

Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians

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Common law dictates that individuals possess autonomy and self-determination, which encompass the right to accept or refuse medical treatment. Management of medical treatment can be complicated in situations when the ability of the patient to make reasonable decisions is called into question. Our legal system endorses the principle that all persons are competent to make reasoned decisions unless demonstrated to be otherwise. This review will discuss the standards upon which capacity and competency assessments are made. Practical suggestions are offered for clinicians to employ in patient interviews conducted to assess capacity. Issues related to advance directives, surrogate decision making, guardianship, and implied consent are also discussed. The role psychiatric consultants take in capacity assessment can assist the primary care physician confronting the complexities encountered when attempting to treat the incapacitated or incompetent patient.

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The first 10 amendments of the U.S. Constitution, known as the Bill of Rights, were outlined to protect citizens from infringement on their basic freedoms, e.g., freedom of speech, the press, religion. A corollary to the basic foundation established by the Bill of Rights is the common-law principle of self-determination that guarantees the individual's right to privacy and protection against the actions of others that may threaten bodily integrity.¹ An extension of self-determination includes the right to exercise control over one's body, for example, the right to accept or refuse medical treatment. It is expected that when one freely accepts or refuses treatment, he or she is competent to do so, and is, therefore, accountable for the choices made. However, concerns naturally arise when an individual is deemed to be incompetent, specifically, to

protect the patient from the consequences of imprudent decision making. An individual determined to be incompetent can no longer exercise the right to accept or refuse treatment.

Competency is a legal term referring to individuals "having sufficient ability...possessing the requisite natural or legal qualifications" to engage in a given endeavor.^{2(p257)} Unfortunately, this definition is a broad concept encompassing many legally recognized activities, such as the ability to enter into a contract, to prepare a will, to stand trial, to make medical decisions, and so on. The definition, therefore, must be clarified depending on the issue in question. Simply put, competency refers to the mental ability and cognitive capabilities required to execute a legally recognized act rationally.³ The determination of incompetence is a judicial decision, i.e., decided by the court. An individual adjudicated by the court as incompetent is referred to as *de jure incompetent*. After determining that the *de jure* incompetent cannot make prudent decisions in his or her own best interest, the court will assign a guardian to make decisions on the person's behalf.^{4,5}

Because an adjudication of incompetency effectively denies an individual autonomy to make decisions, such court cases become labor intensive. An individual is presumed to be competent unless demonstrated to be otherwise. The standard of proof required for judicial finding of incompetency is that of "clear and convincing evidence."⁶ This standard of proof, based on evidence presented by licensed health care practitioners and others, is set at a standard between the high level of proof required for criminal convictions, i.e., "beyond a reasonable doubt," and the lowest standard of "preponderance of the evidence."⁷

To ensure that individuals retain as much autonomy or self-determination as is legally possible, the court makes a determination of one's competence in a task-specific manner. For example, one can be determined to be incompetent to execute a will, but may be deemed competent to make treatment decisions. Whenever possible, efforts are made to adjudicate incompetency in this manner. However, there are statutes that allow for the determination of general incompetency.^{8,9} In such cases, individuals who are in persistent vegetative states, severely demented, severely mentally retarded, or actively psychotic would be considered incompetent generally, i.e., incapable of any rational decision making while suffering from the prevailing impairment.

The cumbersome and potentially expensive efforts to undergo a legal proceeding are often prohibitive. The delays involved in arranging for and undergoing a formal court proceeding can add substantially to the cost of care of a hospitalized patient and may incur risks to the patient's health.¹⁰ Hence, it is not surprising that many individuals who are deemed incompetent to make treatment decisions are not subjected to an adjudication of incompetency.

The term *capacity* is frequently mistaken for *competency*. Capacity is determined by a physician, often (although not exclusively) by a psychiatrist, and not the judiciary. Capacity refers to an assessment of the individual's psychological abilities to form rational decisions, specifically the individual's ability to understand, appreciate, and manipulate information and form rational decisions. The patient evaluated by a physician to lack capacity to make reasoned medical decisions is referred to as *de facto incompetent*, i.e., incompetent in fact, but not determined to be so by legal procedures. Such individuals cannot exercise the right to choose or refuse treatment, and they require another individual, a *de facto* surrogate, to make decisions on their behalf.

One of the most vexing issues facing physicians is the management of medical treatment when an individual's rational decision-making ability is questionable. Requests for psychiatric consultation by primary care physicians to assess capacity to make treatment decisions have been increasing.¹¹ A retrospective chart review¹² of consultation requests made to psychiatrists in a municipal general hospital and a university-affiliated hospital found that as many as one fourth of all consultation requests were to assist with deciding issues of capacity. Earlier studies found lower rates of referral to psychiatric consultation services for capacity assessment, ranging from 3.3% to 15%.¹³⁻¹⁵ The increase in consultation requests for capacity assessment suggests that physicians may be uncertain about, and perhaps overwhelmed by, the complexities encountered when addressing issues pertaining to medical decision making.

