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COMPETENCY AND COMMON LAW

Why and How Decision-Making Capacity Criteria Should Be Drawn From the Capacity-Determination Process

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Determining competence to request physician-assisted suicide should be no more difficult than determining competence to refuse life-prolonging treatment. In both cases, criteria and procedures should be developed out of the process of actually making capacity determinations; they should not be promulgated a priori. Because patient demeanor plays a critical role in capacity determinations, it should be made part of the record of such determinations through greater use of video- and audiotapes.

As a lawyer trained in the case method and sold on the virtues of common law development, I would have preferred to see guidelines presented that had been drawn out of actual cases and used in those cases to solve actual problems.

The Oregon Death with Dignity Act has been in operation for more than a year. Preliminary data suggest that neither assessment of patient capability to request physician aid in dying nor detection of impaired patient judgment has presented serious obstacles to safe and effective implementation of the Act. The published report of the Oregon Health Division¹ states that, during the first year of operation, 16 Oregon physicians provided 23 Oregon patients with prescriptions for aid in dying under the Act. Only four of these cases involved a referral to a psychiatrist or psychologist for determination as to whether the patient suffered “impairment of judgment.” Because the requested medication was ultimately prescribed for the patients in all 23 cases, we can conclude that (a) in each of the four cases where there was a referral, the consulting psychiatrist or psychologist determined that there was no impairment of judgment; (b) in the other 19 cases, the attending physician and the consulting physician concluded that there was not enough evidence of impairment of judgment to justify such a referral; and (c) in all of the 23 cases, the attending physician and the consulting physician concluded that the patient was not incapable of requesting assisted death under the terms of the Act. Of course, these statistics tell us only that the professionals involved believed themselves able to make the clinical decisions called for by the Act. They do not tell us that the decisions were made correctly. But the fact that there has been so little criticism of the Act’s implementation during its first year suggests that there is a widespread view that the decisions

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¹Arthur E. Chin, Katrina Hedberg, Grant K. Higginson, and David W. Fleming. (1999). Legalized physician-assisted suicide in Oregon—The first year’s experience. *New England Journal of Medicine*, 340, 577–583.

have been appropriate. In light of the intense scrutiny to which the Act has been subjected by its many critics—much of it focused on the problems of screening for mentally incompetent patients—one would expect any failure of implementation to have been uncovered and publicly criticized. Instead, critics have been heard to reluctantly praise the Act's implementation during the first year. Typical is the comment of one priest-ethicist, who said "We'd rather people didn't choose [physician-assisted death], but [the Act] challenges us to provide better care so they won't choose it. . . . [And the Act is] being implemented thoughtfully and carefully."²

I would suggest that the starting point for developing guidelines should be a study of the challenges that Oregon physicians and mental health professionals have actually faced and the methods they have used for handling them with such apparent success. They should be asked what sort of advice their experience would lead them to give to others who may be asked to help patients under the Act and what sort of guidelines they would like to see developed that might help physicians and mental health professionals in the future. At the moment, it is hard to know to what extent problems do, in fact, arise. Only four referrals were made to mental health professionals, and there is reason to believe that at least some of these (perhaps all) were made by physicians who believe that referrals should be made in every case as a matter of course.³ On the other hand, we do not know how many (if any) patients were turned away by physicians on the ground that they were judged to be incapable to make a request for aid in dying. And we do not know what methodology was used for determining whether a patient presented a question of incapability to make a request or impairment of judgment and what methodology was used for determining the answer to the question once it was raised. Unfortunately, the Oregon Health Division was provided with neither the staff nor the funding to conduct a study that could provide us with such information.⁴ Funding and staffing should be provided to the Oregon Health Division to provide that information in the future or some other research body should take on the job of developing and publishing these very important data.

Of course, much relevant data can and should be obtained from other sources as well. For decades, physicians and mental health professionals have been making decisions regarding the mental competence of patients who request cessation of life-prolonging treatment. There is no reason to think that the criteria

²See, Michael Vitez, *Oregon Assisted Suicide Law Little-Used but Well-Regarded: Patients Like Knowing They Have an Option*, Philadelphia Inquirer, January 19, 1999, at 1:

Even those who opposed [the Act] grant the law a measure of respect.

