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COMPETENCY TO REFUSE TREATMENT

ELYN R. SAKS*

What standard must a patient meet in order to be deemed competent to make decisions regarding her treatment? This question has been given little attention by the law, and although many states now permit "competent" patients to refuse treatment, neither statutes nor case law clearly articulate or apply a competency standard. In this Article, Professor Saks identifies the criteria that a compentency standard must meet: the standard must identify the abilities that are necessary to making decisions that deserve deference; must protect a person's expression of her values and beliefs, however unconventional; and must designate as incompetent a reasonably small class of individuals in the face of irrational and unconscious influences. Professor Saks then applies these criteria to evaluate six competing competency standards. The Article concludes that the legal concept of a delusion common in testamentary capacity cases should play a central role in determining compentency to refuse medical treatment, as a standard employing the delusion concept most adequately meets the necessary criteria. Such a standard results in some controversial conclusions, such as that a psychiatric patient is competent to refuse treatment even though her refusal is based on the belief that she is not ill.

I. INTRODUCTION 946
II. THE COMPETING STANDARDS OF COMPETENCY 948
  A. *The "Pure Understanding" View* 952
  B. *The "Modified Understanding" View* 953
  C. *The "Understanding and Belief" Views* 955
  D. *The "Full Reasoning" View* 956
  E. *The "Therapeutic Alliance" View* 958
  F. *The "Different Person" View* 959
  G. *Advantages of the Proposed Classification of Competency Standards Over Other Proposals* 960
III. THE CONCEPT OF A DELUSION AS THE POLESTAR OF INCOMPETENCE 962
  A. *Why Delusions?* 962
  B. *The Concept of a Delusion Applied—Wills Cases* 966
IV. TREATMENT COMPETENCY 977

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A. *The Cases* 978
B. *Typical Reasons for Refusing Medication in Light of the Law's Concept of a Delusion* 984
1. Cases of feelings 984
2. Cases of value judgments 985
3. Beliefs about one's doctor and the recommended treatment 987
4. The belief that one is not ill 988
V. AN OBJECTION TO ANALOGIZING FROM OTHER AREAS OF COMPETENCY: THE "DIFFERENT LEVELS" THESIS 992
VI. CONCLUSION 998

I. INTRODUCTION

Mary Northern was seventy-two years old when she developed gangrene in both feet, probably as a result of frostbite followed by thermal burning of her feet.[1] She lived alone under "unsatisfactory" conditions, with no help available from relatives.[2] Although her doctors believed that amputation of both of her feet was necessary to save her life, Mrs. Northern refused the amputation. The Tennessee Department of Human Services sought an order authorizing substituted consent to the amputation, alleging that Mrs. Northern was in imminent danger of death and lacked the capacity to make her own decision.[3]

The critical issue facing the Tennessee court of appeals in *Department of Human Services v. Northern*[4] was whether Mrs. Northern was competent to decide not to have her feet amputated. Mrs. Northern met all criteria of general competence: she could follow conversations, think and speak clearly, and make unexceptionable decisions about her life. As the court said, she was "an intelligent, lucid, communicative and articulate individual."[5] Yet on the specific subject of her gangrenous feet, Mrs. Northern's comprehension was "blocked, blinded, or dimmed."[6] According to her psychiatrist, the patient was "functioning on a psychotic level" with respect to her feet:

> She tends to believe that her feet are black because of soot or dirt. She does not believe her physicians about the serious infection. There is an adamant belief that her feet will heal without surgery, and she refused to even consider the possibility that amputation is necessary to save her life.[7]

Not surprisingly, perhaps, the court found that Mrs. Northern was incompetent

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1. Department of Human Servs. v. Northern, 563 S.W.2d 197, 202 (Tenn. Ct. App. 1978). For a very interesting discussion of this case, see Abernethy, *Compassion, Control, and Decisions about Competency*, 141 AM. J. PSYCHIATRY 53 (1984).
2. *Northern*, 563 S.W.2d at 202.
3. *Id.*
4. 563 S.W.2d 197 (Tenn. Ct. App. 1978).
5. *Id.* at 205.
6. *Id.* at 209.
7. *Id.* at 204.

to refuse treatment and required her to accept the amputation when it became necessary to save her life.

Northern presents a graphic example of the issue of a patient's competence to decide on the treatment of a serious physical illness. This issue is important because much is at stake—Mrs. Northern's feet, her self-respect, even her life. On the one hand, if the court decides she is incompetent, Mrs. Northern will lose her feet. *She* will have to live with the consequences of the decision, as well as with the sense of shame and degradation that will attend the court's decision to override her choice. On the other hand, if the court finds her competent, she may die. Our notion of competency mediates in this clash between the values of autonomy and paternalism, and because the stakes are so high, we should be clear on just what competency means.

Cases like Mrs. Northern's are especially common in the psychiatric context for the simple reason that the competence of psychiatric patients is often questionable. The patient's interests in this context are also weighty: psychotropic medication produces disagreeable side effects in many and presents a significant risk of a grotesque and irreversible movement disorder. Yet the alternative for the unmedicated patient may be utter madness. Now that a number of states permit competent psychiatric patients to refuse psychotropic medication,[8] the long-neglected question of what the phrase "competent to refuse treatment" means deserves extended study.

This Article takes as a given the liberal or individualistic proposition that the law should override decisions such as Mrs. Northern's only when the decisionmaker is incompetent: autonomy is to be preferred unless the patient cannot adequately protect her interests. The critical question is what separates those who are competent from those who are not. Philosophical analysis and a close examination of competency doctrine in other areas demonstrate that an appropriate standard of treatment competency imposes two requirements. First, the patient must be able to comprehend the treatment information, in the sense of being able to follow what the caregiver says. Mrs. Northern probably met this part of the standard, inasmuch as her intellect was intact. Second, the patient's beliefs must not patently distort reality. Mrs. Northern probably failed this part of the standard. Although she might competently disagree with her doctors about the inevitability of her death from gangrene (notwithstanding the majority opinion's failure to recognize this), she could not competently deny that they *believed* she would die without treatment. Because the majority and concurring opinions suggest that she could not truly accept the fact of her doctors' belief, the court properly judged her incompetent.

Although the holding in *Northern* may seem intuitively correct, the standard that justifies it—competency is incompatible only with patently false be-

8. *See, e.g.*, People v. Medina, 705 P.2d 961 (Colo. 1985); Rogers v. Comm'r of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); Opinion of the Justices, 123 N.H. 554, 465 A.2d 484 (1983); Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); State *ex. rel.* Jones v. Gerhardstein, 141 Wis. 2d 710, 416 N.W.2d 883 (1987).

liefs—supports other, more controversial conclusions. For example, a psychiatric patient's belief that medication will not work does not render the patient incompetent to refuse the medication. And a patient may be competent even though he refuses medication because he does not believe he is ill or because he believes he is bad and deserves to suffer. The reasons for choosing a standard that produces these results, as opposed to one of several competing standards, are the subject of this Article.

The Article begins by presenting a new classification of competency standards and assessing each in light of a number of criteria that any adequate standard must meet. The standards range from one that merely requires that the patient evidence a choice to one that requires that she reach a correct decision. Philosophical analysis in light of the criteria mandates the selection of a standard that does not demand a correct decision, and indeed a standard that demands little in the way of accurate beliefs.

Interestingly, the law, on its best reading, takes just this view in areas of competency that, unlike the area of treatment competency, have a long history and a well-developed formulation for the assessment of beliefs—the concept of a delusion. The Article surveys the courts' use of that concept in the area of testamentary capacity and draws to some extent on the area of criminal competency as well.

Exploring the concept of treatment competency by analyzing cases involving testamentary capacity permits us to consider some hard cases involving psychiatric patients who give questionable reasons for refusing psychotropic medication. The Article then concludes by addressing the objection that analogizing from one area of competency doctrine to another is illegitimate because decisions relating to important subjects like medical treatment require *more* competency than decisions relating to less important subjects like testamentary dispositions. The objection—a distant cousin to the notion that bad decisions are incompetent—is misguided because it clashes with the idea that it is for individual decisionmakers themselves to decide which decisions are good and bad. The Article concludes that the psychiatric patient's right to refuse treatment finds strong support in an area of law—testamentary capacity—with an ancient lineage and a sound philosophical foundation.

II. THE COMPETING STANDARDS OF COMPETENCY

Consider an ideal process of making a treatment decision.[9] The doctor in-

9. The author of this Article is indebted to the work of H. FINGARETTE, THE MEANING OF CRIMINAL INSANITY (1972), and M. MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP (1984).

Legal literature specifically addressing competency to make treatment decisions is scarce. This author located only one article devoted to this area. *See* Annas & Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 U. TOL. L. REV. 561 (1984). One student note is devoted to the narrower idea of suicidal competency. *See* Note, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707 (1987) [hereinafter Note, *Suicidal Competence*].

The literature in specialty and psychiatric journals, as well as books, is more abundant. For works on competency to make treatment decisions that are not addressed in this paper, see C. CUL-

forms the patient of any information necessary to make a reasoned treatment decision, such as the nature of his condition, the risks and benefits of the proposed treatment, and all available alternatives. The patient assimilates the information and accurately assesses its truth. He realizes, for example, that he is sick, and that he has certain treatment options. Reasoning on the basis of what he has learned of the world and what he knows of himself—his own experiences, values, needs, and goals—the ideal patient decides that a particular course is in his own best interest.

The ideal case provides a backdrop against which to understand three criteria that any adequate competency standard must meet. First, the standard must meet the "abilities" criterion: it must faithfully identify those abilities that are necessary to making decisions that deserve deference. This, of course, is no easy matter. For instance, an ability to understand what one is deciding is probably

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VER & B. GERT, PHILOSOPHY IN MEDICINE: CONCEPTUAL AND ETHICAL ISSUES IN MEDICINE AND PSYCHIATRY (1982); N. REATIG, COMPETENCY AND INFORMED CONSENT: PAPERS AND OTHER MATERIALS DEVELOPED FOR THE WORKSHOP "EMPIRICAL RESEARCH ON INFORMED CONSENT WITH SUBJECTS OF UNCERTAIN COMPETENCE" (1981); Appelbaum, Mirkin & Bateman, *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170 (1981); Appelbaum & Roth, *Clinical Issues in the Assessment of Competency*, 138 AM. J. PSYCHIATRY 1462 (1981); Appelbaum, Roth & Lidz, *The Therapeutic Misconception: Informed Consent in Psychiatric Research*, 5 INT'L J.L. & PSYCHIATRY 319 (1982); Bursten, *More on Compassion and Competency* (letter), 141 AM. J. PSYCHIATRY 1491 (1984); Eth, *Competency and Consent to Treatment* (letter), 253 J. A.M.A. 778 (1985); Gutheil & Appelbaum, *More on Compassion and Competency* (letter), 141 AM. J. PSYCHIATRY 1492 (1984); Gutheil, Bursztajn, Kaplan & Brodsky, *Participation in Competency Assessment and Treatment Decisions: The Role of a Psychiatrist-Attorney Team*, 11 MENTAL & PHYS. DISABILITIES L. RPTR. 446 (1987); Hoffman, *Assessing Competence to Consent to Treatment* (letter), 25 CAN. J. PSYCHIATRY 354 (1980); Jaffe, *Problems of Long-Term Informed Consent*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 163 (1986); Janicak & Bonavich, *The Borderland of Autonomy: Medical-Legal Criteria for Capacity to Consent*, 8 J. PSYCHIATRY & L. 361 (1980); Kaufmann, Roth, Lidz & Meisel, *Informed Consent and Patient Decisionmaking: The Reasoning of Law and Psychiatry*, 4 INT'L J.L. & PSYCHIATRY 345 (1981); Kelly, *Competency and Treatment Refusal* (letter), 28 PSYCHOSOMATICS 494 (1987); Leong, *Competency Issues in Referrals* (letter), 29 PSYCHOSOMATICS 140 (1988); Leong, *Shifting Competency* (letter), 38 HOSP. & COMMUNITY PSYCHIATRY 671 (1987); Lesser, *Consent, Competency and ECT: A Philosopher's Comment*, 9 J. MED. ETHICS 144 (1983); Macklin, *Problems of Informed Consent with the Cognitively Impaired and Treatment Refusals: Autonomy, Paternalism, and the "Best Interest" of the Patient*, in ETHICAL QUESTIONS IN BRAIN AND BEHAVIOR: PROBLEMS AND OPPORTUNITIES (D. Pfaff ed. 1983) [hereinafter *Treatment Refusals*]; Munetz, Roth & Cornes, *Tardive Dyskinesia and Informed Consent: Myths and Realities*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 77 (1982); Murphy, *Therapy and the Problem of Autonomous Consent* and *Incompetence and Paternalism*, in J.G. MURPHY, RETRIBUTION, JUSTICE, AND THERAPY: ESSAYS IN THE PHILOSOPHY OF LAW 197 (1979) [hereinafter *Paternalism*]; Myers & Barrett, *Competency Issues in Referrals to a Consultation-Liaison Service*, 27 PSYCHOSOMATICS 782 (1986); Olin & Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 AM. J. PSYCHIATRY 938 (1975); Perry, *A Problem with Refusing Certain Forms of Psychiatric Treatment*, 20 SOC. SCI. MED. 645 (1985); Pies, *Shifting Competency* (letter), 38 HOSP. & COMMUNITY PSYCHIATRY 671 (1987); Roth, Lidz, Meisel, Soloff, Kaufman, Spiker & Foster, *Competency to Decide about Treatment or Research: An Overview of Some Empirical Data*, 5 INT'L J.L. & PSYCHIATRY 29 (1982); Sherlock, *Consent, Competency, and ECT: Some Critical Suggestions*, 9 J. MED. ETHICS 141 (1983); Spencer, *Competency and Consent to Treatment* (letter), 253 J. A.M.A. 778 (1985); Tancredi, *Competency for Informed Consent: Conceptual Limits of Empirical Data*, 5 INT'L J.L. & PSYCHIATRY 51 (1982); Taylor, *Consent, Competency and ECT: A Psychiatrist's View*, 9 J. MED. ETHICS 146 (1983); Tepper & Elwork, *Competence to Consent to Treatment as a Psycholegal Construct*, 8 L. & HUMAN BEHAVIOR 205 (1984); Watson, *Comment*, 141 AM. J. PSYCHIATRY 58 (1984); Weinstock, Copelan & Bagheri, *Competency to Give Informed Consent for Medical Procedures*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 117 (1984); Weithorn & Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982); Zeichner, *The Role of Unconscious Conflict in Informed Consent*, 13 BULL. AM. ACAD. PSYCHIATRY & L. 283 (1985).

necessary for competently making any decision. But is an ability to reason also necessary? What about an ability to know one's true needs and values? Of course the standard will not require all of the abilities which the ideal decisionmaker whom we described above exercises, for the case *is* ideal. Yet *some* of these abilities are necessary to making any competent decision, and it is part of the job of a competency standard to help us decide which ones are necessary, and which are not.

The second criterion, the "unconventionality" criterion, mandates that a competency standard protect a person's expression of her values and beliefs, however unconventional, because one important purpose of competency doctrine is to allow people to pursue their interests according to their own lights. This criterion limits the range and level of abilities we can require under the abilities criterion, warning that even "ideal" decisionmaking simply may be a product of convention. Indeed, we cannot require the patient to have even the beliefs (much less the desires) of the ideal decisionmaker unless they are shown to be knowably correct. Freedom to decide includes, within limits, freedom to decide what is true no less than what is good.

The third criterion, the "irrationality" criterion, requires that a competency standard designate a reasonably small class of individuals as incompetent in the face of the pervasive influence of the irrational and the unconscious. Psychiatrists and psychologists have demonstrated convincingly the ever-present influence of primitive hopes, wishes, and fears on the mental lives of us all.[10] Thus, if any person whose decisionmaking showed irrationality was deemed incompetent, then virtually *no* competent decisionmakers could be found. Indeed, irrational processes may hopelessly compromise certain types of mental functions required in the ideal case. An apparently intact reasoner, for example, may choose a treatment because he has unconscious fantasies of merger with the doctor/parent,[11] or, perhaps less fancifully, because he overvalues a vivid memory.[12] Like the unconventionality criterion, the irrationality criterion limits the reach of the abilities criterion because many abilities inextricably implicate irrationality.

These three criteria pose a severe challenge to a competency standard insofar as they pull in different directions. No standard will meet all three criteria without qualification, although some standards do a better job than others. While the abilities criterion seems to require a full range of faculties, the unconventionality criterion imposes the philosophical or doctrinal limit that a competency standard must not trench on the expression of personality. The irrationality criterion requires us to choose a standard that rationally distin-

10. *See infra* notes 34 and 35 (citing authorities).

11. "Transference," in which characteristics of one's early caregivers are transferred onto other important figures, is not uncommon in patient-doctor relationships. *See, e.g.*, J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 142-43 (1984).

12. For example, one may remember vividly a horrific experience that another has recounted of a treatment and that may influence one's decision more than the bare factual information that such experiences are highly uncommon, and that the results of the treatment, statistically speaking, are quite benign.

guishes among deficient decisionmakers. The unconventionality criterion provides the more conceptual challenge: how can we prescribe merely conventional attributes of decisionmaking when one purpose of competency doctrine is to permit the expression of the unconventional? Of course it is precisely because the apparently irrational or otherwise unconventional person simply may be striving after the good life according to her own lights that overly broad criteria for incompetency are so invidious: they suppress individuality.

The three criteria are clearly rooted in our ordinary language/legal concept of competency,[13] but they do not justify—or purport to justify—the values underlying that concept.[14] Rather, by bringing into focus the purposes and problems surrounding competency doctrine, the criteria sharpen our exploration of competing standards. They thus enable us to replace our vague, inchoate notion of competency with a more rigorously formulated standard that is nonetheless true to our pre-reflective convictions. Two very simple competency standards will show us the criteria at work.

According to one standard, a person is competent if he merely "evidences a choice."[15] This standard does not require that the patient hold particular beliefs and values, and so it avoids infringing on the expression of unconventional beliefs and values. Similarly, the standard does not require that the process of decisionmaking be rational, so that the pervasive irrationality of decisionmaking is unproblematic. While the standard thus meets the unconventionality and irrationality criteria, it squarely violates the abilities criterion. Two-year-old children, after all, can say "yes" and "no," yet we need not honor their choices, nor label them competent decisionmakers.[16] What further abilities competency requires—and why—will concern us below, but the simple capacity to evince some choice is clearly not enough.[17]

A second proposed competency standard suffers from precisely the opposite problem. This standard deems a person competent only if he makes a reasonable decision according to the evaluator.[18] This "reasonable result" standard

13. That the criteria derive in part from our legal concept does not trivialize the finding of this Article that the law's standard does a good job meeting the criteria. Legal concepts often fail to fulfill all that they implicitly promise—indeed, they are especially likely to fail given the way they develop. It is not easy for any of our ordinary language concepts to withstand philosophical scrutiny even when philosophy is, as it must be, guided by those very concepts.

14. For instance, our ordinary language/legal concept of competency evidences a strong preference for liberty, and the criteria, while they reflect this preference, do not justify it.

15. *See* Appelbaum & Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCH. GEN. PSYCHIATRY 951, 952-53 (1982); Friedman, *Legal Regulation of Applied Behavioral Analysis in Mental Institutions and Prisons*, 17 ARIZ. L. REV. 39, 75-80 (1974); Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977).

16. *See* Kronman, *Paternalism and the Law of Contracts*, 92 YALE L.J. 763, 795-96 (1983).

17. *See, e.g.*, PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 61 (1982) [hereinafter PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS]; Freedman, *Competency, Marginal and Otherwise: Concepts and Ethics*, 4 INT'L J.L. & PSYCHIATRY 53, 62 (1981); Sherlock, *Competency to Consent to Medical Care: Toward a General View*, 6 GEN. HOSP. PSYCHIATRY 71, 75 (1984).

18. *See* Roth, Meisel & Lidz, *supra* note 15, at 280-81 (citing Friedman, *supra* note 15, at 77-78). As they point out, this standard often may be used *sub rosa* by courts and physicians. Roth, Meisel & Lidz, *supra* note 15, at 281; *see also* Abernethy, *supra* note 1, at 57 ("reasonable result"

selects people who are quite likely to have adequate decisionmaking abilities. At the least they have shown themselves able to make this particular decision; by definition their choice is reasonable. While the standard may effectively meet the abilities criterion, however, it plainly violates the unconventionality and irrationality criteria. To require a reasonable outcome is both to bar the expression of idiosyncratic preferences and goals and to require an integrity of the reasoning process that many may lack. Thus the second standard must fail: requiring people to live according to someone else's conception of the good completely frustrates the purposes of competency doctrine.[19]

For very different reasons, then, these two preliminary standards fail to meet the three criteria for an adequate standard of competency. We would do better to focus on the kinds of abilities that *are* necessary to adequate decisionmaking—for example, understanding and reasoning. The next section considers several standards that focus on those abilities.

A. *The "Pure Understanding" View*

The first standard—the "pure understanding" standard—deems a person competent if he can assimilate the information that the caregiver provides. "Understanding" in this sense is nothing more than comprehension; the patient need neither accept nor believe the information in order to be competent. If, for example, we say "he understands the theory that the fittest survive," we do not imply that he believes the theory. If, however, we say "he understands that the fittest survive," we do imply that he believes it.[20] In the treatment context, a patient is competent, according to the "pure understanding" standard, if he simply *understands* the doctor's theory that he is sick and that the recommended treatment may help him—his *beliefs* about the truth of what his doctor says are irrelevant. The "pure understanding" view finds incompetent those patients who have organic deficits that prevent them from grasping the meaning of what is said, who are too disorganized or agitated to attend to information or to communicate understanding, or who are unable to retain information for even a short period of time.

The "pure understanding" view has the clear advantage of meeting the unconventionality and irrationality criteria without qualification. It gives full scope to unconventionality, allowing patients to express not only unconventional desires, but also unconventional beliefs; it makes no inquiry whatsoever into the truth of anyone's beliefs. Moreover, the "pure understanding" view incapacitates only a relatively small group of patients. Because it in no way requires

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competency standard used *sub rosa* by courts); Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271, 307 (1944) (same).

19. *See, e.g.*, PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 17, at 61-62; Brown, *Psychiatric Treatment Refusal, Patient Competence, and Informed Consent*, 8 INT'L J.L. & PSYCHIATRY 83, 90 (1986); Faden & Faden, *False Belief and the Refusal of Medical Treatment*, 3 J. MED. ETHICS 133, 135 (1977); Freedman, *supra* note 17, at 61; Sherlock, *supra* note 17, at 75-76.

20. *See* R. FADEN & T. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 250 (1986).

rationality, defending the point at which it deems patients incompetent in the face of our pervasive irrationality is unproblematic.

Although the "pure understanding" view meets the unconventionality and irrationality criteria, it fails to meet the abilities criterion. While comprehending information is clearly necessary to decisionmaking—imagine being asked to make an important decision described in a foreign language[21]—comprehension alone is not enough. Unless the decisionmaker credits the information to some degree, the comprehension is pointless. For instance, if a patient views a doctor's theory as on a par with phrenology, she would not even advert to the theory in making her decision. Requiring only comprehension, however, plainly compromises decisionmaking to the extent that the comprehended information may be true. We want decisionmakers at least to consider the information provided, because making a decision in one's best interests requires knowing how those interests are likely to be affected. The information may well supply that knowledge. The "pure understanding" view, then, fails to meet the abilities criterion insofar as it neglects the ability to view potentially material information as at least worthy of consideration.

