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The Assessment of Mental Competence: Factors Affecting the Process

Determining a patient's mental competence poses a challenge for medical professionals. A psychiatrist looks at some of the factors that can complicate the assessment.

By Richard E. Finlayson, M.D.

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My last column dealt with the topic of cognition, its nature and importance in the assessment of mental competence. In a large sense, cognition is what life is all about for humans and other higher animals. Biologists could enlighten us on what the term means for lower life forms. In this column I address the process of assessment by the clinician, including the factors that facilitate or hamper the determination of competence. Perhaps approaching the subject from the vantage point of a clinician will provide some new insight for the law professional.

The most common hurdle I face in the assessment of mental competence is the failure of referral sources to make the question clear: Competent to do what? This matter would be obvious to most law professionals, but in my experience, many physicians, nurses, social workers, and others lack the specific knowledge required to ask the right question. Is the concern about testamentary capacity, capacity to manage finances or medical decisions, or something else?

The Markson Study[1]

In 1994, L.J. Markson and coauthors reported the results of a survey-based study of physician assessment of patient competence. Questionnaires were mailed to 2,100 randomly selected Massachusetts internists, surgeons, and psychiatrists, who were presented a scenario adapted from a court case that involved an elderly woman refusing lifesaving surgery. The scenario was divided into three sections: Part I, the medical history; Part II, the patient's rationale; and Part III, a psychiatrist's opinion as to whether the patient was competent. The respondents made their assessments before and after learning of the psychiatrist's opinion. Respondents were asked whether the patient was competent, whom they would consult, and how they would respond.

Before learning of the psychiatrist's opinion, 58 percent thought the patient was competent, 92 percent would consult a psychiatrist to help assess compe-

tence, and only 17 percent would go to court.

Part II of the survey posed a series of theoretical questions about competence. In that part, 89 percent knew the correct standard for competence; however, most incorrectly responded that conditions such as dementia and psychosis establish incompetence.

Psychiatrists performed better on theoretical questions but frequently worse on scenario questions. Several conclusions might be drawn from these findings. The authors of the report concluded that "the common clinical practice of relying on expert medical opinion may introduce bias and produce inaccurate results that undermine patient autonomy." (One wonders how the 59 percent of the physicians who received the survey but did not return it would have responded as a group—worse than, the same as, or better than those who reported results?)

After receiving the psychiatrist's opinion, only 30 percent thought the patient was competent and 55 percent would go to court.

Respondents were not told that an appellate court later decided that the psychiatrist had applied the wrong standard of competence, ruling that the patient was indeed legally competent.

Clinicians' lack of knowledge of the legal standards would seem to be a factor influencing the assessment of mental competence and points to the need for education in this area. Although not a point of the Markson report, I would add that another factor affecting the assessment process is the clinicians' access to adequate and accurate information provided by others, usually those making the request for an assessment of competency. This, in my experience, has been of the utmost importance in cases in which testamentary capacity and capacity to manage personal finances are of concern.

The study by Markson et al. points to other equally important factors. The presence of dementia and psychoses (some psychoses are complications of dementia) tends to produce a visceral reaction in others that leads to an assumption that the disturbed person is not generally competent and not to be trusted. Fear of the mentally ill may help to drive this thinking. There is a humorous story of a man who was driving through the grounds of a large state mental hospital. He had a flat tire and set out to change it. A patient of the hospital stood by and looked on. At one point the man at work accidentally kicked the hubcap in which he had stored the nuts from the wheel and they all fell into a sewer drain. He stood perplexed and said, "Now what am I to do?" The mental patient said, "Why don't you just take one nut from each of the other three wheels and attach your spare. It will be enough to get you to a garage." The man said, "That's a great idea, in fact, it's brilliant." The patient replied, "Sure, I may be crazy, but I'm not stupid."

Even catastrophic diseases of the brain, such as dementia, do not compromise all areas, resulting often in preservation of certain memories, rational processes, and other attributes of the "normal." The same is true of a person with a schizophrenic illness, who may have auditory hallucinations, hearing voices of nonexistent persons and having delusions that the television is reporting personal and private tales. This same person may be able to understand a physical disorder that requires treatment and the likely consequences of a decision to consent to or refuse treatment.

Incapacity Versus Incompetence

Speaking a common language in this area is important, especially because disciplines tend to have their own concepts and terms. This introduces the important concepts of incapacity and incompetence. Traditionally, the former is a state of clinical impairment as determined by a clinician, whereas the latter refers to the result of adjudication by a court. Clinicians may use a variety of terms to describe incapacity, for example, in describing a patient who does not have the "clinical capacity" to consent to surgery; or the term "lacking in functional capacity" may be used to describe such a person. The language muddle has thickened in the past decade as a number of states have adopted the term "incapacity" in lieu of "incompetence." The intent of the legislative reformers was to suggest a mental deficit that is less global than the concept of legal incompetency. With the implementation of limited guardianship and the concept of *legal* incapacity, individuals with mental disabilities were to

receive assistance in the areas needed and be free of interference in the areas in which they might exercise independent judgment. The change in the number of court orders, it must be noted, is small.