"It's not the harbinger of destruction that people thought it was going to be, but it's still bad social policy," said the Rev. John F. Tuohey, a Catholic priest who oversees health care ethics at Providence Health System, the state's Catholic hospital network. "We'd rather people didn't choose it, but it challenges us to provide better care so they won't choose it. . . . It's being implemented thoughtfully and carefully."

Another early opponent, the head of the Oregon Hospice Association, now says the Death with Dignity Act is "working well."

³Telephone conversation between Charles Baron and Katrina Hedberg, M.D., Medical Epidemiologist, Oregon Health Division on February 22, 1999.

⁴Id.

or methodology for determining competence in those cases should be different from the criteria or methodology to be used in cases under the Oregon Act. Presumably any patient who is competent to request assistance in dying through having life support removed is competent to request assistance in dying through ingesting a drug. What reason is there to think that a person who can competently process the issues involved in the former request cannot process those involved in the latter? Over the last 20 years, probably thousands of health care professionals have made decisions that thousands of patients were competent (or not) to request aid in dying by way of withholding or withdrawing life support. Alas, we seem to know next to nothing about the criteria and methodologies that have been used in making those decisions. Here again, it is necessary that research be conducted so that these data are developed and made available to serve as a solid, experiential basis for the development of guidelines for such decisionmaking in the future.

Although the authors of the Proposed Guidelines recognize that the law requires every patient to be presumed competent, promulgation of a set of a priori guidelines through which patients must maneuver in every case may have the practical effect of placing on patients a heavy burden of proving that they are competent to request aid in dying. Using such guidelines, it may be too easy to lose sight of the fact that challenges to mental competency raise fundamental issues of human freedom. At base, the question of whether someone is to be allowed to make a decision for him or herself is not a medical or psychological question, it is a philosophical, political, and legal question. In many circumstances, medical and psychological data may seem almost entirely irrelevant. Were we to use a comprehensive set of medico-psychological guidelines like the one proposed to determine whether a person was competent to marry, we might well judge that no one was truly competent to do so. Yet we allow not only teenagers to wed, we allow the mentally retarded to do so. The history of our country is replete with instances where its people have fought hard to establish the principle that they are free to make decisions for themselves—no matter how “poorly processed” others may think those decisions to be. Liberal philosophers, such as Locke⁵ and Hume,⁶ have differed over whether that principle extends to a decision to commit suicide. The Supreme Court of the United States has decided that the United States Constitution does not require recognition of a general right to physician-assisted suicide,⁷ but the people of the State of Oregon have enacted the Oregon Death with Dignity Act in order to make that right available to themselves. We should not superimpose on that Act a set of complicated psychiatric or psychological tests one must pass before being recognized as free to make a decision for oneself.

The Oregon Act explicitly makes its provisions available unless a patient is shown to be “incapable.” The definitions section of the Act defines “incapable,” rather than “capable.” This negative approach to legal definition seems intended to express the commitment of the Act’s framers to the strong normal presumption

⁵See, John Locke, *THE SECOND TREATISE ON GOVERNMENT*, Chap. 2, §§ 4, 6; Chap. 4, §§ 22–23.

⁶See, David Hume, *ESSAYS ON SUICIDE AND THE IMMORTALITY OF THE SOUL* (1783).

⁷*Washington v. Glucksberg*, 527 U.S. 702 (1997).

of mental competency.⁸ Patients are to be presumed competent to request physician aid in dying unless something about their behavior raises a red flag. Perhaps the patient shows an inability to remember facts that are important to the decision or is clearly delusional about such facts. Perhaps the patient makes no sense when trying to communicate reasons for requesting physician-assisted death. Perhaps the patient seems only to parrot statements made by caretakers who appear to exercise a great degree of control over the patient. In my limited experience in representing patients in competency proceedings, it has been such obvious demeanor evidence that has caused the competency of patients to be challenged. And it has been the demeanor of my client on the witness stand—not test results or expert testimony—that has been the crucial factor in the judge’s determination of whether my client was incompetent. I suspect, but do not know, that others who have been involved in such cases—physicians, mental health professionals, judges, and attorneys—have had similar experiences. In developing guidelines, I think it would be valuable to find out.