Protection of the physician naturally arises when an individual freely chooses a course of treatment rationally and with full knowledge of the potential consequences and untoward events. It is not surprising that the frequent requests for psychiatric consultation in matters of competency are often based on the physicians' perceived need to "cover themselves" from a medical-legal perspective.¹² The physician is not automatically authorized to perform medical treatment on the behalf of a patient deemed incapable of making reasoned medical decisions.¹⁶ Similarly, a physician who withholds treatment from an incompetent patient who refused treatment could be liable for any untoward events that occurred to the patient if that physician had not taken reasonable steps to obtain some other legally valid authorization for treatment.¹⁷ Thus, when carefully explored and appropriately employed, the capacity assess-

ment serves to protect the physician rendering treatment. The issues of capacity assessment in medical decision making are not legally pursued merely to assert the value placed on liberty of individual citizens for its own sake.

WHEN IS THE QUESTION OF CAPACITY LIKELY TO BE ENCOUNTERED?

Requests for psychiatric consultation to assess a patient's capacity arise most often for patients who refuse treatment that the physician deems rational.^{15,18} Often, medical professionals feel that a patient who refuses a recommended treatment is incompetent until proven otherwise. Such a stance is inaccurate by legal (and moral) standards and is considered by some to be paternalistic.¹⁹ It is the right to self-determination in treatment, and not the mere refusal of the proposed treatment, that warrants an assessment of the patient's capacity to make reasoned treatment decisions.²⁰

Empirically derived data on treatment refusal found that most refusals were based on disruptions in the patient-doctor relationships, e.g., communication problems between patient and doctor, lack of trust of the treating source, and psychopathologic factors.^{21,22} In the harried pace of most medical centers, patients may be inclined to feel as if they were an inconvenience or feel rushed, slighted, and even neglected. Treatment refusal can be a means of securing attention from one's physician or an expression of hostility for perceived mistreatment.²³ Not surprisingly, many decisions to refuse the proposed treatment were often reversed some time later.²¹ Enlisting the support of psychiatric consultants under such circumstances may be worthwhile to facilitate dialogue and reduce any impediments to treatment. Conversely, a request for psychiatric consultation may fuel the adversarial relationship, particularly if patients are apt to perceive such a consultation request as a statement that they are somehow mentally ill or "crazy." Therefore, it should be made clear to the patient that the psychiatrist's role is to clarify the patient's wishes and interests, and is in no way intended to stigmatize the patient or otherwise coerce the patient into agreement with the treating doctor.

In reality, every aspect of health care, including the most benign events, such as a blood draw or physical examination, is subject to self-determination by the patient. Concerns about capacity to make reasoned decisions around treatment are most likely to be encountered in 2 types of situations (Table 1). If a patient objects to a treatment with a highly favorable outcome and/or low risk or assents to an intervention with unfavorable outcomes and/or high risk, then questions regarding capacity are likely to be raised.¹ In such situations, concerns about the reasoning capacity of the patient warrant formal assessment (and documentation) of capacity, involving relatively high standards (described below). On the other hand, when the patient con-

Table 1. Standards for Capacity Assessment as a Function of Patient Decision and Benefits/Risks Associated With an Intervention^a

Decision	Intervention	
	Likely Beneficial Outcome and/or Low Risk	Likely Poor Outcome and/or High Risk
Accept intervention	Low standard for capacity assessment	High standard for capacity assessment
Refuse intervention	High standard for capacity assessment	Low standard for capacity assessment

^aAdapted from Roth et al.¹

sents to a treatment intervention with a likely favorable outcome and/or low risk, or elects to forgo a treatment which incurs great risks or has questionable or unfavorable outcomes, concerns about decision-making capacity are less apt to be raised. In such cases, a low standard for determining capacity is undertaken, i.e., the capacity of the patient is assumed as long as he or she displays reasonable, nonbizarre behavior; has goal-directed thought processes; has a memory that is reasonably intact; and has not been deemed incompetent by judicial decision.^{1,24,25}

STANDARDS FOR ASSESSING DECISION-MAKING CAPACITY

Established by state law, the standards relevant to the assessment of decision-making capacity can vary from jurisdiction to jurisdiction. Consultation with a psychiatrist with expertise in capacity assessments or an attorney may be required to clarify those legal standards for determining capacity and competence required in one's area of medical practice. Nonetheless, the abilities that most consistently appear to be relevant to a patient's capacity to make reasoned decisions regarding treatment fall into 4 categories.²⁶⁻²⁸

Ability to Evidence a Choice

This component is the least stringent in the assessment of decision-making capacity, but it is generally held that a sign of competence to make reasoned choices is the ability of the individual to reach a decision. Individuals failing to meet this criterion either are unable to express a preference or are unable to make their wishes known effectively. This standard does not factor the specifics of the decision or how the decision was arrived at, but merely whether or not a decision was made. In addition, this concept requires the ability to maintain and communicate stable choices long enough for them to be implemented. Hence, an individual who rapidly changes his or her decision from moment to moment and a psychotic patient who is mute are deemed unable to evidence a choice. Furthermore, individuals with impairment of consciousness (e.g., in a delirious state) or those with significant thought disorders (e.g., psychotic), deficits in short-term memory

(e.g., Korsakoff dementia), or lability that impairs decision making (e.g., mania) are likely to have difficulties with the ability to evidence a choice.

