--Immanuel Kant and John Stuart Mill.²¹ According to Mill, there is a moral demand for non-interference.²² 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.²³

Competence and autonomy are closely related, but not identical concepts.²⁴ Autonomy means self-governance while competence is the ability to perform a task.²⁵ For example, incompetent patients may act autonomously while some competent patients can retain their faculties in some situations but not in others.²⁶ Internal factors such as fear, neurotic compulsions or drug addictions can impair both autonomy and competence.²⁷ In the medical arena, the reluctance to promote total patient self-determination could be due to the influences of the traditional

158.

17. See John Harwig, *What About the Family?*, HASTINGS CENTER REP., Mar.-Apr. 1990, at 5, 10. According to Kant, there are many situations in which people can achieve autonomy and well-being only by sacrificing other important dimensions of their well-being. *Id.* at 8. See generally Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 L. MED. & HEALTH CARE 234 (1989) (discussing autonomy and right to control the future by the use of advance directives); Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N. Y. U. L. REV. 285, 310 (1976) (analyzing possible legislative solutions that emphasize when a patient may refuse life-sustaining treatment).

18. See GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS* 250 (1987).

19. See *id.*

20. See Harwig, *supra* note 17, at 8.

21. See Stewart G. Pollock, *Life and Death Decisions: Who Makes Them and By What Standards*, 47 RUTGERS L. REV. 505, 506 (1989).

22. See *id.*

23. See *id.* at 505. The views of Kant and Mill do not conflict but often overlap; see also BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 12-13 (3d. ed. 1997) (describing Kantian ethical theories in depth).

24. See PELLEGRINO & THOMASMA, *supra* note 13, at 150-159 (providing a thorough discussion of autonomy and beneficence in the doctor-patient relationship).

25. See BEAUCHAMP & CHILDRESS, *supra* note 11, at 83. The criteria for the autonomous person and the competent person are very similar. It is possible that an autonomous person is a competent person. On this theory, a person is generally competent to authorize or refuse an intervention if the person is only autonomous.

26. See PELLEGRINO & THOMASMA, *supra* note 13, at 151.

27. See *id.*

medical model.²⁸ 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.²⁹ 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.³⁰ The court required Martin to satisfy a strict standard before allowing him to chose life, and destroyed his autonomy and his interest in life without vindication.³¹

When dealing with medical treatment decisions, the legal counterpart to autonomy is informed consent.³² In the last two decades, protection of autonomy has been primarily justified by informed consent provisions.³³ 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.³⁴

Studies indicate that many physicians claim that they obtain "informed consent" from their patients prior to medical procedures.³⁵ However, the evidence that establishes "informed consent" differs among physicians as to their subjective perception.³⁶ 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.³⁷

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.³⁸ The

28. See Margolis, *supra* note 6, at 915; see Also FADEN & BEAUCHAMP, *supra* note 12, at 75.

29. See *In re Martin*, 517 N.W.2d 749 (Mich. App. 1994).

30. See *id.* at 751.

31. See *id.*

32. See PELLEGRINO & THOMASMA, *supra* note 13, at 151.

33. See BEAUCHAMP & CHILDRESS, *supra* note 11, at 75.

34. See Annas & Densberger, *supra* note 3, at 562. One of the most famous examples of the paternalistic approach occurred in the treatment of Barney Clark, the recipient of the world's first artificial heart. Clark was very sick and his surgeon, Dr. William DeVries, believed that he had no choice but to accept the artificial heart. The informed consent process was both incomplete and paternalistic. DeVries justified this behavior by stating that the patient only had to look forward to dying. He was not a candidate for a transplant and he was not responding to drug therapy. The procedure was labeled therapeutic and as a result Clark was treated as an incompetent. The choice was made for him. *Id.* at 563

35. Margolis, *supra* note 6, at 915.

36. See *id.*

37. See *id.* at 917; see also FADEN & BEAUCHAMP, *supra* note 14, at 100. According to Katz's view, informed consent in the medical world is more like a fairy tale than reality. All of the changes are on the surface, with no more genuine informed consent than in the past. *Id.*

38. See generally MELTON, *supra* note 18, at 250-256 (outlining the general requirements for informed consent as they relate to competency to consent to medical treatment).

