

Article

Evaluating Decision Making Capacity in Older Individuals: Does the Law Give a Clue?

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Abstract: Adequate cognitive and emotional capacity is essential to autonomous decision making by adult medical patients. Society often attaches legal consequences to decisional capacity evaluations. Even when the legal system is not formally involved in the competency evaluation of a particular individual, clinical practice and ethical conduct occur within and are informed by legal parameters. Using relevant statutory, court rule, and judicial opinion examples from a representative jurisdiction within the United States, this article argues that the law seldom provides much meaningful guidance to health care and human services providers to assist them regarding the content of capacity evaluation. The article concludes by asking how society ought to respond to the paucity of helpful guidance provided by the law in the decisional capacity evaluation context.

Keywords: legal; jurisprudence; guardianship; capacity; competence; ethics

1. Introduction

Adequate cognitive and emotional capacity—as well as sufficient voluntariness and access to material information—are essential elements for the exercise of autonomous decision making, including making choices about the acceptance of specific health care and human services, by older adults. Of necessity, health care and human services professionals have incrementally developed a set of general working criteria for evaluating decisional capacity that balances considerations of individual autonomy with the complementary or competing ethical principles of beneficence (doing good), nonmaleficence (preventing harm), and respect for persons.

Application of these working criteria of decisional capacity to specific cases is an inherently interdisciplinary endeavor. Even when the legal system is not formally involved in the competency evaluation of a particular individual, clinical practice and ethical conduct occur within and are informed by legal parameters. Using relevant Florida statutes, court rules, and judicial opinions as examples that are representative of state law nationally, this article suggests that the civil law seldom provides much meaningful guidance to health care and human services professionals to assist them regarding the content of a capacity evaluation. The article concludes by asking how society ought to respond to the arguable paucity of helpful guidance provided by the law in the decisional capacity evaluation context.

2. The Law's Lack of Guidance

In the arena of evaluating an individual's mental competence to stand trial for an accused crime, state laws are uniformly quite specific and comprehensible, because the standard to be determined and applied derives from a United States Supreme Court decision interpreting the 14th Amendment Due Process clause of the federal Constitution [1]. Thus, for example, Florida Statutes § 916.12 (1) provides:

A defendant is incompetent to proceed [with a criminal trial] if the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding or if the defendant has no rational, as well as factual, understanding of the proceedings against her or him.

Similarly, state law on testamentary capacity (the ability of a testator to execute a will dictating the terms of property distribution to others upon the testator's subsequent death) is rather consistent and unambiguous across jurisdictions. For instance, the Florida Supreme Court has recognized that testamentary capacity is the

“ability of the testator to mentally understand in a general way the nature and extent of the property to be disposed of, and the testator's relation to those who would naturally claim a substantial benefit from the will, as well as a general understanding of the practical effect of the will as executed” [2].

In other realms of civil law, however, such as medical, residential, or financial decision making, the situation is markedly murkier. In those areas, relevant statutory and case law is for the most part much less capacity evaluator-friendly. For instance, Florida Statutes § 825.101 (9), Abuse, Neglect, and Exploitation of Elderly Persons and Disabled Adults, contains the following definition:

“Lacks capacity to consent” means an impairment by reason of mental illness, developmental disability, organic brain disorder, physical illness or disability, chronic use of drugs, chronic intoxication, short-term memory loss, or other cause, that causes an elderly person or disabled adult to lack sufficient understanding or capacity to make or communicate reasonable decisions concerning the elderly person's or disabled adult's person or property.

This definition is potentially of some (but limited) help to a health care or human services professional conducting a formal or informal capacity evaluation of a client in two senses. First, it includes a categorical or diagnostic labeling component (“by reason of mental illness, developmental disability, organic brain

disorder, physical illness or disability, chronic use of drugs, chronic intoxication, short-term memory loss, or other cause”), although the nebulous catch-all phrase “or other cause” significantly diminishes if not destroys the specific guidance seemingly provided by the language that precedes it. Second, this statutory definition also helpfully contains a functional component (“an impairment...that causes an elderly person or disabled adult to lack sufficient understanding or capacity to make or communicate reasonable decisions concerning the elderly person’s or disabled adult’s person or property”), but the seeming helpfulness is mitigated by the statute’s failure to in any way constrain or direct the capacity evaluator’s subjective judgment about what patient/client decisions qualify as “reasonable”.

Another instance of this problem is exemplified by Florida Statutes Chapter 765, Health Care Advance Directives. Here, the legislature begins with a tribute to personal autonomy in medical matters (“The Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment”, § 765.102 (1)) and to the centrality of capacity in protecting autonomous choice:

To ensure that such right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature intends that a procedure be established to allow a person to plan for incapacity by executing a document or orally designating another person to direct the course of his or her medical treatment upon his or her incapacity (§ 765.102 (2)).