The idea of building guidelines “from the bottom up”—out of the experiences of practitioners of a given art—is at the heart of the process of common law development. Lord Edward Coke, the 17th-century English judge and scholar who is in many ways the American legal community’s unacknowledged role model, once said of the common law:

[I]f all the reason that is dispersed into so many several heads, were united into one, yet could he not make such a law as the law in England is; because by many succession of ages it had been fined and refined by an infinite number of grave and learned men, and by long experience grown to such perfection, for the government of this realm, as the old rule may be verified of it, *Neminem oportet esse sapientiorum legibus*: No man out of his own private reason ought to be wiser than the law, which is the perfection of reason.⁹

As has recently been pointed out,¹⁰ similar views were held by contemporary high practitioners of other arts. Abraham Fraunce, a rhetorician, had observed in 1588:

Logic is an art, to distinguish artificial logic from natural reason. Artificial logic is gathered out of diverse examples of natural reason, which is not any art of logic, but that ingraven gift and faculty of wit and reason shining in the particular discourses of several men, whereby they both invent and orderly dispose. . . . This as it is to no man given in full perfection, so diverse have it in sundry measure. . . . And then is the logic of art more certain than that of nature, because of many

⁸Indeed, legislators who have recently proposed amendments for the purpose of vitiating the Act’s impact have suggested language defining “capable” in place of “incapable” for just this reason. See 70th Oregon Legislative Assembly (1999 Regular Session) Senate Bill 491, Section 1: “The following words and phrases . . . shall have the following meanings: . . . (3) ‘Capable’ means that in the opinion of a court or in the opinion of the patient’s attending physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”

⁹Sir Edward Coke, COMMENTARY UPON LITTLETON 97b (Charles Butler Ed., 18th ed., Legal Classics Library 1985) (1628).

¹⁰See, Boyer, Allen Dillard, “Understanding Authority and Will”: Sir Edward Coke and The Elizabethan Origins of Judicial Review, 39 B.C. L. Rev. 43 (1997).

particulars in nature, a general and infallible constitution of logic is put down in art.¹¹

The key to the never-ending process of “fining and refining” principles of logic or of law was to promote constant dialogue among the practitioners of the art in question. This dialogue was to be based on the practitioners’ use of techniques in actual cases to achieve successful results.

Coke saw the determination of the individual case and the application of the legal principle as different functions linked by an equal sign The law can be rightfully followed and applied only where the true facts of the case are fully understood. Coke repeatedly emphasizes the circumstances upon which the judge acts, tying decisions to the facts.¹²

As the authors of the Proposed Guidelines point out, today’s common law courts have thus far failed us as regards development of meaningful standards for determining incompetence. It is the rare judicial opinion that offers truly helpful information as to how criteria for determining incompetence have been applied to the facts of a case so as to produce the result reached by the court. There are even fewer instances of courts engaging in dialogue with each other in an effort to refine such criteria. Perhaps this is because there are relatively few cases in which the competence of patients is challenged in court. In my opinion, it is more likely to be a result of the fact that judges have found it difficult to explain in written opinions precisely what facts have led them to their conclusions. If, as I suggest above, the court’s gestalt assessment of demeanor evidence is what is determinative in most of these cases, then the critical evidence in such cases will not be captured in a written record. What may be needed is greater use of nonwritten records, that is, audio- and videotape recordings. In the recent impeachment trial of President Clinton, we have shared as a nation the experience of seeing the extent to which videotaped depositions are capable of capturing critical demeanor evidence that is lost in a written transcript. Audiotaping or videotaping of testimony of patients could similarly offer the prospect of capturing critical demeanor evidence in incompetency proceedings.

Audio- or videotaping to capture the demeanor of a patient also recommends itself, in my opinion, as a means for protecting physicians and mental health professionals from later claims that a patient should have been found incompetent to request aid in dying. The “Model State Act to Authorize and Regulate Physician-Assisted Suicide,” of which I am a coauthor suggests audiotape and videotape as the preferred means for documenting the required discussions with a patient who requests assistance.¹³ In all of the controversy stirred up by the recent airing on “60 Minutes” of Jack Kevorkian’s assisted death of ALS patient Thomas Youk, criticism of the process on the ground that Mr. Youk did not competently request assistance was forestalled by the fact that videotape enabled

¹¹Abraham Fraunce, *THE LAWIERS LOGIKE, EXEMPLIFYING THE PRAECEPTS OF LOGIKE BY THE PRACTISE OF THE COMMON LAWE* B.ii (1588).

¹²*Op cit.* n. 10, at 61.