B. The "Modified Understanding" View

The second competency standard, the "modified understanding" view, attempts to remedy the shortcomings of the "pure understanding" view while largely retaining its advantages. In its most prevalent form, the "modified understanding" view is that, to be competent, the patient must comprehend the information that the doctor provides and must also believe that the doctor believes it.[22] This theory does seem to put the patient in an adequate position to make a decision, and thus seems to meet the challenge of the abilities criterion. Recognizing that the doctor believes the information at least provides the patient an incentive to consider it, given that society regards doctors as knowledgeable about health. The "modified understanding" view also satisfies the unconventionality and irrationality criteria. Because it requires only one, fairly uncontroversial belief, it leaves room for all other beliefs. In addition, it requires little in the way of rationality.

The "modified understanding" view, however, is untenable. It is impossible to specify any particular belief which, if held, will ensure that the decisionmaker views the information provided as worthy of consideration. Requiring the decisionmaker to believe only that the doctor believes the information, for example, is insufficient. Suppose the patient does believe that the doctor believes the in-

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21. Imagine, for instance, a prisoner facing two contraptions, one which will kill him and the other which will grant his every wish. The prisoner cannot tell from looking at the contraptions what they will do, and he cannot understand his captor's explanation of them because it is in a foreign language. Most people would agree that this prisoner is incompetent to choose between the two contraptions.

22. *See, e.g.*, Burra, Kimberly & Miura, *Mental Competence to Consent to Treatment*, 25 CAN. J. PSYCHIATRY 251 (1980); Culver, Ferrell & Green, *ECT and Special Problems of Informed Consent*, 137 AM. J. PSYCHIATRY 586, 586-87 (1980).

formation, but also believes that all doctors are unwittingly controlled by malevolent spirits. Surely this patient is incompetent.

We might try to characterize the necessary belief neutrally as the belief that the information is worthy of consideration. This belief, however, threatens to implicate *all* one's beliefs, insofar as the best reason not to believe that the information is worthy of consideration may well be the firm conviction that the information is false. Thus this approach acutely raises the problems of unconventionality and irrationality.

Yet may we not read the neutral belief so as to avoid implicating all one's beliefs? The point of the "modified understanding" view is to ensure that the decisionmaker gave the information some thought, not that she believed it. In one sense, a belief about the truth of information is subsequent to a belief about the *possible* truth of the information, and thus whether the information is worth considering. It is possible to specify conditions for believing that information is worth considering that are independent of conditions for believing that it is true. In particular, it is beliefs about the source of the information that determine whether the information has some claim to attention. For instance, if my senses are usually reliable, I am inclined to consider my sense-impressions as yielding true information, even if I finally reject particular items of information. Conversely, if I believe that all news is propaganda, and most unreliable, I am not inclined to ponder the truth of any news. Information may be worthy of consideration, then, whether or not one believes it to be true. Thus, on one version of the "modified understanding" test, a person is competent who has no beliefs about the source of comprehended information that cause it to lose any claim to possible truth.

While this version does limit the range of beliefs that are subject to scrutiny, it produces the odd result that relatively rare crazy beliefs about the source of information—for instance, that evil spirits are speaking through the doctor—disqualify the decisionmaker, whereas relatively common crazy beliefs about the truth of the information—for example, that the medication is poison—do not. If we require the decisionmaker to have the ability to assess evidence about the source of information, it makes sense to require her to have the ability to assess evidence about the information's truth.

Consistency in what we ask of the decisionmaker is not the only issue. Requiring nothing more than a belief that information is worth considering is not enough. An adequate standard must also require that the decisionmaker be able to form acceptable beliefs about the information's truth. Decisions, after all, are made on the basis of beliefs and values. What one *believes*, rather than what one *considers* believing, forms the foundation of one's decisions. Whether mere consideration, or a combination of consideration and adequate assessment of the evidence, is necessary under the abilities criterion is perhaps a close question. But since the "modified understanding" theory does implicate unconventionality and irrationality concerns, and since "understanding and belief" theories may ease those concerns in their own way, these other theories merit our attention.

C. *The "Understanding and Belief" Views*

Unlike the "modified understanding" view, "understanding and belief" theories require that the decisionmaker have the ability to assess all evidence relevant to her decision. These theories exist in naive and sophisticated forms. According to the naive version, a person is competent if she not only comprehends the information that the caregiver provides, but also believes the information.[23] This theory is naive to the extent that it assumes that caregivers can discern the truth, for truth, especially medical truth, is most elusive. It is also naive to reason that the doctor's version of the truth is the best we have, and so must be believed.[24] Absent clear criteria for discerning "truth," each person individually must determine whose "truth" is real. Thus, the naive view clashes with the unconventionality criterion. The naive theory also conflicts with the irrationality criterion insofar as it identifies a large class as incompetent. Many if not most people will hold beliefs that deviate in at least a minor way from the "received" position—perhaps, indeed, because everyone is subject to the influence of the irrational.

Sophisticated "understanding and belief" theories are more skeptical about authoritative versions of the truth. These theories require only that the decisionmaker comprehend the caregiver's information and form no patently false beliefs[25]—that affect the decision.[26] Thus, for example, while a naive "understanding and belief" view requires that the patient believe the doctor's belief that treatment will help, a sophisticated "understanding and belief" view requires

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23. Many commentators on medical competency seem to subscribe to a naive "understanding and belief" view. *See, e.g.*, Annas & Densberger, *supra* note 9 (These authors describe an "appreciation" test, which instead may be a kind of "full reasoning" view; it is nevertheless fair to say they subscribe to at least a naive "understanding and belief" view.); Appelbaum & Bateman, *Competency to Consent to Voluntary Psychiatric Hospitalization: A Theoretical Approach*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 390 (1979); Hoffman, *Assessing Competence to Consent to Treatment*, 25 CAN. J. PSYCHIATRY 354 (1980) (appearing to hold naive "understanding and belief" view supplemented by a delusion test); Roth, Appelbaum, Sallee, Reynolds & Huber, *The Dilemma of Denial in the Assessment of Competency to Refuse Treatment*, 139 AM. J. PSYCHIATRY 910 (1982) (purporting to hold an "appreciation" view, but appearing to hold naive "understanding and belief" view in my schema); Sherlock, *supra* note 17 (supplementing the test with voluntariness prong).

24. For an example of this naive reasoning, see, *e.g.*, Appelbaum & Roth, *supra* note 15, at 956.

25. Once we reject the naive assumption that any beliefs at variance with the doctor's are unacceptable, we have a line-drawing problem. Assume for the purposes of this argument that the notion of "patently false beliefs" provides a reasonable place to draw the line. *See infra* text accompanying notes 52-60 (discussing right place to draw the line).

26. The general rule in competency cases—*e.g.*, testamentary capacity—is that a delusion must actually affect a decision in order to invalidate it. *See, e.g.*, Estate of Nigro, 243 Cal. App. 2d 152, 160, 52 Cal. Rptr. 911, 912-13 (1969); *In re* Estate of Bonjean, 90 Ill. App. 3d 582, 584, 413 N.E.2d 205, 207 (1980). Thus, if there is a rational reason for a bequest, the bequest is good, even if there is also a delusional reason for it. *See, e.g.*, *In re* Estate of Yett, 44 Or. App. 709, 714, 606 P.2d 1174, 1176 (1980) (testator's desire to provide fairly for sisters in need sufficient reason for disinheriting nephew despite persecutory delusions about him); *In re* Meagher's Estate, 60 Wash. 2d 691, 693, 375 P.2d 148, 150 (1962) (testator's desire that younger son carry on family business sufficient reason to give elder son smaller share of estate despite persecutory delusions about elder son). In the treatment context the rule evidently is not always followed. *See, e.g.*, *In re* Hospitalization of B., 156 N.J. Super. 231, 233-34, 383 A.2d 760, 761-62 (1977) (dislike of side effects of medication does not justify finding of competence where delusions also motivate refusal). But an acceptable competency standard will incorporate the rule.

only that the patient avoid patently false beliefs about the treatment that affect the decision, for example, that it will cause a nuclear explosion.

The law's predominant competency test is a sophisticated "understanding and belief" theory of this kind, which characterizes as "delusional" those beliefs that are supported by no evidence,[27] and thus are so patently false that those who hold them must have suffered a severe breakdown of their ability to assess evidence. The concept of a delusion is the law's answer to the concerns of the unconventionality and irrationality criteria. Because only patently false beliefs vitiate capacity, the conflict with the unconventionality criterion is minimal; because only patent irrationality disqualifies the patient, the conflict with the irrationality criterion is minimal as well. Yet the standard meets the abilities criterion inasmuch as it requires the decisionmaker to have the ability to assess evidence.

Some conflict between the standard and the unconventionality and irrationality criteria remains, precisely because of the inherent demands of the abilities criterion. The sophisticated "understanding and belief" view does limit what one may believe (without limiting what one may desire), and so threatens to trench on merely unconventional behavior. The limitation makes sense, however; unless one's belief in some way conforms to the world, it represents a failed attempt to describe the world. By contrast, one is entitled to choose values and desires without constraint because values and desires are neither objectively right nor objectively wrong in a straightforward way.[28] To value something unpopular is not to hold a false value, whereas to believe that the moon is made of green cheese is to hold a false belief.

Placing limits on what a patient can believe is reasonable also because medical treatment decisions take effect in the world. Since the point of a treatment decision is to achieve the best adaptation of one's needs, desires, and values to the world, the decisionmaker must have some grasp of the world. For example, if a person desires to address his obesity, he must grasp that overeating is no cure. Because of this, some tension between the abilities criterion and the unconventionality criterion is inevitable. Yet given this inevitable tension, the sophisticated "understanding and belief" standard does an excellent job of meeting the three criteria.[29]

D. *The "Full Reasoning" View*

Another competency standard, the "full reasoning" view,[30] demands a level

27. *See infra* notes 74-76 (citing cases).

28. *See infra* note 161.

29. While the "understanding and belief" view is one version of the "understanding" theories found in the law and literature, it is clear that, insofar as this view requires the ability to assess evidence, it combines one species of reasoning with the pure assimilation of information. In essence, the view requires that, before an individual is deemed incompetent, she must experience a failure of material understanding based on a severe breakdown of one key reasoning ability.

30. Some competency standards seem to require more or different abilities than the "full reasoning" view, but abilities, nevertheless, of the same genus. For example, Appelbaum and Roth propose an "appreciation of the nature of the situation" test that is more stringent than the "rational manipulation of information" test. Appelbaum & Roth, *supra* note 15, at 954-56. This seems to

of reasoning ability greater than the capacity to assess evidence that the "understanding and belief" views require: one's reasoning must have a good deal of integrity in order for one to be competent. Some formulations of the "full reasoning" theory resist easy application—for instance, that the person must be able to "reason logically" or to "manipulate information rationally."[31] Other, more workable formulations identify factors that may impair the integrity of the reasoning process, such as phobias or obsessive preoccupations, strong emotions, or pathologic (for instance, overly trusting) relations with the caregiver.[32] Yet whatever the phraseology, the "full reasoning" view requires fairly intact reasoning ability.

The "full reasoning" view is untenable because it inevitably produces problems under the unconventionality and irrationality criteria and because it is not clearly warranted by the abilities criterion. The problems derive from the mystery that surrounds the process of reasoning. Reasoning is inaccessible, hard to capture, in a way that beliefs are not. As a result, the role of pure or pristine reasoning in effective decisionmaking remains unclear; intuitive, idiosyncratic processes actually may improve decisionmaking in some cases. As an example, consider cases in which people *dream* of solutions to difficult mathematical problems.

Two points are actually at stake. First, fully intact reasoning may not be necessary for adequate decisionmaking, just as, for example, speaking with a good accent is not necessary for basic communication in a foreign language (compare knowing rudimentary vocabulary and syntax). Thus, the abilities criterion may not require "good" or "intact" reasoning. Second, what qualities of reasoning are "good" may be open to dispute (just as linguists disagree over the appropriate accent for a dead language). If the nature of good reasoning is controversial, to require some particular form of reasoning is to discriminate against deviancy, and so to violate the unconventionality criterion.[33]

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mean that the patient applies the treatment information to his own situation, which, in terms of my schema, could amount to simply a naive "understanding and belief" theory, or instead could amount to a theory requiring "mature" or "deep" understanding. (Lack of clarity about the nature of these commentators' "factual understanding" standard helps to create this confusion.) The latter interpretation seems to be supported by the authors' citation of "denial" and "psychotic level" "distortion, projection, nihilism, and hopelessness-helplessness" as vitiating competency. *Id.* at 955. These interferences seem to be of the same kind as the pathologic distortions that impair the reasoning process cited under my "full reasoning" view. See also Kronman, *supra* note 16, who develops the idea of judgment as key to competency. Because it is a more refined ability, requiring judgment is as problematic as requiring "full reasoning" for the reasons developed in the text.

31. For a number of different formulations, see, *e.g.*, S. SMITH & R. MEYER, LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE 544-587 and 657-681, at 661 (1987); Appelbaum & Grisso, *Assessing Patients' Capacity to Consent to Treatment*, 319 NEW ENG. J. MED. 1635, 1635-36 (1988); Grisso, *Competency to Consent to Treatment*, ch. 10, in EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS 321 (1986) (chart); Marzuk, *The Right Kind of Paternalism*, 313 NEW ENG. J. MED. 1474 (1985); Mills, Hsu & Berger, *Informed Consent: Psychotic Patients and Research*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 119 (1980).

32. *See, e.g.*, Appelbaum & Roth, *supra* note 15, at 955; Michels, *Competence to Refuse Treatment*, in A. DOUDERA & J. SWAZEY, REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS—VALUES IN CONFLICT 115, 117-18 (1982).

33. A third consequence also follows. Because reasoning is so mysterious, the possibilities of abusing a "full reasoning" standard are very real. For example, if a patient rejects the medical treatment proposed by his doctor, it is open to the doctor to find that the patient is "denying" the

The "full reasoning" view also raises acute irrationality problems. Even generally effective decisionmakers who clearly have the ability to form accurate beliefs misuse statistics, misunderstand probabilities, and accord undue weight to vivid examples.[34] They also may be affected profoundly by irrational and unconscious factors.[35] If, as under the "full reasoning" view, something short of patent irrationality will make one incompetent, then most, if not all, people are incompetent, because everyone's reasoning is invaded to some degree by irrational processes. This result is clearly untenable, and so we must reject the "full reasoning" view.

E. *The "Therapeutic Alliance" View*

Lawrence Hipshman originated the "therapeutic alliance" standard, which bears a more complicated relationship to the three criteria.[36] Hipshman is sensitive to the need to formulate a competency standard that does not impose conventional values on decisionmakers, and so proposes that a person's "decision should be assessed according to the person's particular system of personal, cultural, and social beliefs, and not by the value system of the observer."[37] If the person is "able to express his or her health belief system in the context of making treatment decisions,"[38] then he or she is competent. Hipshman attempts to operationalize this standard in a "clinically useful" way, by identifying it with the capacity to "consult, or work with, a doctor (clinician) in the business of treatment."[39]

Hipshman attempts to identify a decisionmaking capacity, as required by the abilities criterion, that does not intrude on expressions of personality, and so violate the unconventionality criterion. While interesting, the effort is a failure for three reasons. First, Hipshman's characterizations of the decisionmaking capacity cannot be equated. While Hipshman suggests that expressing decisions in accord with one's values can be "operationalized" as being in a therapeutic alliance, the two abilities are clearly not coextensive: one can express decisions in accord with one's values without being in a therapeutic alliance—a "real relationship" and a "working relationship"[40]—and one can be in a therapeutic alliance without being able to express decisions in accord with one's values.

Second, each characterization is objectionable under one or another of the three criteria. The requirement that a patient be able to express decisions in accord with her values may be interpreted two ways. The standard may require

truth—that the patient cannot fully accept, in a mature way, that he needs the treatment or that certain consequences will follow if he does not agree to it.

34. *See, e.g.*, PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 17, at 87-97.

35. For the idea that irrational and unconscious processes pervasively affect thinking, see, *e.g.*, the psychoanalytic theorists cited *infra* note 181; J. KATZ, *supra* note 11.

36. *See* Hipshman, *Defining a Clinically Useful Model for Assessing Competency to Consent to Treatment*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 235 (1987).

37. *Id.* at 236.

38. *Id.*

39. *Id.* at 239.

40. *Id.* at 240.

nothing more than conversation—a demonstration that one is trying to choose in light of one's values. Conversely, it may require a fairly coherent account of one's reasoning. While the first interpretation describes an ability that is plainly necessary for competency, such an ability alone is probably insufficient; trying to do a task is not the same as having the ability to do the task. The interpretation thus runs afoul of the abilities criterion. The second interpretation, by contrast, may require too much rationality, violating the irrationality criterion.

Again, neither interpretation describes the equivalent of having a good working relationship with a therapist. Moreover, that ability—requiring a good working relationship with a therapist—violates the abilities criterion by identifying the wrong type of skill. An ability to form a close working relationship, which may indeed permit effective treatment, is nevertheless irrelevant to whether one can decide on treatment. It speaks to one's interpersonal skills, not to one's judgment about one's interests. Moreover, a therapeutic alliance model invites unwitting abuse by professionals who are unhappy about the lack of cooperation of their patients; the psychiatrist may see an inability to sustain the therapeutic relationship when the patient merely is disagreeing with the therapist about treatment goals.

Third, Hipshman's "working relationship" model violates his own desideratum of avoiding the imposition of values. He requires the patient to have treatment goals, however unconventional, that he pursues with the help of the therapist. Because an unconventional person may choose to pursue other values at the expense of his health, this requirement is squarely in conflict with the unconventionality criterion. Thus the "treatment alliance" view also is flawed and must be rejected.

F. The "Different Person" View

The "different person" theory says that a person is incompetent, not if her values and beliefs are unacceptable according to some external standard, but rather if they are not *her* values or beliefs—because she has been transformed (for example, by mental illness) into a "different person." The notion is that the person is incompetent because she has lost touch with her own values and ways of looking at the world; she is simply not herself. For example, a person may flatly repudiate medical science during an episode of severe mental illness even though she is quite receptive to it in her saner moments. Such a person would be incompetent to make a medical treatment decision. The "different person" theory deftly sidesteps the irrationality and unconventionality criteria, inasmuch as the decisionmaker's irrationality is irrelevant, and her thinking and feeling are not forced into a conventional mold. All the "different person" theory requires is that the decisionmaker be true to herself.[41]

41. Some such theory, not necessarily justified in this way, underlies several commentators' views. For example, Macklin seems to be one such "authenticity" theorist. *See* Macklin, *Treatment Refusals*, *supra* note 9, at 46-47. A rather strict authenticity requirement for decisions to die is proposed in Note, *Suicidal Competence*, *supra* note 9, at 754-55. The President's Commission sometimes seems to explicate its competency standard in such "authenticity" language. *See* PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 17, at 171. And Paulo, Bursztajn,

While attractive, this theory does produce some significant problems. Most crucially, the theory professes a confidence in our ability to identify another's inauthentic choices—choices of the "different person"—that the doctrine of competency itself belies. Consider that if we knew what decisions a person's needs and values dictated we would not have nearly so great a need for a competency doctrine: others could choose for the person based on that knowledge. Others, however, are in a relatively poor position to make choices for a person in light of that persons' values. Values often conflict. Moreover, values can be too general for an outsider to determine a particular choice under the press of the patient's individual circumstances.

When a person's values appear to be in flux, as, in the "different person" context, when uncharacteristic choices are made, predictions are even more precarious. One must then determine not only what choice is most consistent with a person's past values, but also whether that person would have chosen to accept new values on reflection, either on that occasion alone or permanently. This means that we cannot distinguish the mentally ill choices of a "different person" from the choices of the same person who has simply changed; and change, even radical, does not render one incompetent.

In short, the "different person" theory fails by supposing that we can tell when a choice is not truly the person's own, but rather that of "someone else." This ability requires either profound knowledge of a person's values and needs—indeed, of her values and needs as they appear to be changing—or clear criteria for identifying "different persons." Since it is doubtful that we have either, we must reject the "different person" theory.

G. *Advantages of the Proposed Classification of Competency Standards Over Other Proposals*

This section has considered six competing competency standards, selected and organized to highlight their advantages and disadvantages. These categories are more useful than the schemata usually found in the commentary. For example, Roth, Meisel, and Lidz propose a classification that distinguishes among (a) the "evidencing a choice" view, (b) the "reasonable result" view, (c) the "understanding" view, and (d) the "rational reasons" view.[42] Simply distinguishing between understanding and reasoning views, without further subdividing these groups, however, has strange consequences. For example, the "understanding" theorists criticize the "reasoning" theorists for not recognizing that irrationality is pervasive.[43] But because "understanding" means "understanding and belief,"

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and Gutheil seem to suppose that identifying patients' true values is at least part of evaluating their competency. *See* Paulo, Bursztajn & Gutheil, *Christian Science and Competence to Make Treatment Choices: Clinical Challenges in Assessing Values*, 10 INT'L J.L. & PSYCHIATRY 395 (1987). Moreover, the case law explicitly adopts a "different person" rationale at times; for example, a testator's will may fail because it is not "her" will. Cases using this language generally are older. *See, e.g.*, Scott v. Scott, 212 Ill. 597, 599, 72 N.E. 708, 708 (1904); Orchardson v. Cofield, 171 Ill. 14, 31, 49 N.E. 197, 202 (1897); O'Dell v. Goff, 149 Mich. 152, 158, 112 N.W. 736, 738 (1907); Irwin v. Lattin, 29 S.D. 1, 12, 135 N.W. 759, 764 (1912).

42. *See* Roth, Meisel & Lidz, *supra* note 15.

43. *Id.* at 281.

the "understanding" theorists are forced to disable a person with a slightly distorted belief, while they protect a person with a patently distorted belief so long as he recites accurate medical information. Thus, a patient who believes that medication will have some side effect it does not have would be incompetent, while a patient who believes that the medication will ease his tension, but also that his resulting mental state will trigger international conflict, would be competent. Making finer distinctions among standards would avoid this anomalous result.

Similarly, the theory proposed by Appelbaum and Roth fails to make sufficiently fine distinctions.[44] This classification distinguishes among (a) the "evidencing a choice" view, (b) the "reasonable result" view, (c) the "factual information" view, (d) the "rational manipulation of reasons" view, and (e) the "appreciation" view.[45] Is the "factual information" view a "pure understanding" theory in this Article's terms, whereas the "appreciation" view is a naive "understanding and belief" theory? Or is the "factual information" view a naive "understanding and belief" theory, while the "appreciation" view requires understanding and belief together with a deep or mature appreciation of information? We can assess different competency standards adequately only if we understand them clearly. Appelbaum and Roth simply are not clear.

The classification proposed here has the virtue of settling a dispute between a different manner of the "reasoning" theorist and the "understanding" theorist with which the "reasoning" theorist contrasts himself. Both Moore and Fingarette, for example, claim that patent irrationality rather than the presence of ignorance of any kind is the key to incompetence.[46] These theorists are both right and wrong. They are right to the extent that mere ignorance—a mistaken or purely unconventional belief—is not enough for incompetence. Rather, the incompetent must have lost the ability to discern truth. But Moore and Fingarette are wrong to the extent that they claim irrationality is enough. Mere irrationality is insufficient as a standard. Rather, the irrationality must encompass the patient's misunderstanding of a material term, or else it is not adequately tied to the decision and the person is penalized by the finding of incompetency for his status as irrational. Once again, the sophisticated "understanding and belief" view combines the virtues of both emphases. Incompetence is seen as a breakdown of reason leading to a patent misunderstanding of material terms.