Therefore, the capacity to evidence a choice can be tested quite simply by asking patients who have been informed about their medical condition and proposed interventions to respond to what they have just heard. The stability of the choice that they express can be examined by simply rephrasing the same question some time later.²⁶ Certainly, patients have the right to change their mind, hence a reasonably justifiable alteration in one's decision does not necessarily constitute an inability to evidence a choice.

Ability to Understand Relevant Information

This component is adhered to by every jurisdiction. This standard goes beyond evidencing a choice by assessing the individual's ability to comprehend information disclosed by the treating physician in the informed consent process. Expressing a preference about a treatment decision is meaningless if patients cannot understand what they are deciding. It stands to reason that an individual who cannot understand what he or she has been told about a proposed treatment or diagnostic intervention is not capable to decide to assent or refuse. The ability to understand relevant information will obviously be affected by patients who display deficits in attention span (e.g., significant attention deficit disorder, anxiety, or mania), intelligence (e.g., significant mental retardation), and memory (e.g., significant dementia or delirium). The ability to understand relevant information can be best assessed by asking patients to disclose their understanding of the proposed treatment intervention or diagnostic procedure. It is best to ask them to paraphrase it.²⁶

Although the ability to understand relevant information is more stringent than the ability to evidence a choice, this standard does not factor in patients' abilities to weigh the options before them and understand the implications the decision has for their lives. Toward this end, a higher standard of capacity is employed, i.e., appreciation.

Ability to Appreciate the Situation and Its Likely Consequences

Beyond the mere comprehension of factual information about a proposed treatment or proposed diagnostic intervention, this standard assesses whether the patient comprehends what the proposed intervention means for him or her.²⁹ Here the information that is being assessed is whether the individual understands what having the illness means, including its course and likely outcomes. In addition, the probable consequences of treatment or its refusal and the likelihood of each of a number of consequences, such as undergoing treatment versus forgoing treatment versus alternative treatments, are assessed.

The concept of appreciation is a rather individualized component of the capacity assessment. Assessment of the

patient's ability to appreciate is not based upon the comparison of the patient's expressed wishes against the standard of what most reasonable persons would endorse in that situation. It does involve an appreciation of how the individual values each risk and benefit of the proposed treatment in question. Severe denial as a defense mechanism, delusions, or other psychotic processes can impair appreciation.^{30,31}

Unfortunately, this standard of capacity assessment is more subjective than the previously mentioned standards since it involves an assessment of whether the individual can understand the implications of his or her decisions and whether he or she is, in effect, willing to live with the consequences of that decision. Such decisions are, for the individual, quite weighted, involving values assigned to potential consequences and issues related to quality of life. Hence, for one person, the choice of undergoing a procedure that can result in paralysis may be worthwhile over an option of death, whereas for another, death may be preferred over life as a quadriplegic. The assessment of the individual's capacity to appreciate is, therefore, based upon an examination of the ability of the individual to weigh various treatment benefits and risks against personal values and choices. If a patient is able to do so, without impediments from misunderstanding, cognitive deficiency, or psychopathologic states, he or she has capacity. Nonetheless, the subjective nature of decision making at this standard of capacity calls forth an assessment of the ability to rationally decide. Hence, a fourth, and final, standard of capacity assessment is often commonly invoked, i.e., the rational manipulation of information.

Ability to Manipulate Information Rationally

This component refers to the patient's general ability to employ logic or rational thought processes to manipulate information. If patients are unable to use logic and unable to weigh information in a rational manner to reach a decision, they will therefore be unable to compare the benefits and risks of various treatment options or interventions proposed to them. This component does not focus on the ultimate decision that the patient makes, but rather the process with which he or she arrives at decisions. Therefore, the physician examines the ability of individuals to reach a conclusion based on the initial premises with which they start. Conditions influencing logic include psychosis, delirium and dementia, severe mental retardation, severe anxiety, depression, and mania.

Often, psychiatrists will conduct a mental status examination, such as the Folstein Mini-Mental Status Examination,³² the Short Portable Mental Status Questionnaire,³³ and the Cognitive Capacity Screening Examination,³⁴ to have a more formal measure of the patient's ability to manipulate information. Such tests measure cognitive abilities, but not decision-making capacity. Scores yielded by such instruments provide an indication

Table 2. Guide for Assessing Capacity of Patients to Make Treatment Decisions

1. Does the patient understand the current medical condition?
2. Does the patient understand the natural course of the current medical condition?
3. Does the patient understand the proposed treatment intervention?
4. Does the patient understand the risks and potential benefits of the proposed treatment and/or intervention?
5. Does the patient understand what is likely to happen if the proposed treatment/intervention is refused?
6. Does the patient understand whether there are any viable alternatives to the proposed treatment intervention?
7. Does the patient understand the potential risks and benefits of the alternative treatments?

of severity of dementia, but cannot yield a score for and lack sufficient sensitivity for decision-making capacity.^{35,36} It is possible that an educationally disadvantaged person scoring poorly on the Mini-Mental Status Examination or alternative test can retain an ability to make treatment decisions, while a highly educated person adept at responding to the test's questions can fail to make prudent treatment decisions.³⁷ Dementia and cognitive deficits, e.g., mild mental retardation, may not necessarily preclude decision-making capacity.³⁸

Formal measures of cognitive ability fail to take into consideration other features important in the ability to manipulate information. These include disturbances in thought form (i.e., circumstantial or tangential thought process), delusions, and illusions or hallucinations. The behavior of the patient, relevant mood states, stability and appropriateness of affective states, thought form and content, and perceptual disturbances must be carefully documented when a capacity assessment is conducted.