¹³Baron, Charles H., Bergstresser, Clyde, Brock, Daniel et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 *Harv. J. on Legis.* 1, 29 (1996).

the public to judge for itself whether his demeanor was that of a man likely to be incompetent to make the decision for himself. Protection of physicians and mental health professionals from later claims of malpractice is stated by the authors of the Proposed Guidelines to be one of their goals—perhaps, in the end, their main goal—in promulgating the guidelines. Having concluded that “[m]aterial in the mental health and medical literature is more useful for the psychiatrist or psychologist . . . than the legal literature,” (p. 359)¹⁴ they suggest that mental health professionals operating under the Act should be guided by what the literature and expert witnesses would establish as the standard of practice in a malpractice action if one were later brought against them. They recommend the Proposed Guidelines by saying:

If the course of action described below is adopted as appropriate, then the mental health boards, physicians, significant others, prosecutors, expert witnesses, and judges could use these guidelines to determine whether the consulting psychologist or psychiatrist had performed a reasonably prudent evaluation. Consultants whose evaluations were deemed to have fallen below this standard would be at risk of ethical and legal reprisal; professionals who meet or exceed the guidelines would be immune from censure: (p. 362)¹⁵

But, as I have argued above, the Proposed Guidelines purchase protection from malpractice exposure at the price of forcing the patient to run a gauntlet of tests that will have the practical effect of placing on him or her a heavy burden of proving competence. In the end, videotaping of informed consent discussions, despite the incursion it involves on the patient’s privacy, seems to me to place less of a burden on the patient’s freedom.

In any event, whatever the role to be played in the process by videotaping, immediate steps need to be taken to promote case-based dialogue among professionals who make determinations as to the incompetency of patients. To the extent that courts continue to fail to draw helpful criteria out of the incompetency cases that come before them, physicians and mental health professionals need to begin to share with each other the critical facts of instructive cases that they have decided and explain to each other why those cases were decided as they were. The reports of such cases should be drawn on as precedents for decisionmaking in later similar cases, and the decisionmakers who draw on such precedents should then share with others how they have used the precedents. If they have extended the precedents to apply to new facts, they should explain how the guidelines for decisionmaking that the earlier cases seemed to stand for have been broadened and why. If they have refused to apply the earlier precedents to the facts of the case before them, they should explain how the guidelines for decisionmaking of the earlier cases have been restricted and why. Out of this process should emerge increasingly precise guidelines that respond to all and only problems that arise in the real world of the doctor–patient relationship and that are constantly “fined and refined” on the basis of actual experience in order to better handle those problems.

¹⁴James L. Werth, G. Andrew H. Benjamin, and Tony Farrenkopf, *Requests for Physician-Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 PSYCHOL. PUB. POL’Y & LAW, 348–372 (2000).

¹⁵*supra* note 14.

In closing, my fellow commentators all make interesting and challenging points.

I share the concerns of Professors Burt, Martyn, and Bourguignon. And yet those concerns do not lead me to share their conclusion that it is pointless or unacceptably dangerous to establish institutions for determining whether patients lack capacity to make medical decisions. As Professors Martyn and Bourguignon point out, all of the dangers of the “Trojan Horse” that they fear in the area of physician-assisted suicide are present when patients make requests to withhold or withdraw life-prolonging treatment. *Lane v. Candura*, the case they offer as a horrible example of physicians using their own values in determining whether patients are competent, involved a woman who was refusing amputation of a gangrenous leg. Yet neither Professors Martyn and Bourguignon nor Professor Burt suggest that we should abolish the right of patients to refuse life-prolonging treatment or abandon the effort to decide when a patient lacks capacity to exercise that right for himself or herself.

On the one hand, we want to protect the right of patients to have their expressed wishes followed as regards medical treatment. This is the fundamental principle of patient autonomy. On the other hand, we want to make sure that such expressed wishes have not been obtained by duress, misrepresentation of facts, or by some other method that takes advantage of the patient. The balance that needs to be worked out here cannot be achieved by a priori imposition of prophylactic rules. It is not satisfactory to say that a patient’s expressed wishes should be followed under all circumstances. It is certainly not satisfactory to say that the patient’s expressed wishes should never be followed. Yet the latter is what Professors Burt, Martyn, and Bourguignon seem to be suggesting with regard to physician-assisted suicide.