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 Preference*, 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).

43. See Norman L. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973); see also *Natanson v. Kline*, 350 P.2d 1093, 1104 (1960) (holding that exercise of patient self-determination may translate into refusal of lifesaving assistance). See, e.g., *Moujan M. Walkow, Informed Consent—Legal Competency Not Determinative of a Person's Ability to Consent to Medical Treatment—Miller v. Rhode Island Hospital*, 625 A.2d 778 (R.I. 1993), 28 SUFFOLK U.L. REV. 271, 271 (1994) (exercising the right to forego medical treatment remains central to the right of 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. Marzen, *Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach*, 1 ISSUES L. & 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.⁴⁹ 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.⁵⁰ 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.⁵¹ Doctors routinely make competency determinations during the course of their practice that are rarely reviewed.⁵² Often, this assessment takes place without the party's awareness.⁵³ 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.⁵⁴ 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.⁵⁵

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.⁵⁶ 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.⁵⁷ 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.⁵⁸

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.⁵⁹ Ordinarily, there should be more than one examination before a patient is deemed

49. *See id.* Often there are cases where the physician believes that the patient's decision is not genuine, but a product of psychological, sociological, and economic factors. *Id.*

50. *See id.*

51. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, WHO IS INCAPACITATED AND HOW IS IT TO BE DETERMINED? 169-175 (1982) [hereinafter DETERMINATION].

52. *See* Margolis, *supra* note 6, at 919.

53. *See* Appelbaum, *supra* note 6, at 1635. *But cf.* Marshall B. Kapp et al., *Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"*, 2 PSYCHOL. PUB. POL'Y & L. 73, 82 (1996) (conducting a formal capacity assessment for every person at every junction is not a realistic or desirable alternative).

54. *See* Warren F. Gorman, *Testamentary Capacity in Alzheimer's Disease*, 4 ELDER L. REV. 225, 227 (1996).

55. *See* Margolis, *supra* note 6, at 919; *see also* *In re Farrell*, 529 A.2d 404 (1987); *In re Dinnerstein*, 380 N.E.2d 134 (1978) (stating that a significant treatment choice is to be made by a competent patient); *In re Nemser*, 273 N.Y.S.2d 624 (1966) (courts should not make determinations of patient competence); DETERMINATION, *supra* note 51, at 175 (determinations of incapacity are best made without routine recourse to the courts); Margolis, *supra* note 6, at 922 (courts increasingly condon this approach either implicitly or explicitly); *see generally* Timothy A. Salthouse, *Cognitive Competence and Expertise in Aging*, in HANDBOOK OF THE PSYCHOLOGY OF AGING 310-319 (James E. Birren & K. Warner Schaie eds., 3d. ed. 1990) (illustrating the relationship between increased age and cognitive function for decisionmaking).

56. *See* MELTON, *supra* note 18, at 251. This is probably the most common situation.

57. *See id.* In this example, patient evaluation is more for the physician's protection than for respect of the patient's autonomy. A tort action may be brought if the procedure is performed on the patient who has not given consent. *Id.*

58. *See id.* This may be motivated as a defensive practice by physicians rather than for the sake of the patient.

59. *See* Kapp, *supra* note 53, at 73.

to be incompetent for health care decisionmaking.⁶⁰ 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.⁶¹

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.⁶² 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.⁶³ Also, the physician must assess the cause of the patient's limitation, and the recommendation for treatment if it is feasible.⁶⁴ 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.⁶⁵ 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.⁶⁶

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.⁶⁷ An extensive analysis of all of the instruments developed to determine capacity over the past twenty years is beyond the scope of this Comment.⁶⁸ The following tests are

60. See Appelbaum, *supra* note 6, at 1638. If there is reason to suspect that the impairment is caused by specific circumstances, such as 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 examiners experience in 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

Rational Reasons Legal Standard, ARCHIVE NEUROLOGY, Oct.1995, at 955, 959 (identifying neuropsychologic predictors of competency performance and status in Alzheimer's disease using a rational reasons legal standard for treatment choice).