Another issue that may complicate the assessment of competence in persons with mental disorders is the stability of the condition(s) with which the patient is afflicted. A classic example is the disorder known as delirium, a state of confusion brought on by a variety of conditions that impair the brain in a global fashion. Typically, something has interfered with the function of the cerebral cortex, the area that does most of our "thinking." Intoxication or withdrawal reactions are common causes of delirium; perhaps the most common is alcohol intoxication or withdrawal (delirium tremens). Various metabolic disorders such as diabetes mellitus or electrolyte imbalance may cause it. The stress of surgery and anesthesia may be followed by "postoperative delirium." One of the features of delirium is instability or variability of mental functioning. The person who has had surgery the day before may seem totally coherent to the physicians on their rounds, yet have been reported to be very confused during the early hours of the morning. Elderly persons are generally more susceptible to these kinds of problems than the nonelderly.

The problems of assessing this type of incapacity are not peculiar to acute conditions only. I have personally encountered considerable difficulty in assessing an elderly person with early to mid-stage dementia. Any one who has come in contact with such persons will have observed that their mental abilities vary from day to day, even though dementia such as Alzheimer's disease is generally thought of as a chronic progressive illness. Observers might report, "Mom is real clear in her thinking today. Yesterday she was all mixed up." Many factors can contribute to this, such as the amount and quality of sleep, medications, other medical conditions, and undoubtedly factors that we do not understand or can't identify. The lesson is that the timing of the assessment is very important and multiple assessments may be necessary to determine a state of mental competence. (This differs, of course, from the retroactive analysis of a court asked to determine whether a presumptively competent adult was in fact competent at the making of a disputed contract; that determination involves only whether the court will enforce the terms of the contract, and the evidence of competency is only one of the factors at issue.)

The role of emotion in thinking is illustrated by such expressions from the vernacular as "love is blind" or "he was blind with rage." In both examples, the idea is conveyed that a person isn't thinking rationally due to intense emotion. We see this frequently in conditions such as depression or anxiety disorders. Virtually anything that may adversely alter mood can also affect thinking. The usual result, however, is irrationality rather than diminished cognitive capacity. The effect of psychodynamic factors on social judgment is a good example of how combined personality dynamics may influence important decisions.

Let me provide an example, a situation that I have observed a number of times in my practice. An individual with a long-standing hostility toward and mistrust of authority is diagnosed as having cancer. The person's antipathy toward modern medicine may have arisen out of unfortunate experiences with the medical establishment in the past. Religious or philosophical beliefs may be factors. State-of-the-art, standard medical treatment is offered but refused by the person, who opts for "natural" treatment (herbs, vitamins, draconian diets, coffee enemas, etc.). The patient embarks on a pilgrimage to "alternative medicine" practitioners, spending huge amounts of money and eventually impoverishing his or her spouse and family. The family is worried about what will happen, especially if the cancer advances. Is this person "competent" to manage finances and participate meaningfully in medical care? If one were to ask the person the standard questions assessing cognitive capacity, one would likely get the correct answers. He or she would seem to have a rational basis for the decision to take the route chosen, even though many others would conclude that the person was not rational. Clearly, we cannot fully assess the various qualities of personality in isolation. Cognition, emotion, motivation, and observed behavior are constructs we use to attempt to understand and describe the human personality. In reality it is a unity, integrated and of course highly complex.

The application of a legal standard should be seen as assessing a specific final common pathway of the brain's complex functions.

Last, I will comment briefly on the influence of setting and circumstances in assessing mental competence. Admission of an elderly person to a nursing home is often a signal to family members that the end is not far off and whatever legal matters should be settled must be taken care of right away. The older person may not have made a will. There are end-of-life decisions to be made, including whether to resuscitate in an emergency. The elderly person, however, is experiencing what has been referred to as a catastrophic reaction, the powerful awareness that most of one's independence has been lost and that one is nearing the end of life.

The relative quiet of home is gone and replaced by an often noisy background of persons, usually complete strangers, moaning and yelling out. The psychological reaction to this experience commonly involves anxiety, anger, despair, and even depression. The anger is frequently directed at children who facilitated the admission. One can readily understand how the assessment of mental competence may be influenced by these circumstances. Of course it is always best if legal matters are settled before people arrive at these circumstances. If they must be addressed at such a junction it is best to give the person newly admitted to a nursing home time to make an adjustment to the new surroundings before dealing with legal matters that require consent.

Endnote

1. L. J. Markson, D. C. Kern, G. J. Annas, and L. H. Glantz, *Physician Assessment of Patient Competence*, 42 J. AM. GERIATRICS SOC. 1074–80 (1994).