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MEDICAL TREATMENT DECISIONS AND COMPETENCY IN THE EYES OF THE LAW: A BRIEF SURVEY[1]

The question of mental competence arises in many different areas of the law. In order to make contracts and wills, have criminal responsibility, be a witness, or stand trial, a person must be mentally competent. Obviously, however, not every degree of mental deficiency or peculiarity is legally significant. Moreover, there is no single test of competence for these various contexts; rather, competency is defined in different ways for different purposes [56]. As a result, and somewhat paradoxically, a person can be legally incompetent in some areas while remaining legally competent in others. For example, since the law requires a lower degree of capacity in the making of wills than it does for the execution of contracts, one may be competent to make a will but incompetent to transact ordinary business affairs.

The law has only recently begun to be concerned with determining the competency of patients to make decisions concerning their medical treatment.[2] The tests used by courts to determine competency in this new context mirror those used to determine the capacity to contract [38]. This has likely occurred because, except in certain emergencies, the law does not allow nonconsensual medical treatment. (See, e.g., [4], [8], [23], [41], [51], [53]) A doctor must, in certain respects, enter into a contract with a patient in order to diagnose and treat him ([36], [65]). In order to explore the use of legal competency as a condition of making treatment decisions, we must therefore trace the development of the notion of competency in contract law.

I. COMPETENCY TO CONTRACT

It has long been a principle of the common law that contractual obligations can be assumed only by free and intelligent consent ([48], [42]). Traditionally, therefore, an incompetent person who was incapable of giving such consent could not form a valid contract ([42], [46]). This view prevailed in the United States well into the nineteenth century. An incompetent person, having "nothing which the law recognizes as a

Mary Ann Gardell Cutter and Earl E. Shelp (eds.), Competency, 149—164.

mind", could not in principle make a contract, for this required the assent of two minds ([7], [42]). He simply did not have mind enough for the "meeting of the minds" required to contract. As a result, the mental incompetency of one of the parties made a contract entirely void ([30]; [43], p. 496).

A more recent view has been that incompetents require protection from their own actions.[3] Thus, rather than being void, their contracts are 'voidable' ([43], p. 497). The contract is voidable at the election of the incompetent or, more likely, his personal representative, but recission will be denied if the other party to the contract was, at the time of the contact, ignorant of the incompetence and the *status quo* cannot be restored. The interests of those who deal with the disabled person and who are unaware of the disability are thereby given some measure of protection [43]. But, also in contrast to earlier law, it is nonetheless possible for the incompetent party to enforce a transaction that has proved advantageous to him.

The test most frequently used to assess a person's competency to contract is what has become known as the 'understanding test' [57]. Although the phraseology varies among and within jurisdictions,[4] the common element is a focus on the person's ability to understand and appreciate the nature and consequences of the act or transaction in which he is engaged [40]. It is crucial that the person understand the nature and effect of the particular act or transaction that is challenged [45]. This helps explain why there are different standards of competency for different legal contexts. The test itself need not vary, just its application. Since some contexts are simpler than others, the capacity needed to understand their nature and consequences differs appropriately.

The understanding test for competency to contract is perhaps better approached by looking at what does *not* constitute incompetency. Proof of mental weakness or even of insanity are not in themselves enough to show incompetency; rather, the disorder must be shown actually to have destroyed the capacity to understand the questioned transaction [3], [47]. Other factors that alone have been held to be insufficient to prove incompetency include *senile dementia,* old age, the influence of drugs, physical distress and pain, and commitment (([57], p. 1032) and the cases noted there). None of these is sufficient because with each it is sometimes possible for the afflicted person to have 'lucid intervals' during which he does have the requisite capacity to contract (e.g., [3], [33]). The key is twofold. In order to render someone

incompetent, a mental disorder must be significant enough to have made the person incapable of having understood the situation and it must in fact have impaired the person's capacity to understand the particular transaction in question.