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.

72. See Kevin R. Wolff, *Determining Patient Competency in Treatment Refusal Cases*, 24 GA. L. REV. 733, 743 (1990).

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.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.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.⁷⁷

2. "Reasonable" Outcome of Choice

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

The "reasonable" outcome of choice test requires the evaluator to agree with the patient in their decision.⁸¹ If that is not the case, then the patient's decision is overridden.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.⁸³ The reasonableness of a result is based on a balancing test of complex factors and is likely to be subjective rather than objective.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

75. See Roth, *supra* note 70, at 280. In psychiatry, this test encompassed the mute patient who cannot or will not express an opinion.

76. See *id.*

77. See M.C. McDonald, *And Things Get Rough*, PSYCHIATRIC NEWS, Nov. 5, 1975, at 13-14.

78. See Roth, *supra* note 70, at 280.

79. See *id.*

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).

81. See Wolff, *supra* note 72, at 743.

82. See *id.*; see also Freedman, *supra* note 1, at 58-60.

83. See Paul R. Friedman, *Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons*, 17 ARIZONA L. REV. 39, 77 (1975).

84. See *id.*

the patient.⁸⁵ In medicine, there is a common presumption of patient incompetence in that the physician knows best.⁸⁶ Medical scepticism of patient's decisional capacities can be traced back to the time of Hippocrates.⁸⁷ 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.⁸⁸

This notion was reflected in early professional codes of the early nineteenth and twentieth centuries and continue on into the medical practice of today.⁸⁹ A modern example of this idea is the case *United States v. Charters*.⁹⁰ 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.⁹¹

Lastly, this test is used more often than might be admitted by both physician and the courts.⁹² 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.⁹³

3. Choice Based on "Rational" Reasons

This test evaluates whether the patient's decision is due to a mental illness.⁹⁴ 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.⁹⁵

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.*

90. *United States v. Charters*, 829 F.2d 479 (1987).

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.⁹⁶ The test may express a value preference for a certain type of thinking.⁹⁷ Any attempt to assess the quality of reasoning runs the risk of the competency evaluator to substitute their own manner of thinking.⁹⁸ Another problematic area is proving the causal link between the irrational decision and the patient's incompetence.⁹⁹ Conditions such as phobia, panic and depression can lead to an irrational decision but do not necessarily equate with incompetence.¹⁰⁰

4. The Ability to Understand

The ability of a patient to understand is consistent with the law of informed consent.¹⁰¹ Under the informed consent doctrine, patients may make treatment decisions only when those decisions are informed, voluntary, and competent.¹⁰² 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.¹⁰³

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.¹⁰⁴ 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.¹⁰⁵ One last shortcoming of this test is that its application depends on evaluating mental processes rather than concrete and observable elements of behavior.¹⁰⁶

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.¹⁰⁷ This test obligates the physician to educate the patient and directly ascertain whether the patient has actually understood.¹⁰⁸ 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 decisionmaking process.¹⁰⁹ This test articulates a potentially high level of competency thereby being difficult to achieve.¹¹⁰ Further, this test amplifies the subjectivity problem found in the ability to understand test because the focus is on whether the patient actually understands.¹¹¹

Despite these problems, a court has held that this test can be the most exacting standard to determine competency for a patient.¹¹² 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.¹¹³

All of the elements of the tests are combined when the enumerated test is applied.¹¹⁴ Most importantly, one authors stress that "the circumstances in which competency becomes an issue determine which elements of which tests are stressed and underplayed."¹¹⁵ 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.¹¹⁶

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.