THE CAPACITY EVALUATION

A capacity assessment essentially determines the validity of a patient's decision to undergo or forgo a particular proposed treatment. A physician who desires a reasonable guide for presenting information to a patient about the medical condition and proposed treatment interventions can refer to the lines of inquiry presented in Table 2. Responses to inquiries should be systematically recorded in the medical record, preferably in quotation marks. In the event a question is raised about the capacity assessment—what was assessed and how—it is also advisable that the interaction with the patient is witnessed and the documentation in the medical record countersigned by the witness. Failure at any component of this line of inquiry would mean that the individual does not have the capacity to make reasoned decisions regarding the proposed medical treatment.

Understanding the Medical Condition

Making certain that a patient understands his or her condition can be best assessed by open-ended inquiry, for

example, "Can you tell me what your medical problem(s) consists of?" or "Why have you been brought to the hospital?" Avoid questions that elicit a yes or no reply, e.g., "Do you understand what your medical condition is?" since an affirmative reply does not clearly convey that the person comprehends the nature of the illness.

Recognize that some descriptions of the medical condition by patients may lack sophistication. A physician is looking for the essentials of the prevailing problem, but some patients may be unable to go beyond their immediate experiences, e.g., complaints of pain or a particular disability or limitation. It is imperative that a physician query the patient's understanding of the cause of the pain or disability, such as, "What is your understanding of why you can no longer use your left arm and leg?" Patients whose emphasis is on pain or particular disability may be so focused on the immediate experience that they are unable to make reasoned decisions regarding the alternatives facing them. Hence, they may request analgesics without having an appreciation of the diagnostic evaluations and interventions required to prevent the disease state from progressing, leading to greater complications and death. Without an understanding of the prevailing medical condition, a patient cannot reasonably understand relevant information or possess the ability to appreciate likely consequences.

Understanding the Natural Course of the Medical Condition

Ask questions probing the course of illness, e.g., "What do you understand will happen to you over time with this illness?" Here, a physician must be given some specifics about the illness; therefore, replies such as "I'll get sick" or "Things will get worse" are not acceptable. These replies do not reflect a clear understanding of the course of illness. Such replies will require persistent inquiry, for example, "In what ways might you become sick?" or "In what ways might things worsen?"

Understanding the Proposed Treatment Intervention

To address this issue, a physician must inquire about the evaluations/treatments: "What is/are the test(s) that your doctor recommends?" and "What is/are the treatment(s) that has/have been advised?" In this area more than any other, avoid the temptation to invoke directed questions that merely elicit yes or no replies, such as, "You understand you require a mastectomy?" Again, an affirmative reply cannot imply an understanding of the advised treatment. It is also necessary to assess the patient's understanding of how the procedure is conducted.

Understanding the Risks and Potential Benefits

Systematic lines of inquiry can tap into risks and benefits, for example, "What can happen to you if you have

the surgery?" "What is your understanding of the side effects of this particular medication?" or "The proposed test carries some risks; can you indicate what they are?" Frame questions assessing the benefits of the proposed interventions in a similar fashion and attend to the patient's understanding of probabilities of favorable or unfavorable outcomes.²⁶ Patients may well understand the reasons for the proposed procedure and how it is conducted, but may distort the likelihood of success or deny likely untoward or adverse consequences.

Understanding the Consequences of Treatment or Intervention Refusal

To convey capacity when refusing a diagnostic test or treatment, the patient must be able to indicate an understanding of the likely consequences of such a refusal. This understanding can be assessed by asking questions such as "What can happen if you elect not to take the medication recommended?" or "What can happen if you elect not to have surgery at this time?" The patient's responses need to reflect rational thought processes; thus, the replies to such inquiries must follow logically from the patient's understanding of the natural course of illness. Failure to do so would be indicative of a failure to appreciate the course of the illness, its gravity or severity, and the consequences of treatment refusal.

Understanding Viable Alternatives

To assess capacity, a physician also needs to clarify whether the patient is informed of his or her options, in other words, alternative treatments and the risks or benefits associated with those alternatives. Inquiries in this area can include "What other options have been presented to you other than medication?" or "Your doctor suggested other avenues for treatment of your condition; can you indicate what they are?" The alternatives may have been suggested by a medical source. However, some patients may rely upon holistic alternatives. No matter how reasonable or absurd the alternative, the issue at hand is whether the patient can describe the potential benefits or consequences of the alternatives.