In addition to the 'understanding test' of incompetency to contract, there is what has been referred to as the 'insane delusion' test. An insane delusion, the belief in the reality of facts that do not exist and in which no rational person would believe, can lead to the avoidance of a contract if the delusion is deemed to be sufficiently related to the contract's subject matter [45]. A delusion will not, however, affect the validity of a contract if it concerns a matter that is not connected with the transaction itself. The question then becomes whether the contract was *motivated* by the delusion [45].[5]

There is some support for the view that the insane delusion test is a distinct and sufficient test of contractual incompetence. The claim is that a person who understands what he is doing but who is motivated by a deluded belief is as much in need of protection as one who cannot understand what he is doing [57]. This rationale uses the term 'understanding' in a limited sense. Alternatively, an insane delusion may be viewed as a species of failure to understand. On this view, the test is merely one of the ways in which the understanding test may be applied ([51], [38]).

A more recent trend in assessing competency to contract focuses on a person's ability to control his actions in relation to the transaction. Thus, "[i]ncompetence to contract also exists when a contract is entered into under the compulsion of a mental disease or disorder but for which the contract would not have been made" [9]. While this view found some support in dicta in the 1950s (see [57]), it was first articulated by a court in 1963 in *Farber v. Sweet Style Manufacturing Corp.* [9]. In this case, a contract made by a manic-depressive was voided where the illness was recognized as affecting his motivation but not his ability to understand. This test now finds support in the *Restatement (Second) of Contracts.* A person is incompetent to contract if, among other things, "he is unable to act in a reasonable manner in relation to the transaction" (Section 15) [37].

The "ability to control one's actions test" is thought to be important because the understanding and insane delusion tests "fail to account for one who by reason of his mental illness is unable to control his conduct even though his cognitive ability seems unimpaired" [26].

For a long time, the only competency to contract tests articulated by courts were versions of the understanding test or the insane delusion test (however conceived). Milton Green, a leading commentator on mental incompetency in the law, noted, however, that in many cases the articulated standard was being ignored and an unarticulated one was being followed [47]. He found, not surprisingly, that courts, rather than focusing on whether the alleged incompetent could understand, often directed their attention to ascertaining whether the transaction itself turned out to be a fair one. They would test the competency of the person only after finding that it had not. Green felt that this 'inarticulate standard[1] was the actual rationale for the results in many difficult cases where the understanding test could not be easily applied.

Green's 'inarticulate standard' has since been articulated by a number of courts. For example, in *Ortelere v. Teachers' Retirement Board,* a 1969 New York case, a contract was voided where the choice made by the person judged incompetent was felt to be "so unwise and foolhardy that a factfinder might conclude that it was explainable only as a product of psychosis" [26]. *Krasner v. Berk,* a 1974 Massachusetts case, was also very candid in its use of objective tests of overall fairness [18]. This case was a very close one on sufficiency of understanding; there was evidence that showed *some* understanding of the terms of the agreement. The court stated that in such a case the controlling consideration should be "whether the transaction *in its result* is one which a reasonably competent person might have made"[6] (emphasis supplied). Thus the court based its finding on the actual outcome of the transaction, not on whether the alleged incompetent actually understood its nature and consequences.

In contracts, as well as in other areas, the law starts with a presumption of competency [11]. The burden of proof in competency proceedings is therefore on the party alleging incompetence. In a proceeding for the appointment of a guardian, for example, the burden is on the petitioner to prove that the alleged ward is incompetent [34]. In a case seeking to avoid a contract, the burden of persuasion is on the person who asserts incapacity to contract [57].

The question of legal competency is viewed as a question of fact to be determined from the circumstances of each individual case [10]. This is consistent both with the idea that the competency determination tests an individual's understanding of the nature and likely consequences of a *particular transaction,* and with the idea that it can test the beliefs that

motivated him in the transaction. Only by looking at the facts surrounding each individual case can either determination be made. The question is thus ultimately determined by the trier of fact — either a judge or jury. The testimony of psychiatrists will not be decisive, for the central focus on one transaction is not the ordinary one in the course of diagnosis and treatment (|43], p. 503). By focusing on competency as a question of fact, the law also recognizes that a person can be competent in some areas but incompetent in others, or that a person's competency can change from day to day even within one context [38].

Many of the competency issues raised in the contact of contract law carry over into the area of medical care decision-making. Against this backdrop, we shall now explore how the notion has developed there.