112. See *In re Farrell*, 529 A.2d 404, 409 (1987).

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.¹¹⁷ 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.¹¹⁸ 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.¹¹⁹

First, a framework of values must be ascertained and stable.¹²⁰ 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.¹²¹ Second, the patient must have the ability to give and receive information. The Commission stipulates that these abilities can be evaluated only as they relate to the decision at hand.¹²² Using this ability, a person also needs to have sufficient life experience to appreciate the meaning of the different alternatives.¹²³ Third, the patient must have the ability to compare the impact of the alternatives on personal goals and life plans.¹²⁴

The measurement of these abilities can be very complex. In the context of informed consent, it is critical that a patient make a specific medical decision.¹²⁵ 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.¹²⁶ 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.¹²⁷

C. *The Sliding Scale Model*

Some suggest a sliding scale model or a risk-benefit analysis for assessing

117. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL RESEARCH, DECISIONMAKING CAPACITY AND VOLUNTARINESS 55-68 (1982) [hereinafter DECISIONMAKING].

118. *See id.* An example of a person's status in the Commission's view would be age.

119. *See id.* at 57; *see also* Annas & Densberger, *supra* note 3, at 569-570. The President's Commission's test of competency has been broken down into three approaches: the Outcome Approach, the Status Approach, and the Functioning Approach. The Outcome Approach deals with a patient's values and goals. The Status Approach is based on the patient's physical or mental status. The Functioning Approach focuses on the patient's actual functioning in decisionmaking situations. *Id.*

120. *See* DECISIONMAKING, *supra* note 117, at 58.

121. *See id.*

122. *Id.*; *see also* Appelbaum *supra* note 6, at 1635. The ability to communicate "may be affected by an impairment or consciousness, a thought disorder, a disruption in short-term memory, or a degree of ambivalence so extreme that it produces repeated, rapid, alterations of choice." *Id.*

123. *See id.* Examples of meaning between alternatives would include: "what it would probably be like to undergo various medical procedures, or to live in a new way required by a medical condition or intervention."

124. *See id.*; *see also*, Annas & Densberger, *supra* note 3, at 570 (stating that this approach helps insure that the decision that the patient makes is one that he or she realizes will have the consequences for himself or herself).

125. DECISIONMAKING, *supra* note 117, at 60.

126. *See id.*

127. *See* Appelbaum *supra* note 6, at 1635.

capacity for medical decision making.¹²⁸ Under this analysis, the amount of capacity required should depend somewhat on the seriousness of the medical decision at hand.¹²⁹ When the decision approaches a life or death situation, the courts may require a greater capacity for the individual.¹³⁰ 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.¹³¹

The sliding scale model had three general categories of medical situations: (1) easy, effective treatments; (2) less certain treatments; and (3) dangerous treatments.¹³² Within each category, as the consequences of the person's decision become more serious, the more stringent the standard.¹³³ 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.¹³⁴ Second, the concept of reasonableness is found at every level within the model.¹³⁵ Third, the reasonableness assumption justifies some paternalistic behavior.¹³⁶

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.¹³⁷ Significantly, the least stringent category of the model establishes the rationality of the decision with the competency of the decision maker.¹³⁸ 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.¹³⁹ Additionally, the medical delivery system would be overrun with surrogate decision

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.¹⁴⁰ 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.¹⁴¹

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.¹⁴² 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.¹⁴³ The instruments were developed to establish measures of decisionmaking abilities related to the components enumerated by Roth, Meizel and Litz.¹⁴⁴

The MacArthur Treatment Competency research group surveyed the various standards of competency that have developed through case law, judicial discretion, and legislation.¹⁴⁵ 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.¹⁴⁶ 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).

142. *See* Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 360 (1996) (discussing the MacArthur study in great detail).