In addition, assess how the patient will decide when it would be appropriate to make changes in the treatment regimen. For example, an individual with a gangrenous toe may wish to forgo surgical amputation until a reasonable trial of I.V. antibiotics is employed. A physician could inquire, "Which of the options presented to you are you inclined to pursue?" "Would you reconsider your options if the intervention you selected appears to fail?" and "How would you decide when the best time to reconsider your options would be?"

An inability to accurately convey an understanding of the medical condition, its course, the proposed treatment intervention, and the risks and benefits associated with the intervention and/or alternatives might not mean that

there are underlying comprehension difficulties or a distortion of previously disclosed facts. It is possible that in the assessment of capacity, a physician might discover that the patient may not have been informed fully of the condition, treatment, risks, etc. Alternatively, the patient may have been fully informed, but was incapable of assimilating or comprehending the disclosed information at the time due to intense anxiety, pain, or delirium, for example. Many factors, such as hearing and vision deficits, can interfere with the ability to understand disclosed medical information.

If incomplete or conflicted information or no information was provided to the patient or the patient appears to have been unable to process the disclosed information, then an explanation or re-explanation is required. Appropriate measures should be undertaken to bypass any physical limitations that constitute barriers to the informed consent process.³⁹ The patient's comprehension and appreciation should be subsequently reassessed. If, after reasonable measures have been undertaken to inform the patient, he or she still is unable to appropriately respond to the inquiries above, then the patient is deemed *de facto* incompetent (lacking capacity).

Clearly, patients may alter their decisions, from accepting or refusing treatment to changing decisions between available treatment options. The capacity of the individual to make informed medical decisions can vary as the patient's status changes cognitively, emotionally, and/or physically and as the proposed treatment interventions change, for example, if complications arise.²⁵ Decisional capacity is, therefore, dynamic. This is illustrated by psychiatric disturbances such as delirium or other emotional disturbances when a patient's cognitive abilities can fluctuate.⁴⁰ Patients may display capacity at one point in time, but not at others. Consequently, if a patient is deemed to lack sufficient capacity to make reasoned decisions regarding treatment, it is advised that the documentation reflect that the lack of capacity is based upon the condition of the patient at the present time. It is possible that the barrier(s) to decisional capacity can lift, even temporarily, either spontaneously or after treatment (e.g., with hydration or nutritional support) to allow for restoration of capacity and informed consent.

PSYCHIATRIC DISORDERS AND CAPACITY ASSESSMENT

Contrary to popular belief among medical professionals, patients with psychiatric conditions and cognitive impairments cannot be assumed to lack capacity to make reasoned medical decisions.⁴¹ Given that the criteria employed to evaluate *de facto* competency (capacity) are cognitive in nature, disorders of cognition are likely to be encountered when questions of capacity arise. Patients with dementia are likely to evidence deficiencies in com-

prehension, precluding adequate appreciation of the medical condition, course of illness, and treatment options. However, mildly demented patients may still have reasoning capacity. Every effort should be made to clarify any limitations to comprehension and, as much as is possible, circumvent those limitations by educating the patient, repeating information as necessary, and using alternative means of patient education, e.g., videotapes, instructional materials, models.³⁹

Delirium (abrupt onset of memory impairments) associated with fluctuation of consciousness and inattentiveness to one's surroundings can present the clinician with many questions regarding capacity. Clearly, such patients are disoriented, disorganized in thought form, and may experience hallucinations that interfere with reasoning.⁴² It is possible to reverse, even temporarily, a delirium impeding decision-making capacity.⁴³ Treatment of the cause of the delirium can restore the cognitive capabilities of the patient, thereby restoring capacity to make treatment decisions. Hence, frequent reassessment of capacity may be required, particularly if there are changes in the medical conditions and/or required treatment interventions.²³

Affective states can also influence capacity. However, the mere presence of intense emotion does not preclude decision-making ability. It is only in the extreme that reasoning may be adversely affected. One expects to see anxiety in the patient facing a medical decision. However, in the extreme, anxiety may interfere with comprehension, retention of information, assigning of weight to available options, or decision-making ability.

Similarly, depression and grief can interfere with decision making.^{44,45} Mild-to-moderate depression does not appear to impede capacity.⁴⁶ When depressed and non-depressed patients were given vignettes depicting hypothetical medical situations about which they were asked to make medical decisions, no statistical differences were found between the 2 groups as regards life-sustaining interventions.⁴⁷ In a 6-month follow-up, previously depressed patients who were successfully treated did not appear to significantly alter decisions regarding life-sustaining treatment.⁴⁸ More severe forms of depression, particularly if accompanied by hopelessness and/or delusions, can disturb the decision-making process. Severely depressed patients may underestimate the benefits of treatment or overestimate the risks of treatment, interfering with rational decision making.⁴⁶ Some patients with severe depression may favor a high-risk medical intervention, viewing potential risks as a desirable outcome to end their misery.¹ Hopelessness is common in the depressed patient and may interfere with understanding the available treatment options and risks and benefits and appreciating likely consequences. Furthermore, hopelessness is a good predictor of suicide⁴⁹ and, in that sense, should prompt real concern about decision-making ability in the depressed patient.