II. COMPETENCY TO MAKE MEDICAL CARE DECISIONS

The importance of competency in the medical treatment area derives from the common law notion of consent. An often-quoted passage from a 1914 case sets forth the principle that "[ejvery human being of adult years and sound mind has a right to determine what shall be done with his own body" (28]. A physician who treats a patient without consent is viewed as committing a battery — an intentional interference with a person without his or her consent [49]. More recently, the law has gone further and required not only that consent be obtained, but that it be *informed.* To comply with the requirements of informed consent, a physician must give a patient all of the information that might reasonably influence his decision, including information about his condition, the risks and benefits of the proposed treatment, and its alternatives [49].

There are only a few exceptions to the requirement that a physician obtain the patient's informed consent before he begins to treat him. A doctor need not obtain consent in an emergency situation and in unusual circumstances the doctor may withhold information from a patient if he thinks that the information itself would harm the patient [57]. Additionally, and most importantly for our present purposes, the informed consent requirement is excepted when the patient is not competent; an incompetent patient lacks the capacity to give valid consent.

When a patient is not competent, the physician must obtain consent to treat him from someone else. The patient's right to make his own

treatment decisions is transferred to another person (or to a court or to an institutional review board [38], and the patient may well be treated against his expressed desires.[7] Thus the competency determination is crucial.

It is not surprising, given the similarities between the patient-physician relationship and a contractual one, that the usual test for determining competency to make treatment decisions has turned out to be the same as that usually used to determine competency to contract — whether the person can understand and appreciate the nature and consequences of his actions [22]. While, as for contracts, this standard has been criticized as being vague [44] and overly general [55],[8] it is given meaning by the specific context in which it is used. Here, once again, the key question is whether the person understands the nature and effect of the *particular* transaction being contemplated. Does the patient understand the treatment decision with which he is faced? Just as the capacity needed to make a simple will is lower than that needed to make a complex contract, so is the capacity standard lower for treatment decisions that are fairly straightforward and involve little risk [61]. Accordingly, the most stringent competency standards are found in the area of experimental treatment [60], where it is the most difficult for patients to understand and appreciate the nature of the treatment decision, and where the risks are often very high relative to the potential benefit [61].

Historically, an incompetent's contracts were void because the incompetent lacked the mental wherewithal required for "a meeting of the minds". Today they seem to be voidable, at least in part because of some sense that the incompetent needs protection. Some variant of the latter motivation must underlie the requirement of patient competence in informed consent. The doctor wants (we hope) to do what he thinks is best for the patient, but he needs the patient's informed consent in order to proceed. If the patient is incompetent and either refuses or is incapable of giving the needed permission, we do not simply deny him medical treatment (thereby, in effect, voiding his relationship with any doctor). Rather, we appoint another to look out for his best interest and allow that person (or court or institutional review board) to substitute his (or its) judgment for the patient's in dealing with the doctor. The requirement of patient competence thus seems designed to attempt to maximize (or at least increase) the chances that the actual treatment decisions made with respect to that patient are in fact in his best interest.

While most of the recent cases which involve competency to make medical treatment decisions focus on an adult patient's capacity to refuse treatment ([38], p. 573), the earlier medical competency cases typically had a rather different posture. They tended to be suits brought by the patient against the doctor and they sought damages for assault and battery for alleged unauthorized treatment. (See, e.g., [10] and [24]).

These cases are highly unusual today, in large measure one suspects, because many were successful. In recent years, hospitals and physicians have become scrupulously careful to establish and follow standardized procedures for obtaining patient consent to treatment and, now, determining competency to consent. In recent times what we more frequently see are doctors questioning the competency of patients to give or withhold that consent.[9] Such cases are usually brought to court through the invocation of state statutory provisions that allow the appointment of a guardian for the purpose of making treatment decisions for one judged mentally incompetent [44].

The discussion of incompetency that is found in these recent cases is instructive. The concerns and standards expressed in them mirror those found earlier in the discussions of incompetency to contract. Probably the most often cited of the cases involving the question of competency to refuse medical treatment are *Lane v. Candura* [19], *In re Quacken-bush* [16], *In re Yetter* [17], and *Department of Human Services v. Northern* [6]. It will be useful to look briefly at each of them.