As I argued earlier, what is needed in this field is solid research into what determinations of capacity are being made, on the basis of what facts and by what procedures. Since the early “right to die” cases of the 1970s, thousands of physicians have acceded to the wishes of thousands of terminally ill patients who have expressed preferences not to have their lives prolonged by medical means. Have the physicians who dealt with these patients faced problems in determining the mental capacity of these patients? If so, what are they and how were these problems handled? Or are Martyn and Bourguignon correct in saying that physicians are making these decisions for patients on the basis of the physician’s values regarding life in general and the life of the particular patient by—among other things—determining a patient to be mentally capable only when he or she agrees with the physician? If Martyn and Bourguignon are correct, we are faced with a much bigger problem than that posed by the “Trojan Horse” of the Proposed Guidelines. How we handle the very few cases of physician-assisted suicide that are likely to arise in a year’s time is very small potatoes compared with what may be going on already regarding the extraordinarily large number of cases involving refusal of food and water, artificial ventilation, life-prolonging medication, and so on.

In light of the special risk that Professors Burt, Martyn, and Bourguignon see posed by determinations of mental capacity in the context of physician-assisted suicide, it is ironic that the most reassuring data we have regarding such determinations appear to come from information developed in that context. The report

of the Oregon Health Division regarding the first year of experience under the Oregon Death with Dignity Act evidences no influence of the prejudices that Professors Burt, Martyn, and Bourguignon fear. None of the data suggest bias against women, or minorities, or even those who could be characterized as having an especially poor quality of life. Indeed, as many have noted, poor quality of life was not the predominant reason for making and granting requests for physician-assistance in suicide. Rather, the predominant reason was the strong desire of the patient to exert control over the process of dying. Hopefully, Professors Burt, Martyn, and Bourguignon take some comfort from the revelation of these facts. And hopefully, they draw comfort as well from the detailed account recently published in *Lancet*¹⁶ reporting on the first case of assisted suicide under the Oregon Act. Much of Professors Martyn and Bourguignon's commentary is built on what they admitted to be the "obscure and incomplete data of [news] reports" that questioned the competency of the patient involved in that case. Unless one is ready to suggest that Peter Reagan, the patient's physician, is lying in the account that he published in *Lancet*, we now have facts that suggest that their worries on that score can be set aside. Not only did the patient's original physician not suggest that she lacked competence (the reason he gave for not prescribing the medication was that he "didn't want to be involved"¹⁷), he sought out Dr. Reagan after the patient's death to thank him for taking over her care.¹⁸ And, although the second physician consulted did record in his notes that the patient was "probably depressed," Dr. Reagan's description of the consulting psychiatrist's report on the patient suggests that the second physician as well simply did not want to be involved:

During a home visit lasting 90 minutes or so, [the psychiatrist] had painstakingly evaluated Helen's competence and her mood, and concluded that she showed no signs of depression. My own impression confirmed, I had to accept that this really was going to happen. Of course, I could choose not to participate. The thought of Helen dying so soon was almost too much to bear, and only slightly less difficult was the knowledge that many very reasonable people would consider aiding in her death a crime. On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.¹⁹

Consistent with the facts contained in the Oregon Health Department's report and Dr. Reagan's *Lancet* article, I have long believed that we have less to fear from legalized physician-assisted suicide than we do from current practices regarding withholding and withdrawing treatment. Among other things, I think that patients, physicians, and family members are likely to take much more seriously decisions to assist suicide than decisions to "just let nature take its course." But this is just conjecture on my part, and it is time for all of us to move on from mere conjecture to fact finding and the development of protocols and regulations based on facts. We need for this purpose to establish procedures by

¹⁶Peter Reagan, Helen, 353 *Lancet* 1265 (1999).

¹⁷*Id.* at 1265.

¹⁸*Id.* at 1267.

¹⁹*Id.* at 1266.

means of which such protocols and regulations can be constantly refined in the context of practice. In this process, scholarly comment certainly has a role to play. Professor Youngner, for example, in his commentary, makes some interesting suggestions for improvement in the Oregon Act. The Oregon legislature recently amended the Death with Dignity Act to respond to suggestions of commentators and to problems that have arisen in practice. Among the amendments was one removing the comma on which Professors Martyn and Bourguignon, among others, had based a proposed limiting interpretation of the statute. The sort of “feedback loop” that this represents should be encouraged, refined, and extended.

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