In the psychiatric setting, severe suicide attempts along with suicidal ideas, intent, or plans constitute prima facie evidence for a psychiatric disorder and the lack of capacity to make reasoned decisions regarding interventions, such as the need for psychiatric hospitalization and treatment. However, in medical settings, a patient's refusal of potentially lifesaving measures cannot necessarily be equated with suicidal intent. However, this issue has triggered some controversy.⁵⁰

The physician wishing to override a refusal of treatment must prove the incompetency of the patient with a reasonable degree of medical certainty. Hence, if the patient has incurred the medical crisis prompting decision making, e.g., by means of an overdose or self-inflicted shooting, it is clear that suicidal intent was a factor, and refusals for intervention may reflect a desire to complete the suicidal act. In such cases, the evidence necessary to override a patient's expressed wishes regarding treatment can be supported by psychiatric evaluation and corroborating evidence provided by collateral informants. On the other hand, patients with serious, or perhaps terminal, illnesses may elect to forgo treatment, understanding that death may ensue. As stated previously, the capacity assessment must take into account the patient's appreciation of the meaning of the decision. However, examining the capacity to appreciate the decisions regarding treatment must take into account the patient's perception of his or her quality of life.

The legal system has been receptive to the idea that for terminal and/or incurable illnesses and severely incapacitating disabilities such as quadriplegia, a decision to forgo aggressive measures to sustain life would be respected, e.g., the landmark case of Bouvia.⁵¹ By contrast, those situations in which the perception of dissatisfaction with quality of life is less obvious trigger concerns regarding decision-making capacity. Psychiatric consultation may be prudent when concerns about depression, and in particular suicide, arise. It is desirable to delay decision making until after the depression, or the psychiatric condition underlying the suicidal ideation, is successfully treated.

Lastly, psychosis can interfere with reasonable decision making. The patient may have a preexisting psychotic disorder or may have regressed under the stress of illness and/or hospitalization and become psychotic. Despite the presence of bizarre behaviors, inappropriate affect, and disturbances in thought processes or content, such patients may retain the cognitive abilities to understand, recapitulate, and appreciate those factors required to make treatment decisions. The physician must be aware of the possibility that psychosis can result in denial of illness, impeding decision making,³¹ and that a patient might incorporate the treating physician, hospital staff, and others into a delusion, which can preclude making prudent medical decisions.

A psychiatric consultation in these cases would be prudent, particularly to treat an underlying psychiatric condi-

tion such as depression or psychosis that may interfere with rational choices.⁵⁰ Successful treatment may restore the patient's capacity. However, resolution of an underlying psychiatric condition may not occur immediately, and it may be impossible to defer medical decisions for the time required for the psychiatric condition to resolve. In such cases, the clinician would be expected to consult advance directives and/or defer to designated surrogate decision makers.

WHAT TO DO AFTER THE PATIENT IS DETERMINED TO LACK CAPACITY

After determining that a patient lacks capacity, physicians are often unclear about what options and limitations are available or necessary to contend with. The physician can undertake a treatment intervention that is life-sustaining in emergent situations, e.g., those medical conditions with imminently dangerous consequences, if no surrogate is available or if the emergent nature of the medical condition precludes locating a surrogate. In such circumstances, the physician can provide treatment immediately, invoking the common law principle of implied consent. This principle assumes that the physician is acting on behalf of the patient in a manner consistent with what any reasonable person in that emergent situation would prefer. The physician should document the nature of the emergent situation, the fact that the patient lacks capacity to provide informed consent, and the benefit of proceeding with treatment without delay.

It is also advisable to obtain the opinion of another physician to support the decision to act under implied consent. The second physician's statement, documented in the medical record, should likewise reflect the need for expediting treatment owing to the danger of postponing it. Unfortunately, the time required to locate a second opinion may be unreasonable, in which case the treating physician's statement may be sufficient.

A corroborating statement from a colleague would be required when the urgency of the prevailing medical condition is less clear or when the benefits of treatment are unknown or unclear. For example, if the diagnosis of delirium is uncertain, a psychiatric or neurologic consultation would be advisable. On the other hand, if the diagnosis is clear, but the benefits of the intervention or choice of the best alternate intervention are unclear, then a medical or surgical specialist might be best suited for the second opinion. The opinions of both clinicians should be clearly documented in the medical record.⁵²

The physician cannot override the patient's rights of autonomy and privacy. Hence, even in imminently dangerous situations, there can be limits to the extent of medical and surgical interventions, for example, if the patient has explicitly written directions in place, i.e., advance directives. If no advance directive exists, then the

physician can invoke implied consent in emergencies or defer decisions to an available surrogate.

The issues become more complex when the patient is not facing imminent danger. The person deemed to lack capacity to make reasoned medical decisions, i.e., the de facto incompetent individual, is denied the right to accept or refuse treatment. A surrogate would need to be enlisted to make decisions on the patient's behalf.

Preferably, the surrogate is someone selected by the patient, such as a previously designated health care proxy or power of attorney. If a health care proxy has not been designated or if the designee is unavailable or somehow incapacitated, the physician must locate a reasonable surrogate to act on behalf of the patient, i.e., a de facto surrogate.