Lane v. Candura [19] involved a 77-year-old woman who refused her doctor's recommendation that her gangrenous leg be amputated. Her daughter petitioned the court to be appointed temporary guardian with authority to consent to her mother's operation. In holding that Mrs. Candura was competent to decide for herself, the appellate court overturned the trial court's determination that Mrs. Candura was incompetent because her decision was irrational. Stressing that the irrationality of her decision did not justify a finding of incompetence in the legal sense, the higher court found Mrs. Candura competent because she was capable of appreciating the nature and consequences of her acts. This was so despite earlier vacillation, and times of forget-fulness and confusion. The court also stressed the legal presumption of competence, and found that there was insufficient evidence to show that Mrs. Candura's areas of forgctfulness and confusion in any way impaired her ability to understand the consequences of her decision.

The *Candura* court drew on the competency to contract background in a number of ways. It recognized the legal presumption of com-

petency, and noted that the question of legal competency is a question of fact.[10] Most importantly, the court employed the 'understanding test' for determining competency by looking at the patient's capacity to appreciate the nature and consequences of her action. The court took the position that the patient's mental disabilities were not in themselves determinative of her incompetence; rather, to justify such a finding, the disabilities would have to have been found to impair her ability to understand.

In re Quackenbush [16] is another case where a patient was found competent to refuse an amputation of a gangrenous limb despite periods of disorientation. This case came to court when the hospital, alleging the patient to be incompetent, petitioned the court for the appointment of a guardian to consent to the amputation. Although the patient exhibited some fluctuations in mental lucidity, these were found insufficient to affect his competency to make an informed decision. The patient was found to understand the nature and extent of his physical condition, the risks involved with or without the proposed operation, and to appreciate fully the magnitude of his illness. Thus, here too, the court used the 'understanding test' to find the patient competent.

A test closely related to the 'insane delusion test' was employed by a Pennsylvania court in *In re Yetter* [17]. There the court upheld a patient's refusal to submit either to a surgical biopsy or to any additional corrective surgery that might be needed for breast cancer. Mrs. Yetter was, at the time, committed to a mental hospital and some of her reasons for refusal were clearly delusional. Citing an earlier Pennsylvania case [27], the court stressed that mere commitment to a state hospital does not destroy a person's competency. That must be examined on a case-by-case basis. The court employed an understanding test in its finding that Mrs. Yetter was lucid, rational, and appeared to understand that the possible consequences of her refusal included death. In addition, the court addressed the difficulty presented by the fact that Mrs. Yetter's refusal was accompanied by delusions consistent with her mental illness.[11] It upheld her competency, however, by finding that her delusions were not the primary reason that she rejected the treatment. It also noted that a refusal based on fear may be irrational and foolish, but does not warrant a finding of incompetence.

The *Yetter* court expressed an unwillingness to override the patient's decision just because *some* of her reasons were delusional. Such a

finding is consistent with the 'insane delusion test' used in the earlier contracts cases. There, a delusion did not affect competency to contract unless the transaction in question was motivated by that delusion. Here, Mrs. Yetter's delusions were not determinative of her competency to refuse treatment where the court found that her decision was not a *product* of those delusions.

Department of Human Services v. Northern [6] is a case where a patient's irrational beliefs *were* found to affect her competency to refuse medical treatment because they affected her ability to understand her condition. The patient was generally lucid and sound of mind, but she was found nonetheless to be incompetent to refuse the amputation of her gangrenous feet. Apparently she did not appreciate the danger she was in and she refused to accept the impossibility of both living and keeping her feet. The court found the patient's denial of this unpleasant reality a 'delusion' which rendered her incapable of making a rational decision with respect to the proposed surgery. Unlike the delusions in the *Yetter* case, this patient's delusions were found to affect her competency to make this particular decision because they were felt to be the motivating force behind the decision.

The *Northern* case has been criticized for adopting "an unduly narrow test of competence" [60]. It should be noted, however, that the decision is basically consistent with the standards established in the competency to contract area. The crucial inquiry involves understanding and appreciating the nature and effect of the *particular* transaction at issue. Because the patient in *Northern* would not accept the seriousness of her condition, she was unable to understand that the consequence of her decision to refuse amputation would be her death. It did not matter that she was found to be lucid and sane in all other respects. She was found to be incompetent to decide this one (albeit large) issue. Similarly, in applying the 'insane delusion test', the patient's delusions were the motivating force behind her refusal.