The classification of competency standards proposed here also has the advantage of permitting an easy assessment of each standard in light of the three criteria. This section has demonstrated that the "pure" and "modified understanding" views fail to require that the patient have sufficient ability to make decisions. On each of these views, a patient who refuses medication because she believes it will trigger a nuclear war is competent. The "full reasoning" view, by contrast, requires a facility in reasoning that few people, if any, achieve. A pa-

44. *See* Appelbaum & Roth, *supra* note 15.

45. *Id.*

46. *See, e.g.*, H. FINGARETTE, *supra* note 9, at 123-216; M. MOORE, *supra* note 9, at 217-49.

tient who declines medication because he overvalues his friend's bad experience is incompetent under this standard even if he understands and believes everything the doctor tells him. The "therapeutic alliance" view focuses on the wrong ability, the ability to enter a therapeutic relationship, and requires that people have treatment goals, even though an unconventional person may prefer other values to health. And the "different person" theory requires the patient's beliefs and desires to fit, not a conventional mold, but a mold of the patient that we fashion in the end according to *our* own lights, because we can never really know the patient's true nature. Among "understanding and belief" views, the naive version uncritically requires an acceptance of the doctor's beliefs even though doctors can be wrong. The sophisticated version, by contrast, is highly satisfactory, focusing on the requisite ability and at the same time giving appropriate rein to the irrational and unconscious, and permitting patients to pursue even unconventional wisdom.

III. The Concept of a Delusion as the Polestar of Incompetence

This Article's analysis has concluded that the sophisticated "understanding and belief" view provides the most satisfactory standard of competency. In contrast to a naive "understanding and belief" view, which requires that the patient both comprehend and *believe* the treatment information, the sophisticated "understanding and belief" view gives the patient scope to reach his own judgments about the truth of the information. But when, in pursuit of unconventionality, has he gone too far? Which false beliefs should the abilities criterion rule out? This section first argues that the law's concept of a delusion—a belief for which no evidence exists[47]—marks the place at which we should draw the line between acceptable and unacceptable beliefs. The Article then explores that concept in selected testamentary cases, first showing that testamentary capacity makes use of the concept of a delusion to arrive at a sophisticated understanding and belief view, and then showing why an exploration of the concept of a delusion is so essential to wills and treatment cases. Finally, it considers the application of that standard in testamentary cases, thus enabling the treatment competency section of this Article to consider classic reasons patients give for refusing medication in light of the law's concept of a delusion.

A. *Why Delusions?*

The law defines a delusion as a belief for which there is no evidence.[48] According to this definition, only extreme distortions, or patently false beliefs, count as delusions. Using a delusion standard to arrive at a sophisticated "understanding and belief" view of competency appears to be a promising way to meet the demands of the three criteria. If the standard reliably singles out patent falsehoods, it is not finding incompetency on the basis of unusual ways of looking at the world—or, worse yet, prescribing beliefs that misconstrue reality.

47. *See infra* notes 74-76 (citing cases).
48. *Id.*

Rather, it rules out beliefs that plainly fail to do what they purport to do, that is, portray the world accurately. These beliefs are the kind that pose a serious impediment to adequate decisionmaking. Further, a person who believes in a patent falsehood is clearly incapable of assessing evidence, at least on the subject of the falsehood. Because the misjudgment is so basic, it demonstrates that the person is incapacitated, and not simply in error.[49] While adherence to a merely possibly incorrect belief may suggest mere carelessness or eccentricity, belief in a gross falsehood demonstrates a plain incapacity to assess evidence, and hence an inability to reach competent decisions.

The law's concept of a delusion, however, is not entirely successful in distinguishing the incompetent from the mildly irrational and idiosyncratic. This lack of success is a result of the fact that the law's criteria for delusions fail to identify falsehoods with complete reliability, much less to single out falsehoods so patent that no capable person would believe them. Philosophers have long bemoaned our inability to prove the very existence of the physical world.[50] The existence of nonphysical entities and events—spirits and spiritual events that we either share culturally as religion or suffer silently as madness—is of course even harder to prove or to disprove.[51] The law's central criterion—that a belief supported by no evidence is false—is in fact inadequate to identify falsehoods. The evidence simply may be inaccessible. Alternatively, the evidence may be abundant but apparently irrelevant; what counts as evidence may be as controversial as what is true. Even if these problems are tractable, the "no evidence" criterion may involve us in an infinite regress, and thus be fundamentally inapplicable.

The delusion standard, in short, does not clearly label beliefs as patently false, so that the standard may at times simply identify very unconventional beliefs. Nevertheless, to the extent that society is generally right in certain beliefs (all doubts of the philosophers aside), the concept of a delusion identifies beliefs that are likely to be false, and people who are likely to be incompetent. As such, the concept provides a rational, though not a foolproof, basis for distinguishing the incompetent from among the many who are unconventional or mildly irrational.

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49. Consider a person who fails in an effort to raise his arm. Such a person is likely to be incapable of doing this very basic act, while a person who fails in an effort to do a complex movement simply may not have been trying hard enough.

50. *See, e.g.*, G. BERKELEY, A TREATISE CONCERNING THE PRINCIPLES OF HUMAN KNOWLEDGE (1710); G. BERKELEY, THREE DIALOGUES BETWEEN HYLAS AND PHILONOUS (1713); D. HUME, A TREATISE OF HUMAN NATURE (1739); D. HUME, AN ENQUIRY CONCERNING THE HUMAN UNDERSTANDING (1758).

51. Beliefs that are not supported or defeated by sensory evidence in a straightforward way are a real problem for the "no evidence" delusion standard. Religious beliefs—not only "alternative," but also ordinary religious beliefs—present precisely this problem. One case succinctly states the problem: "unless the fallacy [of a belief] is demonstrated, it cannot be said that no rational person would entertain the belief." Scott v. Scott, 212 Ill. 597, 603, 72 N.E. 708, 710 (1904) (belief in Swedenborg society). Thus most cases hold that religious beliefs are not delusions. *See, e.g.*, Owen v. Crumbaugh, 228 Ill. 380, 398-99, 81 N.E. 1044, 1050 (1907); *In re* Keeler's Will, 3 N.Y.S. 629, 631, 51 Hun. 636 (1889); Taylor v. Trich, 165 Pa. 586, 600, 30 A. 1053, 1056 (1895). Whether all religious beliefs, no matter how bizarre, should be considered nondelusional is unclear. If not, differentiating them from acceptable religious beliefs in terms of their evidentiary support would seem to be most problematic.

Yet, given the inherent weaknesses of the delusion standard, one may wonder if that standard strikes the best balance between the unconventionality and the abilities criteria. For the unconventionality criterion requires us to permit at least some false beliefs, while the abilities criterion requires us to balk at other, more extreme false beliefs. Thus, we face a line-drawing problem in deciding which false beliefs to treat as undermining competency. Does the delusion standard draw the line at the right place? Given its weaknesses, are any other candidates better suited to the task?

One might suggest an even more radical standard than the delusion standard—a standard that rules out even fewer beliefs. The law's distinction between beliefs lacking evidence[52] and beliefs impossible in the nature of things[53] suggests that a competency standard might rule out only beliefs that are impossible in the nature of things. The problem with this distinction is twofold. First, anything is possible. Just as with the delusion standard, people holding apparently impossible beliefs may just be very unconventional—and they may also be right. Second, beliefs that appear impossible given our ordinary assumptions about the world may even indicate more intact reasoning ability than "possible" beliefs that are flatly contradicted by the evidence. Compare, for instance, a belief that one has killed millions by one's thoughts, replacing them with automatons indistinguishable from humans, with a belief that one has shot millions while locked in a hospital: the first belief, while bizarre, at least does not contradict the senses in the straightforward way that the second does. Yet beliefs such as the second, for which there is no evidence, should disqualify a patient from competence even though they are not "impossible."

Another possibility is to draw the line at the other end of the spectrum. A pure mistake standard, for example, says that a person is incompetent if his beliefs are mistaken. While not so naive as a standard that makes a patient's doctor the authority on truth, this standard still violates the unconventionality criterion. Because we often cannot identify what is "mistaken," people should be free to pursue the truth as they see fit. Indeed, the law often holds that pure mistakes, as distinct from delusions, do not invalidate transactions.[54] Many wills cases, for example, justify this view on the grounds that too many wills

52. *See infra* notes 74-76 (citing cases identifying delusions as beliefs lacking evidence).

53. *See, e.g.*, Jackman v. North, 398 Ill. 90, 101, 75 N.E.2d 324, 330 (1947); Scott v. Scott, 212 Ill. 597, 603, 72 N.E. 708, 710 (1904); Lang v. Lang, 157 Iowa 300, 305, 135 N.W. 604, 606 (1912).

54. In the testamentary context, for example, mistakes generally do not invalidate wills. *See, e.g.*, Thompson v. Estate of Orr, 252 Ark. 377, 381-82, 479 S.W.2d 229, 231-32 (1972); Estate of Henrich, 389 N.W.2d 78, 83 (Iowa Ct. App. 1986); Kaufhold v. McIver, 682 S.W.2d 660, 667 (Tex. Ct. App. 1984). Courts are careful to distinguish mistakes from insane delusions. *See, e.g.*, Pennington v. Pennington, 1 Ark. App. 311, 314-15, 615 S.W.2d 391, 392-93 (1981) (testator's belief that son was stealing from him); Thornton v. Hulme, 218 Ga. 480, 485, 128 S.E.2d 744, 747 (1962) (belief that brother wanted to challenge property ownership); Bohler v. Hicks, 120 Ga. 800, 804-05, 48 S.E. 306, 309-10 (1904) (belief that wife hired hit man); Dixon v. Webster, 551 S.W.2d 888, 894 (Mo. Ct. App. 1977) (belief that friend stole); Navarro v. Rodriguez, 235 S.W.2d 665, 667-68 (Tex. 1950) (testator's belief that sister went home to feed the animals while testator needed care).

But note that some commentators' philosophical accounts of incompetency include ignorance as well as irrationality. *See, e.g.*, J.S. MILL, ON LIBERTY 117 (1859) (well-known broken bridge example); Murphy, *Paternalism*, *supra* note 9, at 167.

would be invalidated if mistakes vitiated competency[55]—a variant of the irrationality problem—and that people have the "undoubted right" to decide the truth of a matter for themselves[56]—a variant of the unconventionality problem.[57]

Other standards improve on the pure mistake standard, but still draw the line with insufficient regard for unconventionality. For instance, a standard according to which a patient cannot believe what ninety percent of doctors consider false is still too naive an "understanding and belief" view: while it does not require belief in what one's particular doctor says, it does require an adherence to the medical vision of the world in general. Not everyone subscribes to this vision, and not everyone should have to. We do not want to be forced to conclude that all Christian Scientists are incompetent.

Should we proscribe beliefs that no reasonable person would hold? Must people be reasonable? Or should we proscribe beliefs that no rational person would hold? At this point we are close to the law's standard for a delusion—a belief for which there is no evidence and which no rational person would believe. How to pick out precisely the patently false beliefs that we wish to proscribe is unclear, and different commentators use different language. For instance, some rule out beliefs that are not "inherently contestable";[58] others prohibit "irrational" beliefs;[59] still others require only "indisputable" beliefs.[60] The law's "no evidence" standard, however, is as good as any, inasmuch as it adequately balances the claims of the three criteria. Yet it also has the advantage of a long history of careful application.

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55. *See, e.g., Estate of Orr*, 252 Ark. at 357, 479 S.W. 2d at 232; Anderson v. Anderson, 220 Tenn. 496, 499-500, 419 S.W.2d 166, 168 (1967).

56. In one case, for instance, testator's attention was directly called to the question of whether a girl was his niece, and the court held "he had the undoubted right to decide it for himself. That he did not avail himself of all the light at his command, and as a consequence fell into error as to the real truth of the matter, cannot be a ground of judicial interference with his will." Young v. Mallory, 110 Ga. 10, 12-13, 35 S.E. 278, 279 (1900); *see also* Thornton v. Hulme, 218 Ga. 480, 485, 128 S.E.2d 744, 747-48 (1962) (error of judgment resulting from failure to investigate a matter does not vitiate will); Bohler v. Hicks, 120 Ga. 800, 804-05, 48 S.E. 306, 309-10 (1904) (same).

57. The cases also frequently note the problem of disgruntled parties who manufacture mistakes. *See, e.g.*, Sadler v. Sadler, 184 Neb. 318, 322, 167 N.W.2d 187, 189 (1969) (The court stated:

> It is more important that the probate of the wills of dead people be effectively shielded from the attacks of a multitude of fictitious mistakes than that it be purged of wills containing a few real ones. The Testator can avoid the latter by due care in his lifetime, while against the former he would be helpless.).

Here is evidence that courts are keenly sensitive to the problem of truth which animates the law of competency to some degree. Indeed, the doctrine of mistake as to legal effect might hinge especially on the difficulty of knowing legal truths. For the doctrine of mistake as to legal effect, see, *e.g., In re* Burt's Estate, 122 Vt. 260, 169 A.2d 32 (1961).

58. *See, e.g.*, R. FADEN & T. BEAUCHAMP, *supra* note 20, at 254, 310-11 (cannot believe beliefs that are not "inherently contestable" or "unjustified" beliefs).

59. *See, e.g.*, M. MOORE, *supra* note 9, at 101-106 (requires "rational" beliefs); Murphy, *supra* note 9, at 101-04 (prohibits "irrational" beliefs, that is, beliefs that no rational person could believe, beliefs resulting from systematic distortions of the weight of evidence, and beliefs for which relevant evidence is not even considered).

60. *See, e.g.*, S. SMITH & R. MEYER, *supra* note 31, at 662 (must believe propositions that are "indisputable and established beyond all question" and that "generally accepted" beliefs are indeed generally accepted; need not believe "matters about which reasonable people may disagree").

B. The Concept of a Delusion Applied—Wills Cases

Because cases on treatment competency are few and tend to be inconsistent with one another, exploration of an area of competency law with a longer history will be helpful. The area with the most clearly articulated concept of beliefs that vitiate competency is the area of testamentary capacity. This is not to say that criminal and contractual capacity cases do not use the same concept in the same way. They do—only less often.[61]

61. Cases addressing criminal and contractual capacity present fewer occasions for the use of the concept of a delusion than do testamentary capacity cases. Yet when the need arises, courts use standards very similar to those used in wills cases in assessing criminal and contractual capacity. For instance, one criminal case defined a delusion as "an unreasoning and incorrigible belief in the existence of facts which are either impossible absolutely, or, at least, impossible under the circumstances of the individual." Guiteau's Case, 10 F. 161, 170 (C.C.D. D.C. 1882); *see also infra* note 76 (citing criminal cases defining delusion standard). Contractual capacity cases apply the same definitions. *See id.* (citing contractual capacity cases defining delusion standard).

Yet the fact that criminal and contractual capacity cases use the concept of a delusion so infrequently makes discerning doctrine difficult and raises the suspicion that the concept of delusions elaborated here is appropriate only for the testamentary context, while a more liberal concept of a delusion is or should be employed in other areas. This Article suggests reasons for the relative absence of the concept of a delusion in other areas that will allay such concerns.

A reason for the prominence of alleged delusions in wills cases that would generate problems for the theory suggested here is that wills cases can arise only after the testator's death. According to this notion, the "no evidence" criterion is necessary in wills cases to ensure that the testator's belief was false, whereas it may well be unnecessary if the decisionmaker is alive and subject to medical examination. The absence of an opportunity for a medical examination generates the stringent requirement for the falsity of beliefs that the courts impose in wills cases. This line of argument is unpersuasive, however, because, like wills, contracts are often challenged after the contract-maker is dead, and insanity is always assessed after the fact. Thus the evidence for any beliefs the defendant may have had, as well as any mental illness he may have suffered, must be reconstructed in contract and criminal cases as well. It therefore should come as no surprise that the cases themselves do not justify the "no evidence" rule on the ground that the rule identifies mental illness in those who cannot be examined.

In the case of criminal competency, courts seldom give attention to the criteria for delusions, as opposed to false or unconventional beliefs, for a number of clear reasons. First, insanity doctrine holds that a delusional belief excuses a crime only if the belief would have the same effect if it were true. *See, e.g.*, Brown v. State, 228 Ga. 215, 217-18, 184 S.E.2d 655, 657 (1971); Merritt v. State, 39 Tex. Crim. 70, 78, 45 S.W. 21, 22 (1898); M'Naghten's Case, 8 Eng. Rep. 718 (1843). *But cf.* Parsons v. State, 81 Ala. 577, 2 So. 854 (1887) (rejecting "if true" doctrine). Many suspect beliefs are simply irrelevant to the issue of excuse, and the question whether they are delusional never arises. Indeed, even when the question arises, the answer often will be clear. As a consequence of the "if true" doctrine, beliefs excusing a crime will tend to refer to grossly demonstrable events, such as an alleged physical attack or the necessity of protecting others, and not to more ethereal, doubtful matters such as the victim's malice; thus, these beliefs tend to pass the strict delusion test without difficulty.

For a different reason, cases addressing competency to stand trial tend not to scrutinize the criteria for delusions. This competency requires an ongoing ability to understand many matters, as well as to assist one's lawyer. Hence, the adequacy of one's ability to assess a small piece of the evidence often is not critical. A competent defendant may hold some patently false beliefs. *See, e.g.*, Heald v. State, 492 N.E.2d 671, 681 (Ind. 1986) (belief that jurors were four-footed animals and the judge a meddler); Commonwealth v. Banks, 513 Pa. 318, 336-37, 521 A.2d 1, 10 (1987) (trial seen as sensation to "unmask devil," *i.e.*, reveal conspiracy, and start race wars). An incompetent defendant may hold no such false beliefs. For instance, defendants without patent delusions who do have pervasive suspicions, or pervasive misperceptions regarding the court officers' motives or integrity, may be incompetent because their beliefs effectively prevent them from assisting their lawyers. In any case, because the presence or absence of delusions in these cases is often not critical, courts often recite evidence of false beliefs when deciding on a defendant's competence to stand trial, but do not attempt to decide whether the suspect beliefs are in fact delusions.

Courts in criminal competency cases typically fail to distinguish delusional from merely mistaken or unconventional beliefs because these courts are far more concerned with identifying simula-

The basic standard[62] in testamentary capacity cases is clear. The testator must be able to understand information central to the will—the nature and extent of his property, the natural objects of his bounty, and the effect his disposition will have[63]—and must not be laboring under a delusion that affects the terms of his will.[64] This test is susceptible of at least two possible interpretations.

Both interpretations require that the testator be able to understand in the sense of comprehending the information central to the will. The first interpretation requires, in addition, that the testator remain free of false beliefs (including delusional beliefs) about the information central to the will, as well as of any other delusions that affect the bequest. The second interpretation, by contrast, requires only that the testator remain free of delusional beliefs about the information central to the will, as well as of any other delusions that affect the bequest. The first interpretation supplements a naive "understanding and belief" view with a delusion test, while the second uses the delusion test to arrive at a sophisticated "understanding and belief" view.

The second interpretation is preferable to the first. According to the first,

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tion than eccentricity. The law always prefers to find a person capable or sane rather than the reverse. On the presumption of sanity, see, *e.g.*, Lotman v. Security Mutual Life Ins. Co., 478 F.2d 868 (3d Cir. 1973). The law can most easily protect this preference for competency or sanity in civil cases by finding a suspect belief mistaken or eccentric—after all, the decisionmaker had no reason to pretend to believe as he is said to. By contrast, the law most easily protects its preference in criminal cases by finding a suspect belief to be feigned—after all, the decisionmaker claims he is or was crazy, not just eccentric or mistaken. *See, e.g.*, People v. Carl, 58 A.D.2d 948, 397 N.Y.S.2d 193 (1977), *rev'd on other grounds*, 46 N.Y.2d 806, 386 N.E.2d 828, 413 N.Y.S.2d 916 (1978); State v. Nix, 327 So.2d 301 (La. 1975). A belief that a criminal defendant claims to hold may, of course, be genuine, yet not represent a sufficient breakdown of reason that we want to exonerate the defendant. Thus we want to protect his unconventionality in the sense of treating him as responsible. Yet criminals are more likely to present as malingerers than as unconventional or mistaken evidence-assessors, so that in the criminal context an inquiry into a defendant's genuineness makes more sense than does an inquiry into the evidentiary support for the defendant's beliefs.

The concept of civil competency to contract seems more analogous to treatment capacity than the concept of criminal capacity, and hence is likely to be more helpful. For instance, the contractual capacity cases do not share the features of the criminal capacity cases that often make delusions irrelevant. Moreover, they are more concerned than the criminal cases with protecting "mere eccentricity or abnormality." *See, e.g.*, Golleher v. Horton, 148 Ariz. 537, 541, 715 P.2d 1225, 1229 (1985); Simmons First Nat'l Bank v. Luzader, 246 Ark. 302, 309-10, 438 S.W.2d 25, 30 (1969); Frieders v. Dayton, 61 Ill. App. 3d 873, 879-80, 378 N.E.2d 1191, 1196 (1978); Laymon v. Bennett, 75 Ohio App. 233, 238, 61 N.E.2d 624, 628 (1944) (citing 28 AM. JUR. 703 ("[m]ere eccentricity or abnormality in personality or conduct . . . does not affect the validity of a contract")). Nevertheless, the number of contractual capacity cases employing the concept of a delusion is small. *See, e.g.*, Curry v. Curry, 31 Ill. App. 3d 972, 976, 334 N.E.2d 742, 745 (1975); Moritz v. Moritz, 153 A.D. 147, 152, 138 N.Y.S. 124, 127 (1912). The number actually defining the concept, or applying a definition, is infinitesimal. *See infra* note 76 (citing cases). Why these cases so rarely involve delusions is unclear, but one commentator's suggestion that business is generally not so fraught with emotion as to implicate a need or desire to escape reality seems convincing. *See* Weihofen, *Mental Incapacity to Contract or Convey*, 39 S. CAL. L. REV. 211, 218 (1966).

62. But at least one state has questioned the delusion doctrine. *See* Havird v. Schissell, 252 S.C. 404, 416-17, 166 S.E.2d 801, 807 (1969).

63. *See, e.g.*, *In re* Langmeier, 466 A.2d 386, 402 (Del. 1983); *In re* Estate of Edwards, 433 So. 2d 1349, 1350 (Fla. Dist. Ct. App. 1983); Quellmalz v. First Nat'l Bank of Belleville, 16 Ill. 2d 546, 554, 158 N.E.2d 591, 595 (1959).

64. *See, e.g.*, Estate of Nigro, 243 Cal. App. 2d 152, 160, 52 Cal. Rptr. 128, 133-34 (1966); *In re* Haywood's Estate, 109 Cal. App. 2d 388, 395, 240 P.2d 1028, 1032 (1952); *In re* Selb's Estate, 84 Cal. App. 2d 46, 54, 190 P.2d 277, 281 (1948).

the concept of a delusion is superfluous to the concept of false beliefs as to central terms confronting the decisionmaker. Many false beliefs that are not delusional will produce incapacity. As to noncentral terms that affect the bequest, by contrast, the concept of a delusion will indicate the appropriate incapacity. But requiring different levels of ability to assess central and noncentral evidence—a high level of ability to discern central falsehoods, a low level of ability to discern noncentral, patent falsehoods—is anomalous. To the extent that evidence is relevant—and evidence objectively peripheral may be central to some, even decisive—either one must be good at assessing the evidence or not.