A physician must recognize that capacity to make reasoned decisions is task-specific. Therefore, it is conceivable that a patient might lack capacity to make reasoned medical decisions, but may be fully capable of selecting a proxy. Hence, inquiry about a proxy designee should be directed to the patient. If the patient is incapable of expressing a preference about a proxy designee or cannot select or refuses to select a proxy, then the physician must defer to available surrogate(s). Some states dictate that family members are allowed to make decisions on the patient's behalf. In other jurisdictions, formal application to a court for a determination of incompetency and appointment of a guardian to act on the patient's behalf are required. Still other jurisdictions may require that a committee of physicians, hospital administrators, and spouse or other family member make treatment decisions regarding treatment for the patient who lacks capacity. Consultation with knowledgeable legal council in one's jurisdiction may be particularly helpful in clarifying which of these rules apply.

Often, medical decisions are made on behalf of the incapacitated patient by the family, even when the family has no legal authority to do so.⁵³ Family members may be best suited to make those decisions since they are likely to know the patient's wishes and values and will hopefully have the patient's interests in mind. It is important to remember that a family can consist of persons outside of traditional family definitions, e.g., a common-law partner, a homosexual life partner, a friend, a roommate.

If no one is available or willing to make decisions on the patient's behalf, a court-appointed guardian must be sought. A court trial to adjudicate de jure incompetency and then to appoint a guardian (de jure surrogate) can be delayed and, once initiated, can be quite time consuming. The delay can be so great that serious, even irreversible, complications might arise, including death, by the time the trial commences and a guardian is appointed. Consequently, the court is viewed as the "forum of last resort" in medical decision making.⁵⁴ Therefore, every measure should be undertaken to locate an appropriate surrogate.¹⁰

The expediency of locating a surrogate is clearly an advantage over seeking a court-appointed surrogate. Furthermore, avoiding the costs of a lengthy trial is an advantage to the patient or his or her estate. On the other hand, there are certain safeguards inherent to a court-appointed guardian. For example, the court can regulate the actions of the guardian to ensure that reasonable measures are undertaken on behalf of the patient. In contrast, a family member's decisions may be influenced by ulterior motives, which are harder for a court to regulate or limit.⁵⁵

Unfortunately, the presence of a de facto surrogate or de jure guardian making decisions on behalf of an incompetent patient does not imply blind acceptance of treatment decisions. Surrogates and guardians may not always act according to nonmaleficence (avoiding harm) and beneficence (doing good). In such cases, the clinician can seek judicial intervention to make modifications in the guardianship for a patient who may be exploited or harmed by a guardian's decision, for example, if a surrogate declines a seemingly benign procedure for an incompetent patient. Concerns naturally arise when this decision will hasten death and the surrogate has something to gain, e.g., if the surrogate is an heir to the patient's estate.^{55,56}

DECISION MAKING BY SURROGATES

The individual's autonomy and self-determination are central to the decision making of surrogates. Hence, the decisions made by surrogates must first be guided by the standard of *substituted judgment*.^{57,58} This refers to decision making by a surrogate based on the known wishes of the patient that have been explicitly written or expressly stated. If no formal wishes were written or stated by the patient previously, the surrogate would have to base decisions on knowledge he or she has of the values and preferences of the patient. In other words, the decisions made by the surrogate should reflect what the patient most likely would have wanted. Primary care physicians can facilitate proxy decisions using the substituted judgment standard by asking the surrogates whether the patient had previously made statements expressing his or her wishes about treatment under the current conditions.

If the surrogate does not know the wishes or values of the patient, as may be the case in situations whereby a guardian (e.g., an attorney, medical professional) is appointed by the court to act on behalf of the patient, the decision should be made according to the best-interest standard.⁵⁷⁻⁵⁹ Here, the treatment decision is based on what any reasonable person would select under the prevailing circumstances given the existing knowledge and available options. The best-interest standard is less desirable since the decisions may not reflect the wishes or values of the individual.

Because surrogate decision making may not reflect the wishes or preferences of the patient, several studies⁶⁰⁻⁶⁴

have attempted to assess the concordance of decisions made by proxies with those expressed by patients using a number of medical vignettes. The proxies in the studies included physicians, other health care professionals, physician-selected surrogates, and patient-selected surrogates. Concordance rates tended to be low, suggesting that decisions made by surrogates may not reflect the preferences of the patient. Therefore, there may be no better substitute for the explicit written direction or preferences of patients as outlined by advance directives.

Physicians may assume that discussions regarding advance directives should be postponed until advanced age or serious illness arises. This approach can be a source of great distress at a time when patients may be overwhelmed by and vulnerable to serious illness and may be viewed as intimidating by the patient.⁵⁸ It appears that patients of all age groups and health statuses endorse discussions regarding such directives and are receptive to planning ahead; however, they are apt to wait for the topic to be introduced by the physician.⁶⁵ Many patients desire planning for such untoward events, yet few have advance directives in place.⁶⁵ Primary care physicians can be instrumental in ensuring that the patient's values and preferences are clear by introducing the topic of advance directives and proxy selection with their patients. Few patients find the topic to be too distressing to discuss.⁶⁵ For those patients, once the topic is introduced, the patient and physician can revisit the issue when the patient is more comfortable. If the issue is not addressed, the patient is potentially left with having decisions made by surrogates who know little about the patient's wishes regarding treatment endeavors, particularly in severe or terminal illness.