A problem that often arises in the competency to refuse treatment cases is what has been referred to as the "outcome approach trap" ([38], p. 571). This is when a finding of incompetency is based simply on the fact that the court feels that the patient made an unreasonable decision, rather than on his capacity to appreciate the factors that go into that decision. The focus then switches to the decision itself and away from the person who made it. The use of this type of test for determining competency has been criticized by a number of commentators, some of

whom have claimed that it is probably used more often than is admitted by doctors and courts [61]. This problem arose in the *Candura* trial court and it has arisen as well in a number of blood transfusion cases (Pl. 132]).

While the 'outcome approach' for determining competency to refuse medical treatment can and should be criticized on a number of grounds, it should at least be noted that such a test is closely related to the 'inarticulate premise' which Milton Green wrote about in the competency to contract area as early as 1944 [47]. Incompetency to contract, according to Green, is often judged not by the actual incapacity of the contracting party, but by the abnormality or unfairness of the transaction in question.

The tests for determining incompetency to contract were developed within a context of concern over distinguishing between those adults who actually had the capacity to make contracts and those who did not. By contrast, at common law *all* children were deemed to be incompetent to contract ([52], pp. 386—394). There have always been certain distinctions made between those contracts made by minors that might be enforced by the child and those that can not, and there have been differences among the states for some time in the relevant age of majority, but traditionally there has not been concern to distinguish among the actual mental capacities of particular children. The *Restatement (Second) of Contracts* conforms to this basic pattern by providing in Section 14 that:

> Unless a statute provides otherwise, a natural person has the capacity to incur only voidable contractual duties until the beginning of the day before the person's eighteenth birthday 137).

The question of the competency of minors to make medical treatment decisions has tended, as well, to be decided without concern for their varying actual capacity. Minors are legally incompetent; they are presumed to be incapable of making important decisions on their own [64]. Thus under the general common law rule, minors are deemed to be incapable of making medical treatment decisions [44]. In most states, the age under which incompetency to consent is presumed is 18 or 19 ([50], [44]). Where minors are considered to be incompetent to consent, their parents have legal authority to make decisions for them.[12]

The requirement of parental consent for the medical care of minors has been challenged, however, as overly harsh [63], and many now

question the traditional presumption that children are incapable of making such decisions (see [64]). Many argue, for example, that minors today are more sophisticated and mature than they were in the past when the general rule was formed. As a result, both judicial and statutory exceptions to the general rule have arisen.

The most interesting and significant departure from the general rule is the judicially created 'mature minor' doctrine. This doctrine allows some minors to consent to their own non-emergency medical care in at least some cases [63]. The cases generally involve a minor who is 'mature' — near the age of majority and of sufficient mental capacity to understand the nature and importance of the proposed medical procedure — and treatment which is undertaken for his benefit [63]. Most significant is the judicial definition of 'maturity'. It closely approximates the standard used to determine competency in adults and indicates a judicial willingness to consider the actual competency of particular young people.

The Supreme Court recognized the mature minor doctrine in *Bellotti v. Baird* [2], where it upheld the right of a minor to consent to an abortion if she had the capacity to make an informed decision. An earlier lower court case that invoked the doctrine was *Younts v. St. Francis Hospital and School of Nursing, Inc.* [35]. There a 17-year-old was held to be "mature enough to understand the nature and consequences and to knowingly consent to the beneficial surgical procedure. Similarly, in *Smith v. Seibly* [30], in determining whether a married 18-year-old minor was competent to consent to a vasectomy, the court regarded his mental competency as a question of fact and asked whether he fully understood the ramifications, implications, and probable consequences of the procedure.[13]

The judicially created mature minor rule is not the only exception to the general rule that minors are incompetent to consent to medical treatment decisions. There are some statutory exceptions as well. These statutes take one of two general forms. Either they give minors authority to consent to all treatment after a certain age, or they set an age at which minors can consent only to specific forms of medical treatment ([62]), [44]). According to the New York Public Health law, for example, any person 18 or older who is married or is the parent of a child may give effective medical consent for himself [62]. State statutes that authorize minors to consent to specific forms of medical treatment usually involve birth control, pregnancy, venereal disease, or

substance abuse [44]. These are areas where it is felt that minors may not secure needed assistance if they are forced to involve their parents. Only the mature minor rule, however, purports actually to examine the competency of the particular minor patient to consent to medical treatment.