Testamentary capacity decisions demonstrate that the courts adopt the second interpretation. They do require accurate beliefs about matters that are indisputable—for instance, that one is engaged in making a will, or that one gave birth to three children.[65] But with respect to information that is neither clearly true nor clearly false, whether central or not, the law does not seem to require accuracy. For example, if a testator's child could be dead, he may believe him to be dead even though most others believe him to be alive. If, however, the child appears and visits the testator, he must surrender his belief that he is dead.[66] In other words, the concept of a delusion furnishes the standard for all beliefs relevant to a decision, whether noncentral or central. Indeed, courts frequently attempt to establish that a central belief was delusional[67]—a showing that would go well beyond the requirements of the naive view.

Finally, the naive "understanding and belief" view threatens to collapse the law's distinction between ignorance and incompetence. If at the time of evaluation "truth"[68] is certain, requiring the decisionmaker to hold "true" beliefs as to the central information would equal requiring a pure ignorance theory of incompetency. The evidence available to the decisionmaker at the time he made his decision might have made his beliefs eminently sensible, and hence in no way indicative of incapacity. Indeed, even if the evidence available at the time he made his decision should have led the decisionmaker to believe otherwise, his false belief might just have been a mistake, and not indicative of any disability. In short, the naive "understanding and belief" view, in order to be true to the law's distinction between ignorance and incompetence, cannot simply proscribe false beliefs, but must offer criteria for when false beliefs are indicative of incapacity. Yet no doctrine in the law undertakes to do this other than the doctrine of delusions.

65. Indeed, most of the information the decisionmaker must understand in the standard competency tests relates to other such indisputable matters, for example, the nature of one's act, whether it is a crime, the purpose of criminal proceedings, and the role of the actors in a trial. It is because most of the information is of this kind that some courts and commentators may be tempted to take a naive view of the competency test as to central terms.

66. This example of a delusion is found in *In re* Estate of Protyniak, 427 Pa. 524, 530, 235 A.2d 372, 376 (1976).

67. *See infra* text accompanying notes 77-88.

68. It seems implausible to suppose that the law would be sanguine about our ability to discern truth in the area of competency, when whole bodies of law in other areas lay down rules to assist factfinders in reaching the truth. Consider, for instance, our elaborate rules on character evidence and hearsay. *See* FED. R. EVID. 404, 405, 608, 801-806 (1984).

The courts often evince an acute awareness that very strict criteria for delusions are needed precisely in order to distinguish merely mistaken from incompetent beliefs. Only when a belief dramatically departs from the evidence can we confidently rule out a mistake.[69] Courts are also keenly aware that inaccurate beliefs often reflect a perverse or eccentric point of view rather than incapacity. Once again, they invoke the doctrine of delusions to protect the expression of mere eccentricity.[70] In short, the law appears skeptical that a less demanding criterion for central beliefs could adequately distinguish those who are merely mistaken or eccentric from those who are impaired.

The standard for testamentary capacity, then, requires the testator to comprehend the terms central to the will, and to have no relevant delusions. The function of the concept of delusions is to expose those who are unable to assess evidence sufficiently to make a decision in their own best interests.[71] One may make an analogy to fraud and draw a contrast with mistake: beliefs that are the product of fraud, like delusional beliefs, are especially difficult to get right. In the case of delusions, internal conditions compromise one's ability to come to accurate beliefs, while in the case of fraud, external conditions do so. Consider fraud's "reasonable reliance" criterion[72] as excluding those cases where there are no unreasonable impediments to acquiring the truth—where external conditions do *not* in fact compromise one's ability to come to accurate beliefs.

The legal concept of a delusion is important to an understanding of competency, because it gives content to the understanding test insofar as that test implicates beliefs. It thus provides the law's answer to the philosophical problems posed by the unconventionality and irrationality criteria. Moreover, as a practical matter, information relating to wills—like treatment information—is often so easy to understand that many patients will pass the "comprehension" prong of the competency test, but nevertheless will fail the delusion prong. It follows that many who *cannot* comprehend other difficult matters will be competent to make treatment decisions so long as they lack relevant delusions.[73]

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69. *See infra* text accompanying note 102.

70. *See infra* text accompanying notes 103-10.

71. While one may hold that delusions are beliefs that one is compelled to hold (or are in any case only relevant to insanity when they do), the view that they indicate a simple inability to assess evidence is far more plausible and prevalent. Indeed, the idea that delusions indicate a compulsion to believe is untenable. Delusions may indicate that it is *hard* for the person to come to the truth, but this is not equivalent to saying that he is compelled to believe falsehoods: I may find it hard to ride a bike, for instance, and may often fall off, but I am not compelled to fall off—I just do. It is nevertheless true that many laboring under delusions do seem to feel compelled to believe as they do, and this may in fact be true of delusions, not as a matter of logic, but of experience, but this is not always the case: many delusions are felt as temptations to believe, not irresistible conclusions. *See, e.g.*, A. NICHOLI, THE NEW HARVARD GUIDE TO PSYCHIATRY 268 (1988).

72. *See, e.g.*, Cohen v. Wedbush, Noble, Cooke, Inc., 841 F.2d 282, 287 (9th Cir. 1988); St. Joseph's Hosp. & Medical Center v. Reserve Life Ins. Co., 154 Ariz. 307, 316, 742 P.2d 808, 817 (1987); Illinois Cent. Gulf R. R. Co. v. Department of Local Gov't Affairs, 169 Ill. App. 3d 683, 690, 523 N.E.2d 1048, 1052-53 (1988).

73. Historically, the doctrine of delusions probably was used to increase the number of people found incompetent, insofar as one could be "partially insane" regarding key information, while apparently sane on all other matters. As the text suggests, however, today the doctrine may be used to decrease the number of individuals deemed incompetent, for one can also be "generally insane" regarding many matters, while comprehending the key information on a matter that is easy to under-

Wills and treatment cases share another characteristic that makes the concept of a delusion central to competency doctrine. Both areas involve matters that are often subject to delusional elaboration: close relationships with family members and doctors that implicate dependency feelings, as well as the prospect of suffering and death. People are simply more likely to form delusions around issues that are psychologically fundamental.

Finally, an analysis of competency as involving comprehension and the absence of delusions does well to focus on the notion of delusions because little can be said about bare comprehension, except that memory and attention deficits are the most likely to interfere with comprehension if adequate intelligence exists. We must await the work of psychologists for a deeper understanding of comprehension. By contrast, the concept of delusions has a legal meaning with a long history.

As an examination of testamentary cases will show, the concept of a delusion is ideally suited to identify those who lack the ability to assess evidence, for delusions are defined as beliefs that lack support in the evidence. Most cases propose a strict criterion for delusions, excluding beliefs that have any evidentiary support. As one court said, "[A] belief grounded on evidence, however slight, . . . is not an 'insane delusion.'"[74] If there is "*any* basis in fact" for a

stand and lacking relevant delusions. Because of this, using a threshold of "general competency" to determine which patients must even be informed of treatment information is unsound, as is a competency standard that requires general competency. For commentators suggesting use of "general competency" as a threshold, see P. APPELBAUM, C. LIDZ & A. MEISEL, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 89 (1987). For a commentator suggesting a "general competency" standard for treatment competency, see Abernethy, *supra* note 1, at 57.

74. *In re* Selb's Estate, 84 Cal. App. 2d 46, 59-60, 190 P.2d 277, 285 (1948) (citing Taylor v. McClintock, 87 Ark. 243, 280, 112 S.W. 405, 414 (1908) and *In re* Estate of Scott, 128 Cal. 57, 62, 60 P. 527, 529 (1900)); *see also In re* Estate of Nigro, 243 Cal. App. 2d 152, 160, 52 Cal. Rptr. 128, 133 (1966) (delusions as beliefs lacking evidence); Ahmann v. Elmore, 211 S.W.2d 480, 486 (Mo. 1948) (same); *In re* Estate of Hodtum, 267 So. 2d 686, 688 (Fla. Dist. Ct. App. 1972) (same).

The "some evidence" rule also has a role as a standard of review in administrative appeals. For the "some/any evidence" formulation, see, *e.g.*, Ritter Transp., Inc. v. ICC, 684 F.2d 86 (D.C. Cir. 1982) (order vacated that carrier can expand products carried); *In re* Desautels Real Estate Inc., 142 Vt. 326, 457 A.2d 1361 (1983) (suspension of license upheld). An even lower standard of "any conceivable basis" is used to review regulations. *See, e.g.*, Borden, Inc. v. Commissioner of Pub. Health, 388 Mass. 707, 448 N.E.2d 367 (1983).

A number of policy reasons are given to justify this low standard of review. For example, courts often cite deference to the legislative branch to justify the standard. *See, e.g.*, American Family Life Assurance Co. v. Commissioner of Ins., 388 Mass. 468, 480, 446 N.E.2d 1061, 1068 (1983) ("deference is necessary to ensure that the courts do not interfere with the separation of powers between the Legislature and the judiciary by substituting their judgment for that of the agency charged with the administration of the legislative mandate"); *Borden*, 388 Mass. at 723, 448 N.E.2d at 379. Similarly, courts also cite the superior competence of the agency to decide to justify the narrow standard of review. *See, e.g.*, Berry v. CIBA-GEIGY Corp., 761 F.2d 1003, 1006 (4th Cir. 1985) ("[R]esponsibility rests with those whose experience is daily and continual, not with judges whose exposure is episodic and occasional."); WWHT v. FCC, 656 F.2d 807, 819 (D.C. Cir. 1981).

Similar concerns also arise in the competency context: deferring to the individual decisionmaker shows him the respect he deserves. Moreover, as the person actually on the scene, the decisionmaker is in a better position to assess the evidence for his beliefs than an evaluator, who often must reconstruct events by relying on others' memories. In any event, use of a very low standard of review in the judicial context, when very serious consequences result from the review, shows that its use in the competency context is not unprecedented.

belief, the belief "will not warrant setting aside [the will]."[75] Indeed, the "no evidence" standard is said to allow even "irrational or unfounded" beliefs or inferences, so long as they are " 'drawn from facts which are shown to exist.' "[76]

In order to understand better the delusion standard, consider what might be called the "family affection" cases. Courts usually find that testators' general charges of family mistreatment are supported by some evidence, even when the evidence is weak.[77] They also usually find that testators' resentment of their

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75. *See* Huffman v. Dawkins, 273 Ark. 520, 622 S.W.2d 159 (1981) (emphasis in original); *see also* Dumas v. Dumas, 261 Ark. 178, 547 S.W.2d 417 (1977) (insane delusion as belief with no basis in fact).

76. *In re* Estate of Nigro, 243 Cal. App. 2d 152, 160, 52 Cal. Rptr. 128, 133 (1966) (quoting *In re* Estate of Scott, 128 Cal. 57, 62, 60 P. 527, 529 (1900)).

Note also that there are several variations on the "no evidence" definition of a delusion. For example, some courts say that delusions are beliefs that no rational or sane person would hold. *See, e.g.*, Graham v. Darnell, 538 S.W.2d 690, 694 (Tex. Ct. App. 1976); *In re* Estate of Price, 401 S.W.2d 98, 102 (Tex. Ct. App. 1966). Other courts say that delusions persist in the face of all argument to the contrary. *See, e.g.*, Huffman v. Dawkins, 273 Ark. 520, 525, 622 S.W.2d 159, 161 (1981); Kirkpatrick v. Union Bank of Benton, 269 Ark. 970, 975, 601 S.W.2d 607, 609 (1980). Finally, still other courts say that delusions originate spontaneously in the imagination and are not products of reason. *See, e.g.*, Sanders v. United States Nat'l Bank, 71 Or. App. 674, 682, 694 P.2d 548, 553 (1985); Potter v. Jones, 20 Or. 239, 249, 25 P. 769, 772 (1891).

As noted above, the "no evidence" standard also appears in criminal and contractual capacity cases, although less frequently than in wills cases. *See, e.g.*, McKinnon v. State, 51 Ga. App. 549, 555, 181 S.E. 91, 95 (1935) (belief that man instrumental in bringing about discharge not a delusion, because, though "no doubt incorrect, . . . there were facts to sustain it"); Petroleum Casualty Co. v. Kincaid, 132 Tex. 325, 93 S.W.2d 499 (1936) (cites to a civil definition of delusions; although a civil case, it grew out of a murder).

More modern cases exist to the same effect. *See, e.g.*, People v. Lechner, 35 Ill. App. 3d 1033, 342 N.E.2d 820 (1976) (defendant's belief that his wife was having an affair with her boss supported by some evidence; concurrence suggests using testamentary definition of delusion in criminal cases); Farmer v. New Jersey, 42 N.J. 579, 582, 202 A.2d 173, 175 (1964) (court refused to try defendant's insanity itself in special proceeding, but leaves question for jury, because whether defendant's belief was a delusion would "depend[] upon the premise that the conspiracy he feared was unfounded in fact, whereas a jury might conclude there was good reason for his belief"); Clark v. State, 718 P.2d 375 (Okla. Crim. App. 1986) (defendant's belief that group of mothers trying to destroy her son not based on evidence); State v. Lafferty, 749 P.2d 1239 (Utah 1988) (psychiatric assumption that defendant's "Messianic grandiosity" involved religious beliefs that did "not accord with reality [was] an unsupportable premise"); State v. Crenshaw, 98 Wash. 2d 789, 801, 659 P.2d 488, 495 (1983) (defendant's belief that his wife was unfaithful not an insane delusion; court approved of psychiatrist's observation that having even "ill based" suspicions does not make one "crazy").

Some cases state a more liberal definition of a delusion. *See, e.g.*, United States v. Sullivan, 544 F.2d 1052, 1055 n.1 (9th Cir. 1976) (delusion a "misperception engendered by mental disease or defect"). Nevertheless, the author's preliminary research shows this case in a small minority and she has found no case actually finding a minor distortion to be a delusion. That no criminal or civil doctrine actually says that the concept of a delusion in criminal cases is more liberal than, or in any way different from, the concept in civil cases reinforces this conclusion.

Contractual capacity cases also use the "no evidence" standard. *See, e.g.*, Swart v. Johnson, 48 Cal. App. 2d 829, 120 P.2d 699 (1942); Eubanks v. Eubanks, 360 Ill. 101, 195 N.E. 521 (1935); Davidson v. Piper, 221 Iowa 171, 265 N.W. 107 (1936). The author has discovered three modern cases applying the concept of a delusion. *See* Velez v. Metropolitan Life Ins. Co., 723 F.2d 7, 10 (10th Cir. 1983) (man's belief that his wife had permanently left him was not a delusion because "sufficiently coincident with fact": his wife was away, and there was "little of the marriage remaining" in any case); Estate of ACN, 133 Misc. 2d 1043, 509 N.Y.S.2d 966 (1986) (belief that uni-trusts were good for charities and that holders would receive immediate payment of eight times their value by the government held to be delusional); Faber v. Sweet Style Mfg. Corp., 40 Misc. 2d 212, 242 N.Y.S.2d 763 (1963) ("grandiose plans" to build apartments did not amount to delusions). We may quarrel with the particular application in some of these cases, but the basic concept of a delusion seems the same in wills and contract cases.

77. *See, e.g.*, *In re* Selb's Estate, 84 Cal. App. 2d 46, 190 P.2d 277 (1978) (there was some

relatives has some basis, even when the relatives were trying to act in the testators' best interests.[78] Of course, in a real sense, testators are the final authorities on what treatment is ill-treatment to them. Yet the courts also generally uphold, on a similar basis, even the apparently more factual belief that one's relatives do not love one: family love is "to a great extent purely a matter of personal opinion," so that a belief regarding it "cannot ordinarily be considered a delusion."[79] Indeed, one court went even further, holding that family love is a feeling that simply "cannot exist independently of a positive belief in its existence."[80]

Cases in which the testator levels particular charges of wrongdoing against a relative illustrate a more straightforward application of the "no evidence" standard. In one case, for example, the court held that the testator's belief that her stepdaughter had stolen from her had some basis, because the testator's possessions had disappeared after the stepdaughter had locked up the testator's house when she was hospitalized.[81] In another case, the court ruled that evidence that the testator and her husband often fought provided support for her belief that he was stealing from her: he may have intentionally mislaid or stolen her possessions to annoy her.[82] In still another case, the court held that the testator's belief that her nephew was stealing from her was supported by her

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evidence for the charge that relation had mistreated testator and hounded her for money; finding of insane delusion reversed); *In re* Estate of Agostini, 311 Pa. Super. 233, 457 A.2d 861 (1983) (testator charged that her daughter had not cared for her properly in illness, although evidence suggested that she had, but there was also evidence that testator and her daughter had disputed; finding of no insane delusion affirmed); Rich v. Rich, 615 S.W.2d 795 (Tex. Ct. App. 1981) (testator charged that son was ungrateful, and had treated testator badly; finding of insane delusion reversed).

78. *See, e.g.*, English v. Shivers, 219 Ga. 515, 133 S.E.2d 867 (1963) (resentment because children did not give mother their share of father's estate; court struck allegation of insane delusion); *In re* Estate of Bonjean, 90 Ill. App. 3d 582, 413 N.E.2d 205 (1980) (resentment because of effort to commit; finding of insane delusion reversed and remanded). A somewhat more doubtful case found that a testator's rage at her children for marrying amounted to monomania. *See* Anderson v. Jarriel, 244 Ga. 495, 162 S.E.2d 322 (1968). Being displeased by acts that normally cause pleasure would seem to be simply idiosyncratic, but not crazy. In a similarly doubtful case, a New Jersey court found resentment against men enough to overturn testator's bequest to the National Women's Party. *See In re* Strittmater's Estate, 140 N.J. Eq. 94, 53 A.2d 205 (1974) (petitioner suffered a "morbid aversion to men," and "feminism to a neurotic extreme;" her beliefs about men were "delusions").

79. *In re* Estate of Sarras, 148 Mich. App. 171, 181, 384 N.W.2d 119, 123 (1986) (family felt no affection—for example, failed to invite testator to gatherings; finding of insane delusion reversed).

80. Bauer v. Estate of Bauer, 687 S.W.2d 410, 413 (Tex. Ct. App. 1985); *see also In re* Millar's Estate, 167 Kan. 455, 207 P.2d 483 (1949) (testator believed that daughters "turned against him," although there was some evidence in that daughters had sided with mother in divorce; finding of no insane delusion upheld); Sanders v. United States Nat'l Bank of Oregon, 71 Or. App. 674, 694 P.2d 548 (1985) (testator's belief that son and daughter "hated his guts" was an overstatement, although there was some evidence for the belief in that his daughter only signed letters "love" after he asked her to, and he had fought with his son; finding of no insane delusion upheld). *But see* Davis v. Aultman, 199 Ga. 129, 33 S.E.2d 317 (1945) (testator not only believed his child hated him, but also that his child had threatened to kill him and wanted him dead; allegations of insane delusion allowed to stand); Graham v. Darnell, 538 S.W.2d 690 (Tex. Ct. App. 1976) (after his son died, all of his other children became "TP [testator's name] haters;" court found that one son always ready to establish a relationship with him, that there was medical evidence testator was paranoid, and that case could have gone either way, but affirmed finding of delusion).

81. *In re* Estate of Supplee, 247 So. 2d 488, 490-91 (Fla. 1971) (belief in stealing had some basis; finding of competency affirmed).

82. *In re* Wicker's Will, 15 Wis. 2d 86, 92-93, 112 N.W.2d 137, 141 (1961) (belief in stealing had some basis; finding of no insane delusion affirmed).

testimony that she saw him moving boxes from her house into his car, even though the boxes actually contained gifts to him.[83] In all of these cases, the testators may have drawn quite paranoid inferences from the evidence, but they nevertheless were not delusional.[84]

The "no evidence" standard is also at work in judicial assessments of other beliefs that typically ground acts of disinheritance—for instance, beliefs in the paternity or nonpaternity of a child,[85] in spousal infidelity,[86] and in acts of harm against[87] or attempts to institutionalize[88] the testator. Instead of attempting to

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83. *In re* Bickner's Estate, 259 Wis. 425, 49 N.W.2d 404 (1951) (belief in stealing had some basis; finding of insane delusion reversed).

84. Some cases find an insane delusion where the alleged incompetent believes that thefts have occurred but there is no evidence of stealing—or the evidence is simply overwhelmed by evidence to the contrary. *See, e.g.*, Doyle v. Rody, 180 Md. 471, 479, 25 A.2d 457, 461 (1942) (belief that niece trying to rob, with court finding only kindness by her; finding of insane delusion affirmed); *In re* Estate of Kesler, 702 P.2d 86, 92-93 (Utah 1985) (testator believed that all her sons were stealing from her, and brought court actions against each, which failed after the sons raised a great deal of evidence that they were not stealing; finding of insane delusion affirmed); *In re* Elbert's Will, 244 Wis. 175, 11 N.W.2d 626 (1943) (testator believed her children were stealing everything from trivial items to securities, although court did not discuss evidence; finding of insane delusion affirmed).

85. Sometimes the evidence plainly counters a belief. For example, one testator steadfastly asserted for fifty years that a girl adopted by his sister was in fact his daughter (by a nonexistent wife), although the testator was only fourteen when the adopted girl was born, had lived in a different town, and had had no opportunity to associate with her mother. *See In re* Estate of Rask, 214 N.W.2d 525, 530-31 (N.D. 1974) (finding of insane delusion affirmed). At other times the evidence plainly supports a belief, as where the belief appears in fact to be true—the mother having confirmed that the testator was the father—or at least quite likely to be true—the mother having spoken of extramarital relations. For the former type of case, see, *e.g.*, Eddleman v. Estate of Farmer, 294 Ark. 8, 10-11, 740 S.W.2d 141, 142-43 (1987) (mother of child confirmed child was testator's; finding of no insane delusion affirmed); for the latter, see *In re* Estate of Coffin, 103 N.J. Super. 1, 4, 246 A.2d 489, 490 (1968) (testator believed child not his and wife admitted extramarital relations; finding of insane delusion reversed). In the middle are cases in which the evidence is equivocal, but because some evidence for the belief exists—for example, the child probably was born too soon and the mother never brought a paternity action—it is not a delusion. *See* Ahmann v Elmore, 211 S.W.2d 480, 486-87 (Mo. 1948) (finding of no insane delusion affirmed).

86. For cases involving beliefs in spousal infidelity, see, *e.g.*, Benjamin v. Woodring, 268 Md. 593, 603-04, 303 A.2d 779, 785-86 (1973) (court should have considered accusations of infidelity found in letter as possible insane delusions; directed verdict reversed); *In re* McDowell's Will, 140 A. 281 (N.J. Prerog. Ct.) (existence of extraneous facts that may have induced the belief not excluded; finding of no insane delusion affirmed), *aff'd*, 103 N.J. Eq. 346, 145 A. 325 (1928); *In re* Joslin's Estate, 4 Wis. 2d 29, 34-35, 89 N.W.2d 822, 824-25 (1958) (wife believed 80-year-old husband unfaithful, nailed windows shut to keep out partners; finding of testamentary capacity reversed because "other reason" affecting bequest was product of this delusion); *see also* Huffman v. Dawkins, 273 Ark. 520, 526, 622 S.W.2d 159, 162 (1981) (testator believed he had a significant love relationship with woman who claimed to be a friend whom he occasionally saw socially; finding of no insane delusion affirmed).