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 an 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.¹⁴⁷

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.¹⁴⁸ 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.¹⁴⁹ Last, patients who experienced more severe psychiatric symptoms, particularly thought disturbances, tended to manifest deficits in understanding and reasoning.¹⁵⁰

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.¹⁵¹ The group's findings may help clinicians better evaluate different types of decisionmaking impairments.¹⁵² 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.¹⁵³

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.¹⁵⁴ Another difficulty is that *several* different cognitive processes form the basis for decisional capacity.¹⁵⁵ 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."¹⁵⁶ Lastly, some advance the position that the MacArthur instruments may not comply with the Fourteenth Amendment's requirements of substantive and procedural due process.¹⁵⁷

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.

153. Kirk & Bersoff, *supra* note 143, at 45.

154. Peter V. Rabins, *Issues Raised by Research Using Persons Suffering from Dementia Who Have Impaired Decisional Capacity*, 1 J. HEALTH CARE L. & POL'Y 22, 32 (1998).

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

158. Appelbaum, *supra* note 6, at 1636.

159. *See id.*

160. *See id.*; *see also* In re Yetter, 62 Pa. D. & C.2d 619 (1973).

161. Appelbaum, *supra* note 6, at 1636.

162. *See* Annas & Densberger, *supra* note 3, at 574. *See Grannum*, 422 P.2d at 814 (stating that the mental capacity necessary to consent to a surgical operation is a question of fact to be determined from the circumstances in each individual case).

163. *See* FURROW, *supra* note 23, at 247. Few opinions exist that explicitly state a test that is used to determine capacity for health care decisions.

164. *See* Kapp, *supra* note 53, at 77. Statutory definitions provide a framework in which informal clinical competency assessments occur. *Id.*

165. *See* FURROW, *supra* note 23, at 247.

166. *See* Lockwood, *supra* note 64, at 1439. There is also the presumption that every person is capable of handling his or her own affairs and is responsible for his or her own acts, and all preceding held to determine capacity for health care decisions should start with the presumption of capacity, until the contrary is proved.

because the stakes in decisionmaking are higher.¹⁶⁷ Subjects that have been commonly litigated include ventilator refusals by patients and their surrogates, cancer chemotherapy, kidney dialysis, surgery, and nasogastric feeding tubes.¹⁶⁸

The case, *Bouvia v. County of Riverside*, exemplifies some of the difficulties encountered in determining competence.¹⁶⁹ Elizabeth Bouvia was a twenty-six year old victim of cerebral palsy that has afflicted her since birth.¹⁷⁰ 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.¹⁷¹ Bouvia sought a restraining order against the hospital due to the staff force feeding her.¹⁷² 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.¹⁷³ 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.¹⁷⁴ *Bouvia* demonstrates the confusion of when a competence determination is appropriate and considers the consequences flowing from the medical decision.¹⁷⁵

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.¹⁷⁶ Most of these legal standards are codified in the state's guardianship statutes.¹⁷⁷ These standards usually contain vague and confusing criteria.¹⁷⁸ Some states have formally defined competency and the elements that are included for healthcare decisionmaking by legislation and case law.¹⁷⁹ 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.

169. 179 Cal. App. 3d 1127, 1149 (1986).

170. See *id.* at 1135.

171. See *id.* at 1136.

172. See *id.* at 1135.

173. See *id.*

174. See Annas & Densberger, *supra* note 3, at 564.

175. See *id.*

176. See Kapp, *supra* note 53, at 76.

177. See *id.*; see also CHARLES P. SABATINO, COMPETENCY: REFINING 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 its guardianship statutes. *Id.*