It is evident that there are many similarities between the tests used to determine competency to contract and competency to make medical treatment decisions. This has likely occurred in part because the consent required for medical treatment gives the physician-patient relationship a somewhat contractual flavor. Caution is urged, however, against taking this analogy too far. While there are obvious similarities, there are also many differences between the physician-patient relationship and the relationship between parties to an ordinary business transaction [65]. For example, a standard business contract often involves competing parties who appear to have relatively equal bargaining power. A typical physician-patient relationship is quite different. The law may well be on the verge of developing standards of competency to make medical treatment decisions which take account of these differences. It seems clear, at least, that it makes sense for it to begin to move in that direction.

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NOTES

[1] This article was commissioned and originally written in 1985. In updating our research, we find that since then there has been surprisingly little judicial attention paid to establishing standards for determining the competency of patients to make medical treatment decisions ([31), p. 496 n. 26) ([58], [59]). To the extent that the question has been litigated, courts have generally used some version of the understanding test described infra at p. 150 (see, e.g., (12), [21], **[54]).**

[2] An American Law Reports Annotation entitled, 'Mental Competence of Patient to Consent to Surgical Operation or Medical Treatment', noted in 1967 that very few cases had been found within the subject's scope **[39].** By the 1970s, however, a number of cases had arisen concerning competency to refuse medical treatment ((6), [16], [17],

[3] Alexander and Szasz have attacked this assumption. They argue that the law should

not recognize mental incompetency as a ground for avoiding contracts because to do so impinges on a person's ability to determine the course of his own life [36].

[4] Various courts embellished the basic test with so many qualifying adjectives that one leading commentator referred to it as "ambiguous, self-contradictory and practically meaningless" **([45),** p. 147).

[5] The insane delusion test is not limited to contracts. A will may be invalidated if its content were motivated by an insane delusion ([38], p. 580 n. 63). In one case, for example, a will was set aside where the testator disinherited his wife because of his deluded belief that she had been unfaithful to him [15].

[6] Quoting the *Restatement (Second) of Contracts,* section 15, comment b [37].

[7] The competency assessment is not determinative of whether a patient will be treated. There may be other overriding interests that lead to a competent patient's being treated without his consent. For example, a prison inmate may not, in effect, commit suicide by refusing needed dialysis [5]. Alternatively, an incompetent patient's expressed desires may well be fulfilled if these are found to be in his "best interests". (See [60].)

[s] By contrast, Annas and Densberger refer to the standard as "probably the most precise concept of competence that we will be able to develop" ([38], p. 572).

[9] Given the likely genesis of physicians' recent sensitivity to the matter of patient competence, it seems surprising that there are not many examples of doctors acting to protect themselves by seeking the appointment of a guardian to authorize the treatment of an agreeable but possibly incompetent patient. (See **[60],** pp. 139—143).

[D] "The principal question is whether the facts established by the evidence justify a conclusion of legal incompetence" ([19], p. 1235).

" Mrs. Yetter, who was 60-years-old, believed that the operation would affect her ability to have babies and would preclude the movie career she dreamed of having [17|.

[12] While these are the *legal* standards, the following quotation from an American Psychological Association position paper gives some evidence of how they are actually followed in practice:

> Despite parents' legal authority to make most decisions for their children, the preferences and concerns of children regarding involvement in treatment are sought and considered. In cases where minors are authorized by law to provide independent consent for a particular treatment, their desire to decide independently is honored. However, where appropriate, such minors are encouraged to involve their parents in treatment decisions [67|.

[B] More recently an Illinois court held that a mature minor has a common law right to consent to or refuse medical treatment, even if the refusal would result in death ([13], [20]).

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