87. *See, e.g.*, *Huffman*, 273 Ark. at 520, 622 S.W.2d at 162 (court affirmed finding of no insane delusion in face of testimony by testator's wife that she had not attempted to kill him); *In re* Will of Maynard, 64 N.C. App. 211, 232-33, 307 S.E.2d 416, 430-31 (1983) (contestant failed to offer evidence that he had not threatened to harm his mother; no insane delusion); *see also In re* Estate of Edwards, 433 So. 2d 1349, 1352 (Fla. Dist. Ct. App. 1983) (mistrust of family and other people did not equal insane delusion; suspicions of patrons shoplifting reasonable; finding of no insane delusion affirmed); *In re* Estate of Yett, 44 Or. App. 709, 714, 606 P.2d 1174, 1176-77 (1980) (strained relations gave "foundation in reality, however slight," for fear; finding of no insane delusion affirmed). On the other side are cases upholding a finding of insane delusion even though the testator's fear had some basis in the evidence. For example, in *In re* Klein's Estate, 28 Wash. 2d 456, 463-64, 183 P.2d 518, 522 (1947), the testator found a piece of chipped glass in a dessert served by the person feared; in *In re* Riemer's Will, 2 Wis. 2d 16, 27-28, 85 N.W.2d 804, 810 (1957), the testator observed the person feared, a weak, old man, behaving in an odd manner by flailing his arms about and wearing nails in his shoes.

give an exhaustive review of each of these areas, this Article will draw some general conclusions about the courts' application of the "no evidence" standard.

The courts seem most willing to find beliefs to be delusional when the beliefs are wild or extravagant—the courts often say "impossible." In one case, for instance, the testator left her property to a man she believed she had "miracled" out of a Ouija board.[89] In another case the testator believed that his nephew had killed the testator's mother, when her death had actually preceded the nephew's birth.[90] This same testator also believed he had been boiled in oil. Even in these cases the courts are careful to ensure that the beliefs *are* wild or extravagant; consider that the court carefully searched for the beneficiary "miracled" out of the Ouija board in the case mentioned above, but to no avail.

Courts seem most comfortable in finding that beliefs are not insane delusions when they refer to ethereal, insubstantial items, such as feelings or intentions, that are difficult to verify or to falsify. Indeed, one court went so far as to hold that a belief that a testator's family did not love her could never be an insane delusion. While a "finding of insane delusion is conditioned on the testator's belief in a state of supposed facts, the existence or nonexistence of 'family love' is a comparatively subjective phenomenon not well suited to proof within our legal system."[91] The court relied, more specifically, on a distinction between "facts" and "ideas": a fact is " '[a] thing done; an action performed or an incident transpiring; an actual occurrence,' "[92] whereas family love "refers to an intangible sensation, an idea; it is a feeling which cannot exist independently of a positive belief in its existence."[93] In short, from the testator's point of view, where "could family love have existed except in his mind?"[94] If he does not feel loved, he is simply not loved in the most important sense. Because "there is no such thing as a false idea," the court concluded, a belief that a testator's family

88. For cases in which no insane delusion was found, see, *e.g.*, *In re* Estate of Carothers, 220 Kan. 437, 439, 552 P.2d 1354, 1356 (1976) (testator believed that daughter attempted to commit her on the basis of hearing of her efforts; finding of no insane delusion affirmed); *In re* Karabatian's Estate v. Hnot, 17 Mich. App. 541, 544-45, 170 N.W.2d 166, 168 (1969) (fact that relative had brought testator to regular hospital was enough evidence for belief; directed verdict of no delusion upheld); *In re* Quam's Will, 10 Wis. 2d 21, 28, 102 N.W.2d 217, 220-21 (1960) (testator could conclude that relative was seeking guardianship, as relative had his name on petition for unrelated reason; finding of no insane delusion affirmed). For cases in which an insane delusion was found, see, *e.g.*, *In re* Estate of Martin, 270 Cal. App. 2d 506, 509-510, 75 Cal. Rptr. 911, 913 (1969) (testator believed that his nephew was trying to commit him and that others had promised to prevent commitment, where, in fact, others denied any such promise; finding of insane delusion upheld); *In re* Leedom's Estate, 347 Pa. 180, 184, 32 A.2d 3, 4-5 (1943) (testator's sudden belief that nephew who had cared attentively for testator was trying to commit him was based solely on fact that nephew asked if testator wanted to move in with him; finding of insane delusion upheld). *See also* Spruance v. Northway, 601 S.W.2d 153, 156-57 (Tex. Ct. App. 1980) (although in need of medical care, testator believed her grandson wanted to "put her away," and hospitalized her to get her property; finding of insane delusion affirmed).

89. *In re* City Nat'l Bank & Trust of Danbury, 145 Conn. 518, 144 A.2d 338 (1958) (imaginary man was the main beneficiary; all efforts to locate him proved fruitless; insane delusion affirmed).

90. *In re* Estate of Martin, 270 Cal. App. 2d 506, 510, 75 Cal. Rptr. 911, 913 (1969) (finding of insane delusion upheld based upon this and other delusions).

91. *See* Bauer v. Estate of Bauer, 687 S.W.2d 410, 412 (Tex. 1985).

92. *Id.* (quoting BLACK'S LAW DICTIONARY 531-32 (5th ed. 1979)).

93. *Id.* at 413.

94. *Id.* at 412.

does not love her simply "does not fall within the class of beliefs about which a judgment as to insane delusion can reasonably be made."[95]

While other courts do not subscribe to this precise analysis, they do seem to appreciate that family feelings are very difficult to assess. One court, for instance, classified "mistaken beliefs as to [family members'] feelings and designs toward the testator and his property" with "capricious and arbitrary dislikes [and] unjust suspicions." Such beliefs, "however visionary," "do not constitute insane delusions."[96] The court went on to distinguish these beliefs, in essence "expressions of general discontent," from beliefs that family members had wronged the testator in some specific way, for example, "had tried to kill him."[97] In much the same way, a court hearing a "stealing" case distinguished a belief that a family member had merely "coveted" some items from a belief that he had actually stolen them.[98]

The cases, in short, recognize that others' feelings, unlike grossly demonstrable physical events, are very difficult to pin down. Indeed, some psychiatrists claim that the mentally ill are especially sensitive to others' feelings, so that a sensitive testator may know better even than his relative himself what that relative is feeling.[99] If this is so, the testator's belief is plainly not a delusion, and perhaps we should hesitate in general to characterize such beliefs as delusions.

Even when a belief does refer to actual actions and events in the physical world, the courts are very careful to search the record for some evidence for the belief,[100] and seem to share a general preference for upholding beliefs. The courts, of course, do not wish to find a belief to be an insane delusion if the belief is true. Consider the case in which the testator's belief that a woman might come to work for him, while antecedently unlikely, might have been supported by her telling him that she would do so.[101] In such cases, courts do not find the

95. *Id.* at 413. It seems wrong to deny that "family love" refers to something going on in the family about which one may be wrong or right. But it does seem right to stress that how the testator felt about his family's love is all that matters to his disposition: the important place for family affection to exist was indeed "in the testator's mind." Of course his feelings of being loved or unloved are not true or false.

96. *See In re* Sarras Estate, 148 Mich. App. 171, 178, 384 N.W.2d 119, 121 (1986).

97. *Id.* at 179-80, 384 N.W.2d at 122.

98. *In re* Estate of Kesler, 702 P.2d 86, 93 (Utah 1985). A similarly difficult claim to establish would be that the testator's child was not "ladylike." *See* Byars v. Buckley, 461 S.W.2d 817 (Mo. 1970). The court noted that the term itself is vague, referring to behavior ranging from rude manners to specific immoral conduct. *Id.* at 821. The court might have added that the testator's perception of rudeness or immorality is not the type of opinion that is normally thought to be true or false.

99. *See, e.g.*, H. KAPLAN & B. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY IV 682 (1985) [hereinafter COMPREHENSIVE TEXTBOOK]. Because of patients' sensitivity to others' feelings, the case of Dumas v. Dumas, 261 Ark. 178, 547 S.W.2d 417 (1977) (insane delusion affirmed), may be wrongly decided. The testator believed that his family and church began "watching" him after he had confessed to adultery. Although his family denied this, the testator could have been correct if he sensed his family's unconscious scrutiny and mistrust of him.

100. One court, for example, suggested at least one rule for certain recurrent cases: if a testator believes something " 'upon the evidence of her senses, or upon the statements of some one in whom she had confidence, no matter how ill-founded her conviction might have been, [the] belief could not be placed in the category of insane delusions.' " Dixon v. Webster, 551 S.W.2d 888, 893 (Mo. 1977) (quoting Estate of Kendrick, 130 Cal. 360, 62 P. 605 (1900)).

101. *In re* Johnson's Estate, 370 Pa. 125, 87 A.2d 188 (1952) (finding of no insane delusion

beliefs to be delusional. Similarly, courts do not wish to characterize beliefs that are merely mistaken as insane delusions. For example, consider the case in which the testator might simply have been mistaken about which of her children owned houses.[102]

More significantly, some courts self-consciously protect even mean and suspicious ways of looking at the world—one form of eccentricity. One testator, for example, was paranoid about his own family, but had indeed had some differences with them. In any event, he had "always been suspicious and secretive and always protective of his property."[103] The court found his suspicions to be nondelusional. Another court held that "a jealous, suspicious mind" does not amount to a fixed belief in infidelity,[104] and still another that strained relations could provide a "slight" but sufficient foundation in reality for the testator's fear that her son was trying to harm her.[105] Contrary decisions would, of course, have risked opening the door to finding incompetence on the basis of mean and unpleasant personality traits.[106] Thus even rather ill-founded suspicions are not irrational enough to support a finding of incompetence. One court summed up the matter by noting that feeling "wronged by another is a very common frailty of humanity."[107]

The family affection cases find the courts protecting other unpleasant personality traits, such as a sense of entitlement or ingratitude. In one case, for example, the testator's relatives were trying to commit her only so that she might be helped,[108] yet her resentment was sufficiently grounded in reality that her will was valid. As the court said, if an "act of disinheritance, whether motivated by prejudice, dislike, or even hatred, can be explained on any rational ground, then the burden of proof necessary to set aside the will has not been met."[109] Character traits or feelings causing one to begrudge one's family an inheritance, then, are protected under the doctrine of testamentary capacity.[110]

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upheld); *see also* Quellmalz v. First Nat'l Bank of Belleville, 16 Ill. 2d 546, 158 N.E.2d 591 (1959) (belief that firemen looking in her window; finding of no insane delusion affirmed).

102. *In re* Estate of Protyniak, 427 Pa. 524, 235 A.2d 372 (1967) (finding of no insane delusion upheld).

103. *See In re* Estate of Edwards, 433 So. 2d 1349, 1352 (Fla. Dist. Ct. App. 1983). In Green v. Goans, 458 S.W.2d 705, 707 (Tex. Ct. App. 1970), the testator had actually shot the person he thought was trying to harm him, and then killed himself. One of the experts could, nevertheless, describe the testator as sane, but just "mean as hell."

104. *In re* McDowell's Will, 103 N.J. Eq. 346, 347, 140 A. 281, 283 (1928).

105. *In re* Yett, 44 Or. App 709, 714, 606 P.2d 1174, 1177 (1980).

106. "The line between the unfounded and unreasonable suspicions of a sane mind (for doubtless there are such) and insane delusion is sometimes quite indistinct and difficult to be defined." *In re* McGovern's Will, 241 Wis. 99, 107, 3 N.W.2d 717, 721 (1942) (citing Will of Ebenezer W. Cole, 49 Wis. 179, 182, 5 N.W. 346, 349 (1880)).

107. *In re* Estate of Carothers, 220 Kan. 437, 437, 552 P.2d 1354, 1355 (1976).

108. *See In re* Estate of Bonjean, 90 Ill. App. 3d 582, 413 N.E.2d 205 (1980).

109. *Id.* at 584, 413 N.E.2d at 207.

110. *See, e.g., In re* Estate of Agostini, 311 Pa. Super. 233, 243, 457 A.2d 861, 867 (1983) (testator wished for her daughter to care for her more, evidence pointed to a great deal of care; expert called testator " 'regressed,' vulnerable to misperceptions, childish, and illogical," yet court found testator competent); Rich v. Rich, 615 S.W.2d 795, 798 (Tex. Ct. App. 1981) (competent testator piqued by son's going to father's funeral, and generally displeased by supposed ingratitude). In another case, Jackman v. North, 398 Ill. 90, 75 N.E.2d 324 (1947), the court affirmed the testamen-

Most courts search carefully to find any evidence that might sustain a bequest, thus protecting freedom of testation even when a will is based on mean or eccentric beliefs. Some courts, however, are willing to find an insane delusion despite some supporting evidence for the belief. For instance, one testator's belief that her child was trying to harm her was found delusional even though she had noticed a chip of glass in a dessert the child had prepared.[111] Generally the supporting evidence in these cases is minimal, especially in contrast to considerable evidence to the contrary.[112] Nevertheless, the "no evidence rule" cannot be mechanically applied, and there is some unevenness in its application. At the root of the problem, at times, is that what even counts as relevant evidence may be as contoversial as what is true. Indeed, even when it is agreed that the evidence is relevant, the "no evidence" rule may entail an infinite regress; for we must see if the evidence in support of a belief is itself supported by evidence if we are to invoke it on behalf of the belief. As one court said, "That which no sane mind would believe at all does not rise to the dignity of evidence."[113] Yet although the "no evidence" rule is not problem-free, the problems it produces are rather obscure, and in practice it provides a useful way of identifying unacceptable beliefs without unduly infringing on mere unconventionality or threatening to include too many as incompetent.

IV. TREATMENT COMPETENCY

The concept of competency to make treatment decisions has received little attention in the law. Indeed, while many states now permit competent psychiatric patients to refuse treatment, few cases actually articulate and apply a standard of treatment competency. Those who evaluate treatment competency therefore receive little guidance from the courts. This part begins with a brief consideration of the few cases that have focused on treatment competency of both psychiatric and nonpsychiatric patients. Although the cases purport to employ an "understanding and belief" standard, they fail to formulate and apply

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tary capacity of a testator who levelled multiple charges against her family. The court depicted a very "peculiar" and "selfish" woman:

> The evidence may be summarized as showing that [the testator] was miserly, emotional, egocentric, quarrelsome and given to outbursts of anger. There is evidence that on one or two occasions her emotionalism bordered on to hysteria. The evidence supports the inferences that she was not appreciative of what others did for her, and that overtures leading to the re-establishment of friendship by those she did not like were resented or ignored.

Jackman, 398 Ill. at 96, 75 N.E.2d at 327. For a case in which the testator is characterized as "eccentric," rather than "mean" or "suspicious," see *In re* Estate of Roosa, 753 P.2d 1028, 1035 (Wyo. 1988) (testamentary capacity affirmed, though testator represented himself as having important jobs while he was unemployed, and behaved in idiosyncratic ways; his "eccentricity" did not establish general incapacity or insane delusions).

111. *See In re* Estate of Klein, 28 Wash. 2d 456, 183 P.2d 518 (1947).

112. *See, e.g.*, *In re* Leedom's Estate, 347 Pa. 180, 32 A.2d 3 (1943) (belief that relative wanted to commit him because he had asked testator to come live with him); *In re* Estate of Klein, 28 Wash. 2d 456, 183 P.2d 518 (1947) (belief that daughter trying to harm her because found glass in pudding daughter had prepared); *In re* Riemer's Will, 2 Wis. 2d 16, 85 N.W.2d 804 (1957) (belief that husband, a frail, old man, was trying to harm her because she saw him swinging his arms, and wearing nails on his shoes).

113. *Riemer's Will*, 2 Wis. 2d at 21, 85 N.W.2d at 806 (quoting Taylor v. McClintock, 87 Ark. 243, 279, 112 S.W. 405, 414 (1908)).

consistent criteria for acceptable beliefs. The Article therefore turns to the concept of a delusion to consider standard reasons that psychiatric patients give for refusing medication.

A. *The Cases*

In treatment competency cases, courts generally devote little attention to the precise nature of the competency standard. Some courts simply describe a valid choice as "informed,"[114] "reasoned,"[115] or "rational,"[116] without specifying any particular decisionmaking process. Most courts, however, do indicate that the patient must understand essential information.[117] According to a typical formulation, the patient must have "sufficient mind to reasonably understand [his] condition, the nature and effect of the proposed treatment, attendant risks in pursuing the treatment, and not pursuing the treatment."[118] While the phraseology does vary to some extent, the variations are insignificant.[119] Indeed, even apparently very different standards are often glossed as requiring under-

114. *See, e.g., In re* Moe, 385 Mass. 555, 567, 432 N.E.2d 712, 721 (1982).

115. *See, e.g.,* Eleanor R. v. South Oaks Hosp., 23 A.D.2d 460, 460, 506 N.Y.S.2d 763, 764 (1986) (a "reasoned"/"reasonable" choice).

116. *See, e.g.,* Osgood v. District of Columbia, 567 F. Supp. 1026, 1031 (D.C. Cir. 1983) (refusal a result of "rational choice and religious beliefs, or a product of [patient's alleged] 'paranoid schizophrenia' "); *In re* Mental Commitment of M.P., 500 N.E.2d 216 (Ind. Ct. App. 1986) (a "rational" choice).

117. A small number of courts describe that information generally as "the nature and consequences of [the decisionmaker's] act." *See, e.g.,* Lane v. Candura, 6 Mass. App. Ct. 377, 385, 376 N.E.2d 1232, 1236 (1978); Rivers v. Katz, 67 N.Y.2d 485, 494, 495 N.E.2d 337, 342, 504 N.Y.S.2d 74, 79 (1986); Grannum v. Berard, 70 Wash. 2d 304, 307, 422 P.2d 812, 815 (1967). One case does not specify the information at all, but merely says the subject is incompetent if she lacks "sufficient understanding to make a responsible decision." *In re* Guardianship of Mikulanec, 356 N.W.2d 683, 687 (Minn. 1984) (en banc) (capacity to marry case). Most cases, in contrast, refer more specifically to the treatment context. *See, e.g.,* Keyhea v. Rushen, 178 Cal. App. 3d 526, 535, 223 Cal. Rptr. 746, 750 (1986); Rogers v. Commissioner of Dep't of Mental Health, 390 Mass. 489, 496, 458 N.E.2d 308, 313 (1983); *In re* Farrell, 212 N.J. Super. 294, 299, 514 A.2d 1342, 1344 (1986); *In re* W.S., 152 N.J. Super. 298, 305, 377 A.2d 969, 972 (1977); *In re* Schiller, 148 N.J. Super. 168, 180, 372 A.2d 360, 367 (1977); *In re* Harvey U., 116 A.D.2d 351, 353, 501 N.Y.S.2d 920, 921 (1986); Hanes v. Ambrose, 80 A.D.2d 963, 963, 437 N.Y.S.2d 784, 785 (1981); *Grannum*, 70 Wash. 2d at 308, 422 P.2d at 814. For cases that are somewhere between the more detailed and barer characterizations of the information required for competent consent, but which at least make the treatment context clear, see, *e.g., In re* Boyd, 403 A.2d 744, 747 (D.C. App. 1979); *In re* Osborne, 294 A.2d 372, 373 (D.C. App. 1972); *In re* Quackenbush, 156 N.J. Super. 282, 283, 383 A.2d 785, 786 (1978); *In re* Yetter, 62 Pa. D. & C.2d. 619, 624 (1972). For a case on capacity to consent to sterilization, see *In re* Grady, 85 N.J. 235, 244, 426 A.2d 467, 471 (1981).

118. *In re* Schiller, 148 N.J. Super. 168, 181, 372 A.2d 360, 367 (1977); *see also In re* Farrell, 212 N.J. Super. 294, 299, 514 A.2d 1342, 1344 (1986) (patient deemed competent who was aware of her surroundings and was able to communicate her wishes to others); *In re* W.S., 152 N.J. Super. 298, 304, 377 A.2d 969, 972 (1977) (repeating *Schiller* holding that standard for capacity to contract determines capacity to consent to medical procedure).

119. For example, some formulations speak of "reasonable" understanding, *In re* Schiller, 148 N.J. Super. 168, 181, 372 A.2d 360, 367 (1977); some of "rational" understanding, *In re* Harvey U., 116 A.D.2d 351, 353, 501 N.Y.S.2d 920, 921 (1986); some simply of "understanding" or "knowledge," *In re* Hanes, 80 A.D.2d 963, 963, 437 N.Y.S.2d 784, 785 (1981), but the differences do not seem significant. Nor do the differences seem significant in what precisely is to be appreciated, for example, the seriousness of the condition, as to which the doctors testified in *Hanes*, or the condition alone, as in *Schiller*. *See also* Green, *Judicial Tests of Mental Incompetency*, 6 MO. L. REV. 141, 146-52 (1941) (variations in standards formulated in competency to contract cases not significant).

standing of the specific treatment information.[120]

The "understanding" formulation adopted in most treatment cases focuses on the patient's cognitive abilities and not on her bare evidencing of a choice or on the reasonableness of that choice.[121] Indeed, these cases do not even consider the "bare choice" standard, while a number explicitly reject the reasonableness standard.[122] As one court said in considering a patient's refusal to have her gangrenous leg amputated, "the irrationality of [the patient's] decision does not justify a conclusion that [she] is incompetent in the legal sense. The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise."[123]

While the general formulation of the competency test most naturally suggests a variant of the "understanding" view, which approach to treatment competency the courts in fact adopt is not entirely clear. In particular, there is reason to think that the courts are actually applying the "full reasoning" view. For example, several courts speak of the "rationality" or "reasonableness" of the patient's understanding. While these locutions may indicate merely that a failure to understand implicates a breakdown of reason, alternatively, they may signal a requirement of fuller comprehension than the "understanding" views require. For example, to ask whether the subject "has followed a rational process in deciding to refuse anti-psychotic medication and can give rational reasons for the choice he has made," as one court declared, clearly requires a reasoning ability that goes beyond the mere absence of delusions.[124]

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120. *See, e.g.*, Riese v. St. Mary's Hosp. & Medical Center, 209 Cal. App. 3d 1303, 1323, 243 Cal. Rptr. 241, 254 (1987); Lillian F. v. Superior Court, 160 Cal. App. 3d 314, 319 n.3, 206 Cal. Rptr. 603, 605 n.3 (1984); People v. Medina, 705 P.2d 961, 965-66 (Colo. 1985); New York City Health & Hosp. Corp. v. Stein, 70 Misc. 2d 947, 946, 335 N.Y.S.2d 461, 464 (1972).

121. Similarly, mild suggestions of a "treatment alliance" view are not followed through. *See, e.g.*, *Stein*, 70 Misc. 2d at 946, 335 N.Y.S.2d at 465. But see *In re* Boyd, 403 A.2d 744, 747 (D.C. App. 1979) where, in addition to its finding of incompetency, the court noted that the patient was "unable to assist" the court and her doctors, among others, "in developing a treatment plan." *Id.* The "different person" language also does not appear in treatment competency cases.