178. See Berg, *supra* note 142, at 375.

179. Several states have formally adopted definition to determine capacity for health care decisionmaking. See ALASKA STATUTES § 47.30.837 (d)(1) (Michie 1998); *In re Application for the Commitment of an Alleged Mentally Disordered Person*, 854 P.2d 1027 (Ariz. Ct. App.1993); CAL. WELF. & INST. CODE § 5326.5 (c) (West 1994); *People v. Medina*, 705 P.2d 961 (Colo. 1985); D.C. CODE ANN. § 21-2202 (5) (1997 & Supp.1999); FLA. STAT. § 394.459 (3)(A) (West 1998); IDAHO CODE § 66-317 (I) (1996 & Supp. 1999); KAN. STAT. ANN. § 59-2902 (e)(1994 & Supp. 1998); ME. REV. STAT. ANN. tit. , § 11001 (West 1994); N.Y. MENTAL HYGIENE LAW § 80.03 (c) (McKinney 1996 & Supp. 1999); S.D. CODIFIED LAWS § 27A-12-3.15 (Michie 1999); TEX. HEALTH & SAFETY CODE ANN. § 574.101(1) (West 1992); WIS. STAT. ANN. § 51.61 (g)(4) (West 1997 & Supp. 1998).

surrogate decision maker on behalf of the individual.¹⁸⁰

In 1993, the Uniform Health-Care Decisions Act was approved by the National Conference of Commissioners on Uniform State laws.¹⁸¹ The Uniform Health-Care Decisions Act states, “[c]apacity’ 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.”¹⁸² 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.¹⁸³ However, in the realm of health care decision making, competency is still a legal battlefield for balancing patient’s rights and state interests.¹⁸⁴

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.¹⁸⁵ 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.¹⁸⁶ Other courts have suggested that the standard for determining health care decisionmaking capacity is the same for a person entering into a contract.¹⁸⁷ 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.¹⁸⁸

The contract approach was applied in *Miller v. Rhode Island Hospital*.¹⁸⁹ 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.¹⁹⁰ 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.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.¹⁹² Numerous courts have held that a patient may have capacity to make some health care decisions but not others.¹⁹³ Another trend has emerged enumerating explicit, function-centered, substantive standards for use in capacity assessment for use in medical decision making.¹⁹⁴ Courts also recognize that competence can change from day to day.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.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.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.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.¹⁹⁹ Courts apply different standards of medical competency to

191. See Walkow, *supra* note 43, at 275. See also Freedman, *supra* note 1, at 63 (stating that it is questionable whether a person can obtain adequate medical treatment under the contract).

192. See Altman, *supra* note 8, at 1678; see also In re Guardianship of Ingram, 689 P.2d 1363, 1371 (Wash. 1984) (stating that there are degrees of competency and some individuals are more competent than others).

193. See In re Quakenbush, 383 A.2d 785 (1978); see also Lane v. Candura, 376 N.E.2d 1232 (1978) (desires of the patient, articulated during a period of competence, must be respected. *But see*, In re Schiller, 372 A.2d 360 (1977) (amputation case in which the patient was held to be incompetent). See generally In re Osborne, 294 A.2d 372 (1972) (guardianship denied for consent to blood transfusion); In re Melideo, 88 Misc.2d 974, 390 N.Y.S.2d 523 (1976) (court permission for blood transfusion denied); In re Yetter, 62 Pa.D. & C.2d 619 (1973) (guardianship to consent to biopsy denied, despite patient's delusions on some subjects); Friedman, *supra* note 83, at 76. The problem is further amplified in the context of a prisoner or mental patient. The nature of total institution may impair a person's capacity to make important medical decisions concerning his or her life. *Id.*

194. See Kapp, *supra* note 53, at 77.

195. See Annas & Densberger, *supra* note 3, at 575.

196. See IDAHO CODE §39-4302 (1998) (Any person of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks...is competent to consent...")

197. See Walkow, *supra* note 43, at 271; see also, e.g., United States v. Charters, 829 F.2d 479, 495 (4th Cir. 1987) (holding that a patient that is medically competent despite probability of legal incompetency); Miller v. Rhode Island Hospital, 625 A.2d 778 (R.I. 1993) (concluding that a person's legal competency does not necessarily equate with a person's medical competency); In re Conroy, 486 A.2d 1209 (1985) (holding that a person can have the capacity to make medical decisions despite the presumption of legal incompetency).