Even among individuals who have prepared living wills and advance directives, few have discussed their wishes with family members and potential surrogates, and fewer still have had discussions with their physicians.⁶⁶ This also leaves execution of decisions in accordance with a patient's wishes and values up to chance. Primary care physicians ought to consider initiation of advance directives and preferences regarding health care proxies with their patients well before those patients confront terminal or irreversible illnesses or incapacitation to ensure that the patient's autonomy is respected.

THE PHYSICIAN'S ROLE IN SURROGATE DECISION MAKING

Often, the primary care physician and/or treatment team will be approached to provide the surrogate(s) with information about the incapacitated individual's condition, the likely course of illness, and available options. As with the assessment of capacity of the patient, the physician should be clear, direct, and authoritative, but not dictatorial. A tentative approach may be construed as indeci-

siveness or evasiveness and raise concerns about reliability and skill. Surrogates, particularly those close to the patient, are already distressed about the patient's condition and the decisions facing them. The risk of potential disputes and disagreements with the surrogate(s) can emerge if the physician provides unclear information or inadequate guidance or direction, or if the surrogate(s) experience uncertainty and powerlessness. Hence, the physician can be quite instrumental in facilitating decision making.

The physician should be as explicit as possible about the patient's condition and prognosis. Treatment options should be presented to the surrogate(s) clearly and without the use of medical jargon, along with benefits, risks, and possible outcomes. When discussing specific treatment approaches that should be undertaken with the surrogate(s), avoid using vague inquiries such as "Do you want us to do everything possible?" Such inquiries are apt to leave the surrogate(s) bewildered as to what "everything" entails.⁶⁷ Furthermore, the surrogate(s) may fear or question whether the patient will be left in pain or discomfort or be abandoned by the physician if an affirmative response is not forthcoming. Regardless of the decisions made, surrogates must be reassured that pain and discomfort will be adequately addressed. The surrogates may need to be asked to address decisions regarding treatment in terms of what they think the patient would prefer (substituted judgment) as opposed to what they would prefer for themselves (best-interest standard).

If more than one person has input into treatment decisions, a meeting of all interested parties may be helpful, particularly when discussing the patient's condition, prognosis, and available treatment options. This meeting may need to occur on several occasions, especially if there are dramatic changes in the patient's course or complications ensue.⁵⁴

Preferably, there should be a single person who relates to the surrogate(s), such as the attending physician. In their distress, the surrogate(s) may seek anyone, e.g., nursing staff, residents, medical students, who they believe will know about the patient's condition, progress, and responses to treatment. Unfortunately, this can be a breeding ground for the communication of inconsistencies and misinformation to the surrogate(s). To avoid possible confusion and potentially misleading the surrogate(s), the surrogate(s) should be instructed to direct inquiries to the attending.

The psychiatric consultant can be of help in facilitating dialogue in situations when the family or surrogates are divided, or when there is division between the treating source and the family or surrogate(s). The consultant can make clear the areas of miscommunication, clarify faulty assumptions and reservations had by the surrogate(s), designate channels through which communication should be directed, and facilitate treatment decisions.

CONCLUSION

The complexities involved in capacity assessment have stimulated efforts to develop standardized measures and quantifiable scales to measure capacity.⁶⁸⁻⁷⁰ These efforts are ambitious and worthwhile; however, the clinical utility and adaptability to various clinical situations have yet to be clarified. Referral to such instruments can offer guidelines for the clinician assessing capacity to make treatment decisions. Regardless of the instrument used or the interview approach undertaken, any reasonable assessment of capacity will need to address the patient's ability to comprehend the prevailing medical condition and the available treatment options, as well as the risks and benefits. Appreciation for the seriousness of the medical condition and the ability to weigh risks and benefits are essential components to the capacity assessment, but are subjective and cannot easily be subjected to standardized instruments. Thus, the primary care physician is thrust into the conflict of rendering care for the patient while looking after the patient's interests and wishes. If the patient is deemed to lack capacity, the interests of the patient must be respected as conveyed in advance directives or living wills. Surrogate decisions are necessary if no directives are available. Nonetheless, the wishes and interests of the patient must be adhered to as much as is possible or known. Resorting to the judiciary may be required if no proxy or surrogate is available for decision making.

Primary care physicians can reduce some of the potential uncertainties by introducing the benefits of advance directives and designation of a health care proxy in discussions with their patients. In this way, the patient's autonomy and self-determination can be ensured should he or she become incapacitated and unable to make reasoned decisions.

Invoking the assistance of psychiatric consultants goes beyond mere reassurance that the physician's actions are medically and legally sound. The psychiatrist can assist with the capacity assessment, diagnose and treat underlying psychiatric conditions that may pose an impediment to decision making, and facilitate patient-physician and (if necessary) surrogate-physician communication.

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