122. For courts rejecting the "reasonable result" competency standard, see *infra* note 123. These courts perhaps recognize how tempting the "reasonable result" standard is to some competency evaluators.

123. Lane v. Candura, 6 Mass. App. 377, 385, 376 N.E.2d 1232, 1235-36 (1978); *see also* United States v. Charters, 829 F.2d 479, 496 n.26 (4th Cir. 1987) (a standard "which evaluates competency according to the results of decisions . . . is too paternalistic and poses a tremendous threat to the right of the individual to make choices which reflect his unique concerns."), *diff. result reached on reh'g*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990); Department of Human Servs. v. Northern, 563 S.W.2d 197, 215 (Tenn. Ct. App. 1978) (Drowota, J., concurring) (patient's incompetence based not on her "failure to 'conform,' or do what we or the community might think is 'sensible,' but on her inability to comprehend basic concrete facts relating to her condition."); *see also* People v. Medina, 705 P.2d 961, 970 n.5 (Colo. 1985) (rejecting "reasonable result" standard); *In re* Harvey U., 116 A.D.2d 351, 354, 501 N.Y.S.2d 920, 922 (1986) (same); New York City Health & Hosp. Corp. v. Stein, 70 Misc. 2d 944, 947, 335 N.Y.S.2d 461, 465 (1972) (same).

124. *See Charters*, 829 F.2d at 496.

One might also cite Rivers v. Katz, 67 N.Y.2d 485, 497 n.7, 495 N.E.2d 337, 344 n.7, 504 N.Y.S.2d 74, 81 n.7 (1986), which, in the course of discussing competency to make treatment decisions, refers to Michels's article enumerating some of the ways a patient might fail to be competent to make treatment decisions. *See* Michels, *supra* note 32, at 117-18. Michels includes suffering from phobias or feeling strong emotions as bases for incompetency findings. *Id.* at 117. Permitting the presence of phobias or strong emotions to vitiate competency is characteristic of the "full reasoning" view.

Some cases, however, plainly reject the "full reasoning" view. In one case, for example, the trial court found that the patient was "incapable of making a rational and competent choice"[125] to refuse amputation of her gangrenous leg, basing its finding on medical testimony that her ability was "impaired by the confusion existing in her mind by virtue of her consideration of irrational and emotional factors."[126] Yet the appellate court rejected the conclusion that the patient was legally incompetent. While her decision was in part the product of "strong, emotional factors"[127]—she had been unhappy since her husband's death and did not wish to be a burden to her children[128]—her choice was made "with full appreciation of the consequences."[129] Her decision "may be regarded by most as unfortunate, but . . . it is not the uninformed decision of a person incapable of appreciating the nature and consequences of her act."[130] In short, the influence of irrational and unconscious factors that interfere with fully intact reasoning does not render a person incompetent.[131]

Even without explicit rejection of the "full reasoning" view, the majority of cases strongly suggest a variant of the "understanding" view simply by referring frequently to understanding. Indeed, the cases generally require both comprehension of treatment information and adequate beliefs regarding it. Thus, some patients are incompetent because they have clear comprehension problems. For example, one patient refusing electroconvulsive therapy (ECT) did not remember her doctor informing her about the treatment, and did not understand the treatment information at the time "because" it was false.[132] Another patient refusing psychotropic medication could only attend to treatment information for

125. *See Lane*, 6 Mass. App. at 377, 376 N.E.2d at 1233.

126. *Id.* at 383, 376 N.E.2d at 1235.

127. *Id.* at 382, 376 N.E.2d at 1235.

128. *Id.* at 381, 376 N.E.2d at 1234.

129. *Id.* at 382, 376 N.E.2d at 1235.

130. *Id.* at 385, 376 N.E.2d at 1236.

131. For a similar case, see Grannum v. Berard, 70 Wash. 2d 304, 305, 422 P.2d 812, 813 (1967) (plaintiff suing for lack of effective consent to surgery). Here, the evidence indicated that the patient was "deeply depressed and emotionally distraught." *Id.* at 307, 422 P.2d at 815. For example, nursing notes indicated that he was found crying on a number of occasions; a friend testified that the patient did not recognize him and did not act like himself, speaking freely of his personal problems; and his wife testified that he did not act like himself, appearing very depressed and uncommunicative. *Id.* at 307-08, 422 P.2d at 815. Indeed, the patient was on a number of drugs, including narcotics and minor tranquilizers. *Id.* at 308, 422 P.2d at 815. Despite his emotional state, the court found that the patient had failed to overcome the presumption that he "comprehended the nature, terms and effect of the consent given for the surgical operation." *Id.* at 309, 422 P.2d at 815. In short, the patient was competent despite the influence of irrational and emotional factors on his state of mind.

Another case explicitly limited the factors that may be considered in determining the "rationality" of thought processes in a refusal of psychotropic medication to exactly what is contemplated by the sophisticated "understanding and belief" view: " 'the appropriate test is a negative one: in the absence of a clear link between an individual's delusional or hallucinatory perceptions and his ultimate decision' " it should be assumed " 'that he is utilizing rational modes of thought.' " Riese v. St. Mary's Hosp. and Medical Center, 209 Cal. App. 3d 1303, 1323, 243 Cal. Rptr. 241, 254 (1987) (quoting T. GUTHEIL & P. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 219 (1982)). Incompetence implicates irrationality, in other words, only when thought is marred by delusions, and, as the "understanding and belief" views hold, capacity can coexist with more rarefied defects. The case is also inconsistent with the "full reasoning" view.

132. *See* Conservatorship of Fadley, 159 Cal. App. 3d 440, 444, 205 Cal. Rptr. 572, 574 (1984).

a very short time.[133] Yet another patient refusing amputation of a gangrenous foot was disoriented as to time and place, and did not realize who was talking to him.[134] Thus the courts deemed all of these patients incompetent. Still, most patients are found incompetent at least in part because their beliefs are faulty.[135] Thus, insofar as the courts do inquire into a patient's actual beliefs, they implicitly reject purer versions of the "understanding" view.

Whether the treatment cases' "understanding and belief" view is sophisticated or naive is less clear. The most naive standards require a patient to believe all that her doctor believes. More sophisticated standards, by contrast, proscribe only beliefs that are patently false, that is, delusions. The treatment competency cases are inconsistent as to how patently false beliefs must be in order to vitiate competency.

In *Northern*, it will be recalled, the majority and the concurring judge divided over whether Mrs. Northern needed to accept her doctors' view that she would die without the amputation of her gangrenous feet. The majority required her to accept the *truth* of her doctors' beliefs; the concurrence, only the *fact* of the doctors' beliefs. Because only the fact of the doctors' beliefs was indisputable, only the concurring judge's opinion accorded to those beliefs their proper significance. Both opinions, nevertheless, could correctly base their findings of incompetence on Mrs. Northern's failure to recognize that her feet were black, dead, and odorous.

Of the remaining treatment competency cases, some err in the same way as the majority opinion in *Northern*. These courts fail to recognize that, while a decisionmaker must acknowledge that her doctors hold certain beliefs about her condition and treatment, she need not fully accept her doctor's beliefs as true, since beliefs at variance with those of doctors do not necessarily grossly distort reality.[136] Similarly, some courts find delusional other beliefs that are simply not grossly irrational. Courts have erred, for example, by requiring a patient's acquiescence in his diagnosis of mental illness as a component of competency.[137]

133. *See* People v. Medina, 705 P.2d 961, 965 (Colo. 1985) (patient conceded incompetence on appeal).

134. *See In re* Schiller, 148 N.J. Super. 168, 372 A.2d 360 (1977).

135. *See, e.g.*, *Fadley*, 159 Cal. App. 3d at 443, 205 Cal. Rptr. at 574; *Medina*, 705 P.2d at 961; *In re* Hospitalization of B., 156 N.J. Super. 231, 234, 383 A.2d 760, 762 (1977); *Schiller*, 148 N.J. Super. at 182-83, 372 A.2d at 368 (1977); Eleanor R. v. South Oaks Hosp., 123 A.D.2d 460, 460, 506 N.Y.S.2d 763, 764 (1986); *In re* Harvey U., 116 A.D.2d 351, 353, 501 N.Y.S.2d 920, 922 (1986); Department of Human Servs. v. Northern, 563 S.W.2d 197, 210 (Tenn. Ct. App. 1978).

136. *See supra* text accompanying notes 23-24 (discussing as naive the requirement of believing all that doctors believe).

137. Several courts say in dictum that one must accept a diagnosis of mental illness. *See, e.g.*, United States v. Charters, 829 F.2d 479, 497 (4th Cir. 1987), *diff. result reached on reh'g*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990); Riese v. St. Mary's Hosp. & Medical Center, 209 Cal. App. 3d 1303, 1322-23, 243 Cal. Rptr. 241, 253-54 (1987); *Fadley*, 159 Cal. App. 3d at 446, 205 Cal. Rptr. at 575-76; Eleanor R. v. South Oaks Hosp., 23 A.D.2d 460, 460, 506 N.Y.S.2d 763, 764 (1986). The California cases seem to require a belief in the patient's illness because of a statute which says the patient must understand the information provided by the doctor, including the "reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect." Lillian F. v. Superior Court, 160 Cal. App. 3d 314, 319 n.4, 206 Cal. Rptr. 603, 606, n.4 (1984) (citing CAL. WELF. & INST. CODE § 5326.2(a) (West 1984)). It would not seem unreasonable, however, to interpret the statute to require the patient to comprehend the information, and

But a patient's denial that he is mentally ill may not grossly distort reality. Indeed, the patient's denial finds support in the view of some noted psychiatrists that mental illness is a myth.[138] Yet the courts that require acquiescence in a diagnosis of mental illness also provide other, more appropriate bases for their decisions. In one case, for example, the patient distorted what her doctor said and failed even to assimilate the information he provided.[139] In another case the patient believed that her medication was poisoned with cyanide.[140]

Courts find some patients' beliefs delusional even though they may be interpreted more benignly. For example, one court found delusional a patient's belief that he must "remain alert and strong in order to ward off evil forces."[141] This patient's belief, however, may simply have been a concrete way of saying that being good requires an effort of will—and in any case, belief in evil forces is probably common in some quarters. Similarly, another court found a patient's desire to take revenge on his doctors by refusing medication to be irrational. Such desires, however, because they are common, are hardly grossly irrational.[142]

In contrast, many courts are keenly aware of the need to protect patients' views about their treatment, even when those views are at odds with their doctors' opinions, so long as the patients do not radically distort reality.[143] Califor-

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believe that the doctor believes it, without necessarily believing it himself. The question of whether the patient must believe in the doctor's diagnosis turns on how good the evidence is for the diagnosis. Suggesting, as does *Riese*, 209 Cal. App. 3d at 1322-23, 243 Cal. Rptr. at 253-54, that if the court is persuaded of the illness, so must the patient be, seems impermissible, because reasonable courts can differ: courts do not accept only what is indisputably true.

138. See *infra* note 182 (citing works of psychiatrists).

139. *See In re* Fadley, 159 Cal. App. 3d 440, 445, 205 Cal. Rptr. 572, 574 (1984). Fadley, for example, denied the need for medication "[b]ecause I'm told my mind is all right. My mind is perfect." *Id.* Misrepresenting what has happened may involve a gross distortion of reality. Moreover, Fadley did not remember being informed by the doctor, and claimed that she "didn't understand [the information] because it isn't true." *Id.* Such a failure to comprehend is properly relied on by the court as a basis for finding the patient incompetent.

140. *See* Eleanor R. v. South Oaks Hosp., 23 A.D.2d 460, 461, 506 N.Y.S.2d 763, 764 (1986). The patient also spoke in a "rambling and incoherent manner," which might have called into question her bare ability to comprehend. *Id.*

Another court cited a gangrene patient's denial of the seriousness of his condition, as well as his belief that he would heal naturally, to support its finding of his incompetence. Once again, his beliefs that his physicians were trying to "hurt" him and that his hospitalization and treatment were "experimental" provided a more acceptable basis for the court's finding. *See In re* Harvey U., 116 A.D.2d 351, 353, 501 N.Y.S.2d 920, 921-22 (1986).

141. *See* Hospitalization of B., 156 N.J. Super. 231, 234, 383 A.2d 760, 762 (1977).

142. Rennie v. Klein, 462 F. Supp. 1131, 1153 (3d Cir. 1978) (court seems tentatively to agree Rennie was competent although his refusal was based on vengeful feelings towards his doctors).

Denying a need for treatment also seems a very tenuous basis for a finding of incompetency. *See, e.g., Eleanor R.*, 123 A.D.2d at 460, 506 N.Y.S.2d at 764. Whether a patient "needs" treatment depends on her "needs" in another sense: if she is satisfied with her state, she does not need treatment, whatever the doctors may think about her purely medical needs. Moreover, the doctors may be wrong about what is needed even medically. Note that competency courts may be somewhat too comfortable basing their findings on patients' views about their illness and need for treatment because commitment statutes often expressly require commitment if patients, among other things, do not appreciate their condition or the need for treatment. *See, e.g.*, CONN. GEN. STAT. ANN. § 17-178(C) (West 1988); N.Y. MENTAL HYGIENE LAW § 9.01 (Consol. 1979); *In re* Mohr, 383 N.W.2d 539, 541 (Iowa 1986); *In re* Oseing, 296 N.W.2d 797, 801 (Iowa 1980). These statutes do not purport to determine a patient's competency.

143. Indeed, courts are no less aware than the public that medicine is not an "exact science."

nia, for example, expressly recognizes the state's interest in ensuring that treatment "is not forced on a conservatee who does not want it and who is simply in disagreement with his conservator and his physicians."[144] The California appellate court in one case found that the disagreement between a patient and his doctor over the relative efficacy of medication and ECT did "not show [the patient's] inability to give informed consent."[145] Indeed, in the clearest cases a patient's belief may be completely realistic, as where the patient believed that amputating a gangrenous leg would not cure her when earlier treatments of the same kind had failed.[146] Even when a patient's hope for a particular outcome is against all odds, that hope alone does not clash with reality, inasmuch as hopes are neither true nor false. Thus one patient's hope for a miracle to cure his gangrene did not render him incompetent, for the hope might have been fulfilled.[147] Even very peculiar health care beliefs do not always vitiate treatment decisions, as in the case of one competent decisionmaker who believed that the "forces of the universe" would enable his child to cure himself of a severe cleft palate.[148]

The courts also permit patients to refuse procedures on the basis of fears that their doctors view as unwarranted. Like hopes, fears are neither true nor false, so that to fear something is not to hold a patently false belief. Some courts style fear-based refusals "irrational,"[149] whereas others characterize them as "rational" even when the risks are very remote.[150] All courts no doubt appreciate that fear of medical procedures is very common,[151] and that if fear could produce incompetence, far too many patients would be found incompetent. Indeed, a number of courts find fear of a procedure to justify a refusal to undergo treatment even if the patient has other, plainly delusional beliefs.[152] For in-

See, e.g., Erickson v. Dilgard, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (1962) (doctor argued that refusal of transfusion amounted to suicide; court disagreed, saying "it is always a question of judgment whether the medical decision is correct"). Courts also demonstrate awareness of the fallibility of medical judgment when they require patients to be informed of this fallibility. *See, e.g.*, Lillian F. v. Superior Court, 160 Cal. App. 3d 314, 206 Cal. Rptr. 603 (1984); Rogers v. Commissioner of Dep't of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983). Finally, courts demonstrate this awareness when they mediate medical disputes. *See, e.g.*, Hanes v. Ambrose, 80 A.D.2d 963, 437 N.Y.S.2d 784 (1981) (court disagreed with doctor's finding that procedure was "necessary"); *In re* Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (1966) (court mediates disagreement among family members over mother's need for amputation).

144. *See* Lillian F. v. Superior Court, 160 Cal. App. 3d 314, 206 Cal. Rptr. 603, 608 (1984).

145. *See* Conservatorship of Waltz, 180 Cal. App. 3d 722, 734, 227 Cal. Rptr. 436, 443 (1986).

146. *See* Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978). The patient's toe and part of her foot previously had been amputated.

147. *See In re* Quackenbush, 156 N.J. Super. 282, 287-88, 383 A.2d 820, 824 (1978).

148. *See In re* Seiforth, 309 N.Y. 80, 83, 127 N.E.2d 820, 824 (1955). Beliefs about healing that appear religious may be given even greater protection. *See, e.g.*, *In re* Milton, 29 Ohio St. 3d 20, 505 N.E.2d 255 (1987) (patient's belief in faith healing found nondelusional even though connected with a delusional belief that a prominent faith-healer was her husband, and that, despite his public distancing of himself from her, he would come to heal her).

149. *See, e.g.*, *In re* Yetter, 62 Pa. D. & C.2d 619, 624 (1955).

150. *See, e.g.*, Conservatorship of Waltz, 180 Cal. App. 3d 722, 732, 227 Cal. Rptr. 436, 442 (1986). Indeed, some are eminently rational. *See, e.g.*, Hanes v. Ambrose, 80 A.D.2d 963, 963, 437 N.Y.S.2d 784, 785 (1981) (patient refusing surgical removal of pin had "very real fear" she would not survive another operation).

151. *See, e.g.*, *Yetter*, 62 Pa. D. & C.2d at 624.

152. This position is most consistent with the law of competency in other areas that if a patient

stance, one sixty-year-old woman's fear that a biopsy would kill her was judged competent, even though she also delusionally believed the procedure would make it impossible for her to have a movie career and would prevent her from having children.[153] Another man's rational fear of ECT in his nonpsychotic moments justified a finding of competence, even though in his psychotic moments he tended to be paranoid and delusional about the treatment, repeating over and over, "I don't want it. It will kill me and scramble my brain. I don't want it."[154] In short, courts often seem implicitly to use strict criteria for deciding whether primary, motivating beliefs are delusional, perhaps realizing that some degree of irrationality in decisionmaking is inevitable.

B. *Typical Reasons for Refusing Medication in Light of the Law's Concept of a Delusion*

While the treatment cases appear to be based on an "understanding and belief" standard, not all courts adopt the same standard for the adequacy of beliefs. The concept of a delusion allows us to evaluate common reasons psychiatric patients give for refusing treatment. Some of the common reasons are, of course, completely unobjectionable, as when a patient refuses because he intensely dislikes the medication's side effects, or wishes to avoid the serious risks it poses. The focus here is on the more suspect reasons patients give for refusing. These reasons are assessed in light of the need to protect idiosyncratic feelings, idiosyncratic values, and idiosyncratic beliefs that may be correct, including the patient's belief that he is not ill.[155]

1. Cases of feelings

The law in wills cases seems fairly clear that even an irrational feeling of hatred or resentment toward someone does not vitiate capacity unless the feeling is based on delusional beliefs.[156] Resentment over being committed, for example, even when the commitment was motivated by the best of intentions, is sufficient to support disinheriting one's heirs.[157] Just as anger against a family member does not by itself invalidate a will,[158] anger against one's doctor or

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has a rational reason that affects a decision, then he is not incompetent even if he also has an irrational reason that affects the decision. *See supra* note 26.

153. *See Yetter*, 62 Pa. D. & C.2d at 622. Yetter's fear seemed to have a delusional basis: she believed that the same procedure resulted in the death of an aunt who had actually died of other causes fifteen years after the treatment. The court's basis for its holding is somewhat unclear, for it points out that Yetter originally made an understanding choice in addition to having nondelusional reasons for her choice. Thus it is unclear whether the court is making a competency finding based on the presence of nondelusional reasons, or a species of substituted judgment finding based on her past competent decision.

154. *See Waltz*, 180 Cal. App. 3d at 729, 227 Cal. Rptr. at 440.

155. For an interesting discussion of false advertising as inducing false beliefs as opposed to "irrational" or "emotional" decisions, see Craswell, *Interpreting Deceptive Advertising*, 65 B.U.L. REV. 657 (1985).

156. *See supra* text accompanying notes 77-78 (discussing relation of feelings such as resentment to incompetency in wills context).

157. *See In re* Estate of Bonjean, 90 Ill. App. 3d 582, 413 N.E.2d 205 (1980).

158. *See, e.g.*, Thornton v. Hulme, 218 Ga. 480, 128 S.E.2d 744 (1962) ("The mere dislike of

family should not by itself invalidate a decision to refuse treatment unless integrally connected with a patently delusional belief.[159] If, by contrast, a treatment decision is motivated by anger against the patient's doctors or family that is based on a delusion—for instance, that they have attempted to kill the patient[160]—the decision should be invalid. In short, competency doctrine allows people to be hateful, unusually generous, or unwise—but not to be patently unable to address reality.

2. Cases of value judgments

Value judgments may provide reasons for refusing or accepting treatment, as when a patient refuses because he believes he is bad and deserves to suffer. Value judgments may be defined as involving a belief that some event or thing is good or bad. Because they are neither right nor wrong in a straightforward way,[161] unconventional value judgments do not demonstrate an extreme breakdown of reason. Commentators fail to recognize this,[162] yet other areas of law suggest that it is so. Consider that fraud doctrine distinguishes between fact statements and value statements, holding that only fact statements can be fraudulent.[163] It is reasonable to rely only on fact statements, not on value statements, because only fact statements are clearly demonstrable as true or false, so that a defrauder could plausibly pretend to know the truth about them. Indeed, competency doctrine is designed in large part to protect the expression of individual values, so that excluding value judgments as a basis for incompetency findings makes eminent sense.[164] The concept of a delusion, with its emphasis

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certain persons, or ill feelings towards them, causing their exclusion from a will, is not monomania."). *See supra* notes 77-80 (citing family affection cases).

159. *But cf.* Rennie v. Klein, 462 F. Supp. 1131, 1153 (3d Cir. 1978) (verges toward finding the patient incompetent because his refusal of medication was based on a desire for revenge).

160. For wills cases in which testators hold such beliefs, see, *e.g.*, *In re* Estate of Klein, 28 Wash. 2d 456, 183 P.2d 518 (1947); *In re* Riemer's Will, 2 Wis. 2d 16, 85 N.W.2d 804 (1957). Note that the belief is to have "no evidence" if it is to be a delusion, and many wills cases find some evidence for a testator's belief that an heir is trying to harm the testator. *See supra* texts accompanying notes 81-84 and notes 87-88 (discussing and citing cases).

161. *See, e.g.*, D. HUME, A TREATISE OF HUMAN NATURE, book iii (1739); D. HUME, AN ENQUIRY CONCERNING THE PRINCIPLES OF MORALS (1751); I. KANT, CRITIQUE OF PURE REASON (1781); I. KANT, CRITIQUE OF PRACTICAL REASON (1788).

162. *See, e.g.*, Mental Health Law Project, *Legal Issues in State Mental Health Care: Proposals for Change: Suggested Statute on Civil Commitment*, in MENTAL HEALTH LAW PROJECT, PROTECTION AND ADVOCACY FOR PEOPLE WHO ARE LABELED MENTALLY ILL (1987), at 265 (patient who refuses treatment because of belief that he is unworthy of treatment deemed incompetent).

163. *See, e.g.*, Fifty Assocs. v. Prudential Ins. Co., 450 F.2d 1007, 1010-11 (9th Cir. 1971) (question of land value generally a matter of opinion only); Frazier v. Southwest Sav. & Loan Ass'n, 134 Ariz. 12, 15, 653 P.2d 362, 365 (1982) (appraisal of value of property: "Mere representations as to value are generally considered expressions of opinion and will not support a claim for fraud."); Hall v. Kemp, 71 N.C. App. 101, 106, 322 S.E.2d 7, 11 (1984) (value of bracelet: "representation which is nothing more than an opinion as to the value of property . . . does not constitute actionable fraud."). In circumstances of "confidence," however, some states allow that statements of value can be fraudulent. *See, e.g.*, Kaye v. Pawnee Constr. Co., 680 F.2d 1360, 1368 (11th Cir. 1982); Cory v. Villa Properties, 180 Cal. App. 3d 592, 597-98, 225 Cal. Rptr. 628, 631 (1986).