198. See In re Quakenbush, 383 A.2d 785 (1978). The case involved a seventy-two year old recluse who gangrenous leg would have had to be amputation to avoid a certain death within three weeks. He was belligerent and an objector to medical care for forty years. In deciding the competency issue, the court relied on two psychiatrists and a visit by the judge. The court held that the patient was capable of exercising informed consent to have the operation on his leg.

199. See Wolff, *supra* note 72, at 743.

determine a patient's competence to make medical decisions.²⁰⁰ 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.²⁰¹ Those patients who are comatose or in a persistent vegetative state are rendered incompetent.²⁰² 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."²⁰³ Other courts have implicitly adopted this standard by holding that a patient who is unable to communicate cannot be competent.²⁰⁴ 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.²⁰⁵

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.²⁰⁶ Despite the fact that courts and legislatures include an understanding standard in assessing competency, often they fail to define the term.²⁰⁷ Statutes commonly include language such as "understand the nature and consequences" and could be interpreted to include an understanding and an appreciation standard.²⁰⁸

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.

203. 549 N.E.2d 292, 299 (Ill. 1989).

204. See, e.g., *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 423 (Mass. 1977).

205. See Berg, *supra* note 142, at 353.

206. See, e.g., *In re Boyd*, 403 A.2d 744, 752-53 (D.C. 1979); *McKay v. Bergstedt*, 801 P.2d 617, 625-26 (Nev. 1990); *In re Conroy*, 486 A.2d 1209, 1240-41 (N.J. 1985); *In re Nemser*, 273 N.Y.S.2d 624, 626-27 (Sup. Ct. 1966); *Miller v. Rhode Island Hosp.*, 625 A.2d 778, 786 (R.I. 1993); WIS. STAT. § 51.61 (West 1997 & Supp. 1998).

207. See Berg, *supra* note 142, at 354.

208. See *id.*; see also, e.g., MD. CODE ANN., HEALTH-GEN. § 5-601 (l)(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.²⁰⁹ 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.²¹⁰ 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.²¹¹ 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.²¹²

The Court of Appeals concentrated on her ability to understand and her actual understanding of her situation and the alternatives.²¹³ 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."²¹⁴ 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.²¹⁵ 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.²¹⁶

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.²¹⁷ 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.²¹⁸

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.*

210. 583 N.E.2d 1282 (Mass. 1992).

211. See *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

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.

217. *In re Milton*, 505 N.E.2d 255 (Ohio 1987).

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.²¹⁹ 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.²²⁰

F. Other Compounded Standards

Both case law and statutes exemplify a variety of combinations of different standards to decide competency for healthcare decisionmaking.²²¹ A problem is presented when cases and statutes enumerate some standards but then use broader or vague language that may include other elements.²²² 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.²²³ 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.²²⁴

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.²²⁵ Also, more reliable evidence must be produced regarding how accurately the standards are being applied.²²⁶ Last, there needs to be more information to be able to comment on the relative procedures and their value for determining competence.²²⁷

V. CONCLUSION

There are many types of decision making capacities including consenting to medical treatment, managing financial affairs, power of attorney, and executing a

219. See Berg, *supra* note 142, at 358. See, e.g., In re Conroy, 486 A.2d 1209 (N.J. 1985) (holding that the ability to understand the information conveyed, to evaluate the options, or to communicate a decision are necessary for competent decisionmaking).

220. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 243 Cal. Rptr. 241 (1987).

221. See, e.g., In re A.C., 573 A.2d 1235, 1249-51 (D.C. 1990) (articulating the communication, understanding, and rational manipulation standards); In re Farrell, 529 A.2d 404, 410-413 (N.J. 1987) (using the understanding and rational manipulation standards); In re Waltz, 227 Cal. Rptr. 436 (1986) (adopting the understanding, appreciation and rational manipulation standards).

222. See Berg, *supra* note 142, at 360.

223. *Thor v. Superior Court*, 855 P.2d 375, 381 (1993).

224. See Berg, *supra* note 142, at 360.

225. See *id.*

226. See *id.*

227. See *id.*

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.”²²⁸ 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.