164. For some criminal cases in which people with idiosyncratic values are nevertheless found competent, see, *e.g.*, United States v. Smith, 404 F.2d 720 (6th Cir. 1968) (defendant did not want to appeal death sentence because preferred death to confinement); McKinney v. State, 566 P.2d 653 (Alaska 1977) (defendant "just wanted to get [sentencing] over with"); People v. Deere, 41 Cal. 3d

on truth or falsity, does precisely that.

We may read competency doctrine in other areas to rely on an implicit fact or value distinction. For example, depressed people often feel guilty, as if they deserve punishment—a clear value judgment. This value judgment may motivate some to plead guilty to criminal charges. Yet depressed people rarely are found incompetent to stand trial unless they are so depressed that they are unable to cooperate, for example, they are mute or they are patently delusional.[165] Similarly, standard contract doctrine holds that the adequacy of consideration—a value question—is generally not open to scrutiny; freedom of contract requires allowing people to make their own judgments about the value of a deal, and unwise judgments alone are not enough to render promisors incompetent.[166]

Insanity doctrine on knowledge of the wrongness of an act—another clear value judgment—is most instructive. The law holds that a defendant was insane if he did not know that his act was wrong.[167] If a simple idiosyncratic judgment about the morality of an act were enough for insanity, our view that moral judgments do not indicate a patent breakdown of reason would be problematic.[168] In fact, however, courts have given the insanity doctrine a narrow interpretation that is consistent with this position. Some states excuse a defendant only if he did not know that his act was criminal—a clearly factual judgment.[169] Other

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353, 710 P.2d 925, 222 Cal. Rptr. 13 (1985) (defendant waived penalty jury because did not want to "waste time").

165. For a case in which a competency hearing should have been held for a defendant who confessed to arson, but also confessed in a patently delusional way to many other crimes—claiming responsibility, for example, for the Japanese attack on Pearl Harbor—see State v. Bertrand, 123 N.H. 719, 465 A.2d 912 (1983). Many cases, by contrast, find depressed patients competent. *See, e.g.*, Eathorne v. State, 448 So. 2d 445 (Ala. App. 1984) (at time defendant pleaded guilty to killing another with car he felt extremely guilty, but that his act was not a crime: the mere fact that he was "suffering from feelings of guilt or worthlessness at the time he pled guilty did not render his plea involuntary"); Trawick v. State, 473 So. 2d 1235 (Fla. 1985) (despondency and ambivalence about guilty plea not sufficient to raise question of competency), *cert. denied*, 476 U.S. 1143 (1986). In other cases, defendants with depression expressing the desire to die have had their convictions upheld, although whether their feelings were true remorse for crimes actually committed or depression-induced guilt may be questioned. *See, e.g.*, Smith v. Central Soya of Athens, 604 F. Supp. 518 (E.D.N.C. 1985) (depression with four suicide attempts; told psychiatrist he wrote incriminating and inflammatory letter to newspaper on eve of plea because he wanted to die; conviction upheld); People v. Deere, 41 Cal. 3d 353, 710 P.2d 925, 222 Cal. Rptr. 13 (1985) (symptoms of depression including asking to be killed before crime and self-mutilation; that defendant was "prepared to die" not equivalent to incompetency). Moreover, depression resulting in crying or outbursts in court does not amount to incompetency. *See, e.g.*, United States v. Horowitz, 360 F. Supp. 772 (E.D. Pa 1973); Commonwealth v. Hazur, 372 Pa. Super. 306, 539 A.2d 451 (1988).

166. *See, e.g.*, Bayshore Royal Co. v. Doran Jason Co., 480 So. 2d 651, 656 (Fla. 1985); Kincaid v. Lazar, 405 N.E.2d 615, 620 (Ind. 1980); Hatham v. Waters, 586 S.W.2d 367, 385 (Mo. 1979); Buckingham v. Wray, 219 Neb. 807, 809, 366 N.W.2d 753, 756 (1985) ("consideration based on value of property or performance of a promise is a matter of personal judgment by parties to a contract"); Westgate Bank v. Eberhart, 202 Neb. 762, 765, 277 N.W.2d 104, 106 (1979) ("Valuation of property is a matter of judgment, and a contract based on inadequate consideration will not be set aside on that reason alone."); Jesse v. Smith, 222 Va. 15, 18, 278 S.E.2d 793, 795 (1981); St. Norbert College v. McCormick, 81 Wis. 2d 423, 430, 260 N.W.2d 776, 780 (1978).

167. *See* M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1843).

168. After all, one might think of insanity as incompetency to commit a crime.

169. *See, e.g.*, People v. Perez, 9 Cal. 3d 651, 660, 510 P.2d 1026, 1031, 108 Cal. Rptr. 474, 479 (1973); Blocker v. State, 92 Fla. 878, 892-95, 110 So. 547, 552-53 (1926); State v. Boan, 235 Kan. 800, 810, 686 P.2d 160, 168 (1984).

This does not mean that there are no difficult questions of interpretation or of normative theory

states excuse a defendant if he did not know that his act was morally wrong, but are careful to hold responsible those who merely make value judgments at odds with those of society.[170] To be insane, a defendant must be suffering from patent delusions that themselves obscure moral distinctions.[171] In the usual case, he believes that God has commanded his act and that God's law supersedes man's.[172] In short, holding unconventional values does not indicate a patent breakdown of reason, and hence insanity.

Idiosyncratic value judgments in the competency to refuse treatment area likewise should not vitiate consent unless they are based on patent delusions. Indeed, we should take care to classify as value judgments certain apparently factual statements, as when an anorexic says she is fat, meaning not that she weighs more than the American Medical Association weight guidelines prescribe, but that she weighs more than she would like to weigh. She may believe that emaciation is, for her, desirable or attractive. This patient should not be found incompetent. In the same way, a depressed person who believes that he is bad and does not deserve to get better is expressing a value judgment and not a patent breakdown of reason. He should not be found incompetent on this basis alone. By contrast, an anorexic who believes that she is the fattest person in the world or that she expands tenfold when she eats a grain, or a depressed person who believes that he is bad because he has killed millions of people, is indeed incompetent. The "profound delusion" rule makes good sense; without it, far too many would be found incompetent, for misjudgments about one's weight—and worth—are pervasive.

3. Beliefs about one's doctor and the recommended treatment

Delusional beliefs generally are beliefs that are not supported by *any* evidence. As we have seen, there is authority for saying that a person's beliefs about others' feelings toward him—their love and affection, for example—cannot be delusional. One court suggests that such beliefs refer, in the most impor-

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in applying the criminal law to any given set of facts—it suggests only that whether something is a crime on the books is not essentially a value question.

170. *See, e.g.*, State v. Corley, 108 Ariz. 240, 243, 495 P.2d 470, 473 (1972) (knowing act morally and legally wrong, but personally believing right, insufficient for insanity); State v. DiPaolo, 34 N.J. 279, 292-94, 168 A.2d 401, 408 (1961) (court distinguishes the case of an "insane delusion which negates a consciousness of the immorality of the act from a moral depravity or some notion of morality, unrelated to mental illness, which merely disagrees with the law and mores of our society"); People v. Wood, 12 N.Y.2d 69, 76, 187 N.E.2d 116, 121, 236 N.Y.S.2d 44, 50 (1962) (law does not permit individual to be his own judge of what is right or wrong); State v. Crenshaw, 98 Wash. 2d 789, 797-98, 801, 659 P.2d 488, 495 (1983) ("If wrong meant moral wrong judged by the individual's own conscience, this would seriously undermine the criminal law.") (citing H. FINGARETTE, THE MEANING OF CRIMINAL INSANITY 154 (1982); cases).

171. *See, e.g.*, United States v. Sullivan, 544 F.2d 1052 (9th Cir. 1976); United States v. McGraw, 515 F.2d 758 (9th Cir. 1975); Bethea v. United States, 365 A.2d 64 (D.C. 1976); State v. Johnson, 121 R.I. 254, 399 A.2d 469 (1979).

172. This type of belief is discussed in the famous Cardozo opinion on the right/wrong prong of the insanity test. *See* People v. Schmidt, 216 N.Y. 324, 335, 110 N.E. 945, 948 (1915) ("a delusion that God himself has issued a command" has an "effect in obscuring moral distinctions"); *see also* Merritt v. State, 45 S.W. 21, 23 (Tex. 1898) (command of God exception); State v. Crenshaw, 98 Wash. 2d 789, 798, 659 P.2d 488, 494 (1983) ("act ordained by God" exception is "narrow exception" to rule that defendant must fail to know act criminal).

tant sense, to ideas in the believer, which depend on him for their existence; they are not properly true or false, and so are not properly classified as delusions.[173] On this view, a patient's belief that his doctor does not like him or feels some malice toward him is not a delusion—as compared, for instance, to a belief that the doctor is trying to kill him—and so should not be a reason for finding him incompetent to make treatment decisions.

Other "possible" beliefs will vary and must be considered on a case-by-case basis. One typical reason for refusal may be the conviction that the treatment will not have the effects the doctor predicts. While the doctor's belief, perhaps as well as the treatment's typical effects, may be indisputable, what effects it will have on a particular individual are not so clear. Failure to agree with the doctor does not amount to a gross distortion of reality. The few existing treatment competency cases appear to recognize this fact.[174] Analogously, the law of competency to stand trial clearly allows clients to disbelieve their lawyers about the effects of different trial tactics without being found incompetent.[175] A patient who is pessimistic about a treatment should not be found incompetent, even if the pessimism is related to depression,[176] because her beliefs do not grossly distort reality. If all pessimistic people were incompetent, we would clearly be faced once again with severe "irrationality" problems.

4. The belief that one is not ill

Most commentators who address the issue of denial assert that a patient's denial that he is mentally ill is sufficient to find him incompetent to make treatment decisions.[177] The notion of a delusion as a belief supported by no evidence, however, calls into question the widespread view that deniers of mental illness

173. Bauer v. Estate of Bauer, 687 S.W.2d 410, 413 (Tex. App. 1985); *see supra* notes 79-80 and 91-97 (citing cases) and acccompanying texts; *see also In re* Sarras Estate, 148 Mich. App. 171, 384 N.W.2d 119 (1986) (beliefs about family members' feelings do not constitute insane delusions).

174. *See, e.g.*, Conservatorship of Waltz, 180 Cal. App. 3d 722, 227 Cal. Rptr. 436 (1986); Lillian F. v. Superior Court, 160 Cal. App. 3d 314, 206 Cal. Rptr. 603 (1984).

175. The sixth amendment "speaks of the 'assistance' of counsel, and an assistant, however expert, is still an assistant." Faretta v. California, 422 U.S. 806, 820 (1975). The client, therefore, "must be allowed to control the organization and content of his [or her] own defense." McKaskle v. Wiggins, 465 U.S. 168, 174 (1984). Thus, failing to heed one's lawyer's advice is insufficient to constitute incompetency. This may be so even when there are other indicia of incompetency. *See, e.g.*, People v. Picozzi, 106 A.D.2d 413, 414, 482 N.Y.S.2d 335, 337 (1984) (while defendant's ability to establish a working relationship with counsel is a factor in determining competency, "defendant's apparent disagreement with defense counsel's theory of the case as well as the defendant's somewhat abrupt decision to change defense tactics in the middle of the trial did not indicate incompetency on his part, but rather reflected his realization that he was faced with a strong prosecution case."); Commonwealth v. Logan, 519 Pa. 607, 623-24, 549 A.2d 531, 539 (1988) ("The fact that a defendant raises a bizarre response to his counsel's strategy or refuses to cooperate with that strategy, or displays childish and threatening behavior does not necessarily constitute legal incompetency."); Commonwealth v. Banks, 513 Pa. 318, 343, 521 A.2d 1, 13 (1987) ("failure to heed counsel's advice and/or the failure to agree with counsel's strategy are certainly not to be equated with and do not establish legal incompetency" (citing lower court slip op. at 13-14)).

176. Thus the position of Gutheil and Bursztajn is incorrect. *See* Gutheil & Bursztajn, *Clinicians' Guidelines for Assessing Subtle Forms of Patient Incompetence in Legal Settings*, 134 AM. J. PSYCHIATRY 1020, 1021 (1986).

177. *See, e.g.*, Beck, *Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-making*, 5 MENTAL & PHYSICAL DISABILITY L. REP. 268 (1987); Roth, Appelbaum, Sallee, Reynolds & Huber, *supra* note 23, at 912; Appelbaum & Bateman, *supra* note 23.

are incompetent, for it is by no means clear that their beliefs are totally lacking in evidentiary support.

In assessing denials, courts must recognize that psychiatric diagnoses lack certainty,[178] so that failing to accept them may not reflect a patent breakdown of reason. There are many schools of psychiatry and many theories of the nature of mental illness, ranging from a biochemical disturbance,[179] to learned behavior,[180] to behavior dynamically motivated by childhood needs and desires.[181] Indeed, while it might be bizarre for an oncologist to deny the existence of cancer, some noted psychiatrists deny the very existence of mental illness.[182] Patients who deny that they are ill may similarly reject the notion of mental illness, or may simply disagree with a particular psychiatric conception of illness.

Even if a patient shares with his psychiatrist a particular conception of mental illness, his belief that *he* is not suffering from an internal morbid process may not patently distort reality. Many patients develop their illnesses so gradually[183] that their conviction that they are not ill is completely understandable; their inner life is little different from before, yet no one called them ill then. Hence their belief that they are not ill has some basis in their experience and does not represent a significant break from reality. Similarly, the acutely ill may believe they are simply upset rather than unwell. Even psychiatrists who subscribe to the same theories disagree over diagnoses of particular patients—sometimes over whether they even have a diagnosis. The Supreme Court has ruled that a standard of "beyond a reasonable doubt" is inappropriate in psychiatric proceedings because psychiatry is simply not precise enough to support that degree of certainty.[184] If it is reasonable to doubt a psychiatric diagnosis, it cannot patently distort reality for a patient to doubt it.

Moreover, psychiatric patients may have good reasons for denying that

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178. *See, e.g.*, 1 J. ZISKIND, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 251-88 (3d ed. 1981); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974).

179. *See, e.g.*, G. BALIS, L. WURMSER & E. MCDANIEL, BASIC PSYCHOPATHOLOGY 108-25 (1978); COMPREHENSIVE TEXTBOOK, *supra* note 99, at 669-79, 769-78; A. NICHOLI, *supra* note 71, at 129-52.

180. *See, e.g.*, H. KAPLAN & B. SADOCK, SYNOPSIS OF PSYCHIATRY 85-90 (1985) [hereinafter SYNOPSIS]; B.F. SKINNER, SCIENCE AND HUMAN BEHAVIOR (1953); J. WOLPE & A. LAZARUS, BEHAVIOR THERAPY TECHNIQUES (1966).

181. *See, e.g.*, E. ERIKSON, IDENTITY AND THE LIFE CYCLE (1959); S. FREUD, THE STANDARD EDITION (1986); C. JUNG, TWO ESSAYS ON ANALYTICAL PSYCHOLOGY (1953); C. JUNG, MEMORIES, DREAMS AND REFLECTIONS (1961); M. KLEIN, ENVY AND GRATITUDE (1975).

182. *See, e.g.*, T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961). For another psychiatrist who does not subscribe to the medical model, see R. LAING & A. ESTERSON, SANITY, MADNESS, AND THE FAMILY (1971); R. LAING, THE POLITICS OF EXPERIENCE (1967).

183. Schizophrenia in particular often develops gradually and insidiously. *See, e.g.*, I. BATCHELOR, HENDERSON AND GILLESPIE'S TEXTBOOK OF PSYCHIATRY 257 (1981); H. KAPLAN & B. SADOCK, SYNOPSIS, *supra* note 180, at 260-62.

184. *See* Addington v. Texas, 441 U.S. 418, 429 (1979) ("Given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous."); *see also* Parham v. J.R., 442 U.S. 584, 629 (1979) ("Even under the best of circumstances, psychiatric diagnosis and therapy decisions are fraught with uncertainties."); O'Connor v. Donaldson, 422 U.S. 563, 579 n.2 (1975) (Burger, C.J., concurring) (psychiatry uncertain); Rone v. Fireman, 473 F. Supp. 92, 119 (N.D. Ohio 1979) (same); Rennie v. Klein, 462 F. Supp. 1131, 1145 (D.N.J. 1978) (same).

they are ill. For example, they may be unwilling to admit to something as stigmatizing as mental illness,[185] or they may wish to avoid psychiatric hospitalization.[186] The inability of a patient to admit he is ill, even to himself, may be understandable for these reasons. Indeed, physically ill people commonly deny the severity of their illness, and there is evidence that some do better for it.[187] Many psychiatrists and psychologists consider denial one of the most common and adaptive of defenses.[188]

Finally, it is how patients feel—and react to those feelings—that is most relevant to a decision about treatment;[189] whether the feelings and thoughts are labelled "mentally ill" is at best secondary. Thus, many patients admit to disturbing or painful symptoms even as they deny that they are ill; for example, a patient may admit to feeling restless or agitated, but deny that she suffers from a mental illness. These patients arguably have sufficient reason to accept treatment. Their refusal may simply express a legitimate preference for the symptoms over the cure. Even some patients who deny their symptoms may be saying merely that they are not suffering—and on this, surely, it is they who are

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185. *See, e.g.*, Vitek v. Jones, 445 U.S. 480, 488 (1980) (characterization as mentally ill and transfer to mental hospital had stigmatizing consequences); *see also In re* Appeal in Pima County, 146 Ariz. 435, 437, 706 P.2d 761, 763 (Ariz. Ct. App. 1985) (mental illness stigmatizing); People v. Burnick, 14 Cal. 3d 306, 321, 535 P.2d 352, 362, 121 Cal. Rptr. 488, 498 (1975) (same); *In re* G. Kossow, 393 A.2d 97, 104 (D.C. 1978) (same).

186. In the related context of refusing an insanity defense, the court, in Frendak v. United States, 408 A.2d 364 (D.C. 1979), noted several reasonable grounds a defendant may have for refusing the defense: he may fear a longer confinement in a mental hospital than prison; he may object to the quality of treatment or type of confinement in a mental institution; he may choose to avoid the stigma of insanity; he may dislike the collateral consequences which might follow an insanity acquittal; or, finally,

> a defendant also may oppose the imposition of an insanity defense because he or she views the crime as a political or religious protest which a finding of insanity would denigrate.... In any event, a defendant may choose to forego the defense because of a feeling that he or she is not insane, or that raising the defense would be equivalent to an admission of guilt.

Id. at 376-77. The last is especially interesting, in suggesting that a feeling that one is not insane may be sufficient for a decision not to raise the defense. As the court noted in this case, the defendant maintained that the "CIA framed her for [the victim's] murder as part of a plot, [and] may feel that a finding of insanity would make a lie of the defense that she vigorously and sincerely asserted." *Id.* at 377 n.22. Because the defendant here was probably delusional about the event, the idea may be that a false belief about one's sanity does not amount to a breakdown of reason sufficient to vitiate one's decision. But see the court's later footnote claiming that "[o]ne factor which could impede a defendant's ability to make an intelligent choice would be the inability of one who is currently mentally ill to recognize his or her present condition." *Id.* at 380 n.29. The inconsistency is confusing. Note in any case that such defendants are found competent to stand trial, but may fail to meet the higher "knowing and intelligent" standard.

For further such cases on refusing pleas, see, *e.g.*, State v. Khan, 175 N.J. Super. 72, 417 A.2d 585 (1980) (defendant steadfastly maintained he acted in self-defense and was not insane, despite strong evidence of insanity); State v. Lafferty, 749 P.2d 1239, 1250 (Utah 1988) (defendant may refuse a plea because of belief it would be admission of guilt), *aff'd*, 776 P.2d 631 (Utah 1989).

187. *See, e.g.*, COMPREHENSIVE TEXTBOOK, *supra* note 99, at 1280; Abernethy, *supra* note 1, at 57; Hackett & Cassem, *Development of a Quantitative Rating Scale to Assess Denial*, 18 J. PSYCHOSOMATIC RES. 93, 93-94 (1974).

188. *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III-R 393 (3d ed. rev. 1987) [hereinafter DSM-III-R]; Hackett & Cassem, *supra* note 187, at 93. On denial generally, see, *e.g.*, COMPREHENSIVE TEXTBOOK, *supra* note 99, at 389; A. NICHOLI, *supra* note 71, at 217-218.

189. By contrast, with physical illnesses, patients' feelings may be secondary: gangrene will have serious physical consequences quite apart from how bad the patient feels, while mental illnesses are constituted in large part by how the patient feels.

the final authorities. Indeed, denial in general may be the patient's way of saying that she, who knows her state of mind better than anyone else, is satisfied with the way she is and does not want to change with the help of psychotropic agents. The person herself is in the best position to know what state of mind satisfies her. Taking this position does not demonstrate a severe breakdown of reason, but rather represents a value choice.

This Article has argued that denying illness does not involve a patent distortion of reality, so that denial does not justify a finding of incompetency. A critic may now respond, however, that denial of illness may evidence a kind of overarching "delusion" that all of one's crazy beliefs are true and are not a product of mental illness. If a patient's belief, for instance, that he has killed millions of people (Belief M) indicates a patent breakdown of reason, why does not the very belief that Belief M is true, that is, not a product of mental illness, also indicate a patent breakdown of reason? If so, the critic argues, belief in any delusion will indicate a sufficient breakdown of reason on whether one is ill to render a refusal of medication incompetent.

This argument is flawed, however, because Belief M does not indicate a patent breakdown of reason concerning whether one is ill, but only concerning whether one is a murderer. If Belief M is true, its truth is not substantive evidence of mental health, the way it is of badness; killing millions shows that one is a bad person, but not that one is a mentally healthy person. At best, the truth of Belief M may be thought of as procedural evidence of mental health, in the sense that if one has followed adequate procedures in acquiring the belief, it is less likely that one is mentally ill. By contrast, the statement that is substantive evidence on the issue of mental health is that Belief M is reliable (or, again, not a product of mental illness). But this assertion does not reflect as severe a breakdown of reason as does Belief M. For instance, one has some evidence for the reliability of the belief in the fact that one's beliefs are usually reliable, one's senses usually sound. Because a breakdown of reason must concern a material element of the decision at hand, then, and because belief in any delusion does not indicate a sufficient breakdown of reason concerning whether one is ill, such a belief does not render one incompetent to make treatment decisions.

Nevertheless, there are beliefs about one's illness that ought to vitiate treatment decisions. For instance, if a person denied not only that he was ill or suffering, but also that he was manifesting grossly demonstrable physical symptoms (for example, that he was frenetically pacing or not sleeping), then he would be evidencing a severe breakdown of reason. Of course the denial must be related to the refusal to render the refusal incompetent—the patient must be willing to take medication if he believes he is agitated or insomniac. Similarly, if a patient refused treatment on the ground that his suffering was necessary to save civilization, or that he was properly inhabited by malevolent spirits because he had slept with the devil, then his decision to refuse medication appropriately would be found incompetent: his belief about his mental state would grossly distort reality.

Ordinary denial of illness, however, must not give rise to a finding of incom-

petency. Even in cases in which the patient would accept medication if he thought he were ill, diagnoses of mental illness are simply not certain enough that patients must accept them. The opposing view is in fact fraught with danger. Not only would it permit us to force treatment on an obsessive-compulsive person who denies that he is ill—and who among us does not have some maladaptive personality traits?[190]—but it would also allow us to characterize political dissidents as ill. It would then be possible to use their understandable denial that they are ill as a basis for their involuntary treatment, despite the fact that such denial is to be expected. If all of this is so, denial of illness simply should not give rise to a finding of incompetency.

To summarize, the doctrine of delusions as developed in testamentary cases demonstrates how a coherent concept of treatment competency would handle certain recurrent reasons for refusing medication. Patent delusions concerning the treatment, for instance, the patient's belief that the medication will poison her, are sufficient to vitiate refusal. Other less patently false beliefs, such as the patient's belief that he is not mentally ill, ordinarily should not vitiate refusal. These conclusions are firmly grounded in both doctrine and philosophy.

V. An Objection to Analogizing From Other Areas of Competency: The "Different Levels" Thesis

Some of these controversial conclusions about the nature of treatment competency derive from other competency areas, particularly the area of testamentary capacity. A critic may contend, however, that analogizing from one competency area to another is illegitimate. In particular, one area of decisionmaking may require more or less competency than another. That decisions relating to wills require only a low level of competency[191] does not mean that decisions relating to treatment should require nothing more. Indeed, the critic counters, the idea that different kinds of decisions require different levels of competency appears to originate in the law, for standard wills doctrine says that the level of competency required for making a will is *less* than the level required for making a contract.[192] If analogizing from one competency area to another is illegitimate, the entire project of this Article is flawed.

The meaning of the "different levels" thesis, as we shall use the term, is clear enough. The "different levels" thesis requires "more" understanding for competency to make more important decisions. A person is to have "more understanding" not in the sense that she is to understand something more difficult to understand, but rather in the sense that she is to understand better something equally difficult to understand.[193] Requiring more or less ability for a task is common in the first sense, but not in the second. For example, seeing a stop sign

190. *See, e.g.*, T. Detre & H. Jarecki, Modern Psychiatric Treatment 243-46 (1971); A. Nicholi, *supra* note 71, at 337.

191. One's competency may be less either because one comprehends less or because one's beliefs are more distorted.

192. *See infra* text accompanying notes 195-205 (discussing the possibile interpretations of the "different levels" thesis).

193. "More understanding" could require, in the competency context, that one meet one of the

is easier than seeing a letter on a blackboard, but we require roughly the same degree of ability to make out an item before we say a person can see it. Similarly, speaking Spanish is easier than speaking Greek and roughly as easy as speaking Italian, but we do not require a person's Spanish accent to be better than her Italian accent before we agree that she is able to speak Spanish.

The languages analogy also provides an example of the second sense of "different levels"—the notion that one's ability to do an equally difficult task must be greater in one context than in another. We say of an interpreter that she speaks Spanish only if she speaks the language fluently, while we say the same of an ordinary person if she can make herself understood a reasonable amount of the time—even if they are translating the very same, equally complex sentences. The key point is that we require greater ability in the one context than in the other because of the consequences of exercising the skill well or badly. An interpreter must speak the language better because her job is to serve as a bridge between people who cannot communicate, and mistranslation can have serious consequences. The "different levels" thesis makes the same point: when one class of decisions has more significant consequences than another, one must have greater competency to make decisions in that class. In particular, treatment decisions require a high level of ability because these decisions are often so consequential.

It will be clear that the "different levels" thesis is distinct from, and more controversial than, the long-accepted thesis that the level of competency for a task may vary depending on the difficulty of the task. Because some tasks plainly are more difficult than others—and because some require different, sometimes more complex abilities[194]—single, all-encompassing findings of incompetency are inappropriate. This Article does not question that view, but questions only the view that different competency areas, to the extent that they do require understanding, may require different levels of understanding depending solely on the importance of the task.

The testamentary doctrine probably should not be interpreted in the controversial sense to mean that, given an equally complex will and contract, less understanding is required to make the will. The doctrine, while it has a long history, is by no means uniformly held. Some cases actually deny that making a will requires less ability than making a contract.[195] Moreover, some cases imply that a "same level" doctrine is at work in their jurisdiction by citing wills cases in opinions addressing contractual capacity.[196]

In cases that do adhere to the "different levels" doctrine, its import is far from clear. Most cases that recite the doctrine give no indication of what it

higher competency standards, such as the naive "understanding and belief" view or the "full reasoning" view.

194. For instance, competency to stand trial may require the ability to consult with one's lawyer, and competency to contract may require the ability to negotiate.

195. *See, e.g.*, Bach v. Hudson, 596 S.W.2d 673, 675-76 (Tex. Civ. App. 1980).

196. *See, e.g.*, Ebrite v. Brookhyser, 219 Ark. 676, 679, 244 S.W.2d 625, 627 (1951); Taylor v. Avi, 272 Pa. Super. 291, 298, 415 A.2d 894, 897 (1979).

means, or why it should be held.[197] Some opinions that do address these questions indicate that making wills requires less ability than engaging in more complex transactions,[198] or less ability than conducting business in general.[199] To the extent that the capacity to transact ordinary business implicates *general* competency,[200] it is clear why it requires a higher level of ability.

Although some cases compare the making of wills with the general task of making contracts rather than the special contractual activities noted above, these cases may be interpreted in a nonproblematic fashion. Contracts tend to be more complex than wills, and therefore are more difficult to understand.[201] Other cases suggest that contracting involves abilities in addition to those involved in making wills, for example, the ability to protect one's interests in the bargaining process.[202] Alexander Meiklejohn has proposed that courts may perceive testation as requiring less ability because the relational skills that wills implicate are more fundamental—acquired earlier—than the skills that doing business requires.[203] Once again, a different ability is the focus rather than a different level of the same ability.

Yet the "different levels" doctrine poses a challenge to our analogy only if wills cases and contract cases require different levels of the same skill. If that is the meaning of the doctrine, then one may argue that the level of understanding required for treatment decisions should indeed be set higher than that required for will-making. While some cases contain language suggestive of this interpretation in the wills or contract sphere, none provides strong authority for it.[204] In short, the support for the problematic interpretation of the testamentary "levels" doctrine is by no means firm, and no case actually explains the doctrine

197. *See, e.g.*, McPheters v. Hapke, 94 Idaho 744, 745-46, 497 P.2d 1045, 1046-47 (1972); *In re* Estate of Faris, 159 N.W.2d 417, 420 (Iowa 1968); Dunham v. Holmes, 225 Mass. 68, 71, 113 N.E. 845, 847 (1916).

198. *See, e.g., In re* Estate of Head, 94 N.M. 656, 659, 615 P.2d 271, 274 (N.M. Ct. App.), *cert. denied*, 94 N.M. 675, 615 P.2d 992 (1980).

199. *See, e.g., Faris*, 159 N.W.2d at 420; *In re* Estate of Richards, 5 Utah 2d 106, 116, 297 P.2d 542, 548, *cert. denied*, 352 U.S. 943 (1956).

200. "General competency" is the competency whose absence leads to guardianship. A person is generally incompetent if he cannot perform a wide variety of tasks. The court will appoint a "guardian of the estate" if he cannot perform a wide variety of tasks relating to his property. A "guardian of the person" is appointed if the incompetent person cannot make a wide variety of personal decisions regarding such essentials as food, clothing, and shelter. *See, e.g.*, T. Grisso, *supra* note 31, at 270-72.

201. *See, e.g., Head*, 94 N.M. at 659, 615 P.2d at 274. In the same vein, other cases note that there is a sliding scale of capacity required to form a contract depending on the degree of complexity of the transaction. *See, e.g.*, Golleher v. Horton, 148 Ariz. 537, 540, 715 P.2d 1225, 1228 (1985); Smalley v. Baker, 262 Cal. App. 2d 824, 832, 69 Cal. Rptr. 521, 527 (1968).

202. *See, e.g.*, McAllister v. Schettler, 521 A.2d 617, 621 (Del. Ch. 1986); *In re* Estate of ACN, 133 Misc. 2d 1043, 1047, 509 N.Y.S. 2d 966, 970 (1986).

203. *See* Meiklejohn, *Contractual and Donative Capacity*, 39 CASE W. RES. L. REV. 307 (1988-89).

204. *See, e.g.*, McPheters v. Hapke, 94 Idaho 744, 746, 497 P.2d 1045, 1047 (1972) (executor's challenge of contract can properly coexist with his acceptance of will; case gives no indication that subject was in same mental state during different times of execution); Schwarz v. Taeger, 44 Idaho 625, 631, 258 P. 1082, 1084 (1927) (court speaks of the testator's "dark" understanding, yet in the next breath says he must show "full" understanding); Dunham v. Holmes, 225 Mass. 68, 71, 113 N.E. 845, 847 (1916) (court says in dictum that level of understanding which compels it to overturn contract would suffice for will).

in the problematic way.[205]

Even if the wills or contract doctrine fails to support the "different levels" thesis, the thesis may seem attractive on its own; perhaps one should be required to have more competency to make a more important decision. Yet the thesis cannot withstand careful scrutiny. Observe, first, that the term "competency" itself does not suggest varying degrees of ability in different contexts, but rather a single level of ability in all contexts. Compare the term "negligence."[206] There may be policy reasons for requiring more or less than reasonable care in specific contexts, but we do not say someone is "negligent" who fails to meet a high standard of care; and we say someone is not merely "negligent," but rather "grossly negligent," who fails to meet a low standard of care. Unless we are to change the meaning of the word "competency" by fiat, we should not use "competent" to refer to each of a variety of levels of ability. That courts *do* talk of competency in medication contexts suggests that medical decisionmaking, in law, does not require a higher level of competency than do other tasks.

Indeed, the very idea of varying the level of competency on the basis of the importance of the competency area is unsound. All competency areas encompass decisions ranging from very important to trivial, so that ranking competency areas as generally more or less consequential is extremely difficult. For example, a medical decision may prevent the immediate death of a young, otherwise healthy person, or it may provide relief from a minor headache. A will may dispose of the vast estate of a person whose family is in dire need, or the small estate of a person who has one wealthy, remote relative. A decision relating to trial tactics may lead to either the death penalty or a day in jail. Because of this range of decisions in each area, to say that will-making as an area is less important than other competency areas—in particular, than the area of treatment choice—is impermissible, even though will-making involves interests of people other than the testator (he may care for them more than for himself, as it were), and even though it involves only property. The plain fact is that we cannot decide whether liberty, health, or property is more important without knowing

205. A similar doctrine occurs in the criminal context: that pleading guilty requires more competency than standing trial. *See, e.g.*, Chavez v. United States, 641 F.2d 1253, 1259 (9th Cir. 1981); United States v. Masthers, 539 F.2d 721, 725-26 (D.C. Cir. 1976); Seiling v. Eyman, 478 F.2d 211, 213 (9th Cir. 1973). This doctrine must be interpreted in the way most critical for our thesis, namely, that one must understand better or more when pleading guilty than when standing trial generally. The theory is similar to the "different levels" theory, that is, that pleading guilty is more important than other decisions involved in standing trial because one gives up many constitutional rights with the decision. *See, e.g.*, Myers v. Manson, 192 Conn. 383, 390-91, 472 A.2d 759, 764 (1984). The doctrine is relatively recent, is confined to a few states, *id.*, and has been criticized because it permits a defendant to go forward, only to tie his hands on this most important issue. *See, e.g.*, Note, *Competence to Plead Guilty: A New Standard*, 1974 DUKE L.J. 149, 170.

Yet varying the levels of competency based on importance may still make little sense. We may be able to rationalize the "different levels" doctrine in the criminal sphere not on this basis, but on the basis that one needs little ability to stand trial (and the normal ability to plead guilty), because in the former it is one's lawyer's capacities that are generally most critical. If so, it is not the importance of the decisions that is decisive, but the real abilities necessary to make them.

206. Negligence is also similar to competence in that different contexts may require greater or lesser precautions than others, just as different competency areas may involve decisions which are more or less difficult to understand. But one does not have to take greater *care* in one negligence context than another to be said to be nonnegligent.

how much of each, and with what further consequences: an abstract ranking is simply not possible.

In response to this concern, one approach that commentators on medical competency frequently recommend is for the evaluator to vary the requisite level of competency depending on the importance of each decision.[207] According to this view, when a treatment has substantial benefits, the patient needs only a low level of competency to consent, but a high level to refuse. When the treatment has substantial negative effects, the patient needs a low level to refuse and a high level to consent.[208] Thus the view treats "good" decisions as inconsequential and "bad" decisions as consequential, and, by raising the level of competency for "bad" decisions, would protect those who would harm themselves. The critical problem is, who is to define harm? In fact, this view thoroughly undermines competency doctrine by allowing the evaluator to make an assessment that the doctrine vouchsafes to the patient himself—what is a good or bad decision—and then to limit his liberty on the basis of the expert's personal values. The view, in short, is at odds with a fundamental purpose of competency doctrine.[209]

One may remedy this glaring problem to some extent by saying that a consequential decision is one with potentially serious consequences,[210] for then the evaluator does not prejudge which individual decision is correct. But the remedy is inadequate, because it too deprives the patient of the right to make his own decisions—in this case, decisions about what is important. Indeed, even the original suggestion that importance should attach to areas of competency, while it does limit the power of individual evaluators, permits courts to make the kinds of value judgments about decisions that the doctrine of competency reserves for the decisionmaker herself. All versions of this view are simply self-defeating.

One might argue that competency doctrine itself balances liberty and well-being, so that striking the balance somewhat differently when well-being is potentially at serious risk is not so very anomalous. Competency doctrine judges

207. *See, e.g.*, PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 17, at 60; S. SMITH & R. MEYER, *supra* note 31, at 664; Drane, *Competency to Give an Informed Consent: A Model for Making Clinical Assessments*, 252 J. A.M.A. 778 (1985); Roth, Meisel & Lidz, *supra* note 15, at 283; Schwartz & Blank, *Shifting Competency During Hospitalization: A Model for Informed Consent Decisions*, 37 HOSP. & COMMUNITY PSYCHIATRY 1256, 1256-57 (1986); Silva, *Assessing Competency for Informed Consent with Mentally Retarded Minors*, 10 PEDIATRIC NURSING 261, 263 (1984).

208. Refusal will generally seem harmful because doctors generally do not offer substantially harmful treatments. *But cf.* Kaimowitz v. Michigan Dept. of Mental Health, No. 73-19434-AW (Cir. Ct. Wayne County, Mich. July 10, 1973), *reprinted in* A. BROOKS, LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM 902-21 (1974) (doctors offered institutionalized patient hope of release if experimental psychosurgery proved effective). The fact that the competency of consenting patients is usually not assessed has led some to suggest that a "different levels" thesis informs practice today. A better explanation is that accepting consent to routine or obviously beneficial treatment without question is sensible, because the overwhelming likelihood is that treatment will be approved as the most appropriate course if the patient is found incompetent; hence the finding is of no practical significance.

209. Whether evaluators are skilled enough to make fine distinctions in degrees of competency is another concern.

210. A decision with potentially serious consequences would be a decision that may produce either very positive or very negative consequences. In either case, this view would require a high level of competency either to refuse or to accept.

that freedom generally does not impair people's well-being, and so sets competency at a low level. To raise the level of competency when the effect of choices on well-being is potentially very consequential is to make exactly the same kind of judgment. If the one is legitimate, so is the other.

This argument is unpersuasive, however. That competency doctrine results from a basic value judgment does not mean it permits further value judgments. For the doctrine asks us precisely to entrust all further value judgments to individual decisionmakers because they are the best judges of their own interests. If freedom to choose is thus the prime value, restricting it on the basis of one's own conception of the good simply makes no sense.[211] This remains true even though the doctrine prohibiting this restriction thereby imposes its own conception of the good.

We should be clear that competency doctrine does depend, not simply on a value judgment, but on a value judgment of the exact kind upon which the "different levels" doctrine depends. The doctrine says that freedom is valuable in part because it promotes well-being, and so holds itself out as able to measure well-being. Yet while one cannot in effect say that the individual is the best decisionmaker without setting oneself up as judge of his decisions, competency doctrine escapes this conundrum far better than the "different levels" doctrine for two reasons. First, its preference for the individual decisionmaker is based on antecedent, theoretical considerations (individuals know themselves best and care about themselves most), rather than on actual empirical assessments of decisions. By contrast, the "different levels" doctrine looks at the decisions themselves to judge their worth and importance. Second, competency doctrine's answer to the conundrum is most consistent with the view that individuals themselves should decide on the worth of decisions; it gives them maximal freedom to decide. The "different levels" doctrine, by contrast, further limits individual freedom on the basis of its adherents' own conception of the good, and so deepens the conflict with competency doctrine. As we have seen, any judgment besides the meta-judgment that individuals should have maximal freedom to decide directly clashes with competency doctrine.

Indeed, if varying the level of competency based on the importance of decisions made sense, a competency theorist might urge us to lower the level of competency for potentially consequential decisions. Because people care more about more consequential decisions, we arguably should permit them to choose what they will have to live with. Moreover, taking away consequential decisions may entail a greater assault on individual dignity. For example, telling a person that he may decide what kind of ice cream to have, but that he may not decide where to live, is likely to injure his self-esteem more seriously. Such a theory, indeed, seems already to inform some areas of the law. For example, some states permit minors to accept or to reject psychiatric treatment without regard to

211. Varying the competency level because of someone *else's* values conflicts much more with competency doctrine—and its charter to protect individual dignity and autonomy—than simply randomly raising and lowering the level. While the latter does inhibit freedom, it does not tell the decisionmaker someone else knows better than he what is good for him.

their competency, presumably because the decision is so important.[212] In short, if varying levels of competency is acceptable at all, lowering the level of competency for crucial decisions would be most in the spirit of competency doctrine.

Notwithstanding the popularity of the idea, then, raising the level of competency for important decisions is simply unsound, because it impermissibly encroaches on the decisionmaker's freedom to evaluate the worth and importance of decisions for herself. Analogizing from one area of competency to another is legitimate. Our conclusions about patients' competency to refuse medication must stand.

VI. CONCLUSION

Among a variety of competency standards, the law's standard provides the most sophisticated response to several important philosophical problems. It ensures that patients have certain basic skills necessary for decisionmaking without encroaching too much on the expression of personal values and beliefs or so inevitably implicating irrationality that too many are found incompetent. Competing standards either inadequately equip patients for decisionmaking—as by failing to require an ability to assess evidence—or require an intactness of the reasoning process that few possess. The law's standard, by contrast, nicely balances the goals of the abilities, unconventionality, and irrationality criteria.

In testamentary capacity cases, the law's standard has a long and well-developed history. Most importantly, wills cases present a clearly articulated concept of a delusion—a concept that is especially valuable in both the testamentary context and the treatment context. Both contexts, for example, call for decisions about matters that are likely to give rise to delusions in those who are vulnerable. The wills cases elaborate the concept of a delusion as a belief supported by no evidence, and some clear trends emerge. For instance, courts rarely find beliefs about others' feelings to be delusions, while they do find beliefs that are "impossible in the nature of things" to be so. Most importantly, the courts protect even mean and suspicious beliefs so long as they have some basis in the evidence, however weak.

This Article has formulated a philosophically sophisticated concept of treatment competency that is consistent with settled law. Assessing some standard suspect reasons psychiatric patients give for refusing treatment in light of the law's well-developed concept of a delusion, the Article concludes that even patients who deny they are ill, or believe they are bad and deserve to suffer, are

212. *See, e.g.*, ALA. CODE § 22-8-3 (1984); CAL. CIV. CODE § 25.9 (West Supp. 1991); MD. HEALTH-GEN. CODE ANN. § 20-104 (1990); MASS. GEN. L. ch. 112, § 12E (1985) (drug treatment).

Contraceptive and abortion decisions are similar. In the case of the latter, the law asks if the minor is mature enough to make the decision, a kind of competency inquiry. *See, e.g.*, FLA. STAT. ANN. § 390.001(4)(a)(1) (West Supp. 1990) (abortion); ILL. ANN. STAT. ch. 38, para. 81-65(d)(i) (Smith-Hurd Supp. 1990) (waiver of parental notification of abortion); KY. REV. STAT. ANN. § 311.732(4)(a) (Michie/Bobbs-Merrill Supp. 1990) (abortion); MO. REV. STAT. § 188.028(2)(1) (Vernon Supp. 1986) (abortion); *see also* Bellotti v. Baird, 443 U.S. 622 (1979) (abortion); Planned Parenthood Ass'n v. Matheson, 582 F. Supp. 1001 (D. Utah 1983) (contraception). Nevertheless, the conclusive presumption of incompetency has been changed, presumably because the decision is so important.

competent to refuse treatment. So, too, are patients who suspect their doctors' motives. By contrast, patients who believe they are suffering to save the world or have killed millions and therefore deserve not to get better do have delusional beliefs—beliefs that are supported by no evidence—and are therefore incompetent. The "different levels" thesis—which questioned the analogy between testamentary capacity and treatment capacity—is unpersuasive because it impermissibly substitutes the evaluator's judgment about the importance of decisions for the decisionmaker's.

The concept of treatment competency advocated in this Article has both philosophical and doctrinal support. Yet the concept will make little sense to one who willingly concedes that the law's standard protects and preserves autonomy, yet rejects the very assertion that autonomy is a worthwhile end in and of itself. Indeed, it may be argued, our society's esteem for this value rests on a vision of people as atomistic and isolated—islands unto themselves. In that vision, rugged individualism is valued at the expense of our relatedness to others. Since psychiatric patients are especially vulnerable to the ravages of isolation,[213] a doctrine that supports and underscores their aloneness may make little sense. But this objection underestimates the humiliation and degradation that adults suffer when their decisions about themselves are not honored. A low level of competency spares a patient the indignity of being the "instrument of . . . other [people's] acts of will."[214] It requires doctors to converse with patients as adults, and so nurtures a meaningful relationship between them—one founded on mutual respect. Protecting people's power to decide may promote not increased isolation, but rather improved conversation and relatedness.[215]

213. *See, e.g.*, G. BALIS, L. WURMSER & E. MCDANIEL, *supra* note 179, at 362; DSM-III-R, *supra* note 188, at 189, 339, 341, 351-52; H. KAPLAN & B. SADOCK, SYNOPSIS, *supra* note 180, at 253.

214. *See* PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 17, at 45 (quoting Berlin, *Two Concepts of Liberty*, in I. BERLIN, FOUR ESSAYS ON LIBERTY 131 (1969)).

215. For a critique of rights as emphasizing autonomous individualism rather than communal values, see, e.g., A. MACINTYRE, AFTER VIRTUE (1981); R. RORTY, PHILOSOPHY AND THE MIRROR OF NATURE (1979); R. UNGER, KNOWLEDGE AND POLITICS (1975); Minow, *"Forming Underneath Everything that Grows": Toward a History of Family Law*, 1985 WIS. L. REV. 819. *See also* Minow, *Interpreting Rights: An Essay for Robert Cover*, 96 YALE L.J. 1860, 1865 n.15 (1987) (attempt to reinterpret rights "to embody a richer conception of human interdependence").