In practical terms, how is this ethically laudable legislative intent to be realized? Florida Statutes Chapter 765 continues, at § 765.204:

- (1) A principal is presumed to be capable of making health care decisions for herself or himself unless she or he is determined to be incapacitated. Incapacity may not be inferred from the person’s voluntary or involuntary hospitalization for mental illness or from her or his mental retardation.
- (2) If a principal’s capacity to make health care decisions for herself or himself or provide informed consent is in question, the attending physician shall evaluate the principal’s capacity and, if the physician concludes that the principal lacks capacity, enter that evaluation in the principal’s medical record. If the attending physician has a question as to whether the principal lacks capacity, another physician shall also evaluate the principal’s capacity, and if the second physician agrees that the principal lacks the capacity to make health care decisions or provide informed consent, the health care facility shall enter both physician’s evaluations in the principal’s medical record.
- (3) The surrogate’s authority shall commence upon a determination under Subsection (2) that the principal lacks capacity, and such authority shall remain in effect until a determination that the principal has regained such capacity.
- (4) A determination made pursuant to this section that a principal lacks capacity to make health care decisions shall not be construed as a finding that a principal lacks capacity for any other purpose.

There are a number of positive attributes exhibited by this statute pertaining to the evaluation of decisional capacity. First, the stated presumption of capacity in the health care context is fully consistent with prevailing clinical practice, ethical principles, and American jurisprudence. So, too, is the legislature’s explicit refusal to equate the sole fact of hospitalization for mental illness or retardation with the legally

and practically consequential status of decisional incapacity. The statute also properly acknowledges that maximizing autonomy means that capacity, at least for many individuals, requires a decision-specific rather than a global determination and that a determination made regarding health care decisions does not necessarily translate into a similar determination in the context of different types of decisions.

At the same time, although this statute goes on to guarantee in detail a variety of important procedural rights to the allegedly incapacitated person regarding a determination of incapacity—assuring that the evaluation must be conducted and documented by the attending physician and that an uncertain attending physician must involve a second physician as back-up before treating the patient as an incapacitated person—it provides no guidance whatsoever to the physician evaluator(s) about the expected content of the evaluation(s). The message of the statute might be crudely, but fairly, interpreted as, “Physician, just do the evaluation however best you think it should be done. You’ll figure it out somehow”. Or, to paraphrase Justice Potter Stewart’s famous observation about the Supreme Court’s inability to intelligibly define pornography for others [3]. “Physicians, evaluate the individual’s decisional capacity. We can’t really define incapacity for you, but we’re confident you’ll know it when you see it.”

Another legal provision that concentrates on elucidating the process rather than the substance of a decisional capacity evaluation is found at Florida Statutes Title 42—Appendix I, Probate Rules, Rule 5.900 Expedited Judicial Intervention Concerning Medical Treatment Procedures. This Rule, to be applied by the courts in particular cases, sets out the mechanics of filing a petition to obtain authorization for medical treatment without the patient’s own consent.

- (a) Petition. Any proceeding for expedited judicial intervention concerning medical treatment procedures may be brought by any interested adult person and shall be commenced by the filing of a verified petition which states:
 - (5) facts sufficient to establish the need for the relief requested, including, but not limited to, facts to support the allegation that the patient lacks the capacity to make the requisite medical treatment decision.

This provision fails to meaningfully instruct either the petitioner or the judge ruling upon the petition, let alone any clinical professionals involved in evaluating decisional capacity in conjunction with such a petition, about which “facts” exactly satisfy the pleading and proof requirement. Somehow, the persons involved are supposed to, on their own, come up with the content to satisfy that unelaborated-upon linchpin of the Rule.

Other legal examples of definitional imprecision abound. The Florida Mental Health Act contains the definition:

“Incompetent to consent to treatment” means that a person’s judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment (Florida Statutes § 394.455 (15)).

The term “well-reasoned”, without any further elaboration, could be susceptible to multiple, possibly inconsistent, interpretations by different capacity evaluators, especially in the context of medical or mental health treatment.

In the context of adult guardianship, Florida Statute § 744.464 deals with the issue of Restoration to Capacity thusly:

(2) (e) If an objection is timely filed, or if the medical examination suggests that full restoration is not appropriate, the court shall set the matter for hearing

(3) (a) If no objections are filed, and the court is satisfied with the medical examination, the court shall enter an order of restoration of capacity, restoring all or some of the rights which were removed from the ward. The order must be issued within 30 days after the medical report is filed.

This law is loudly silent on the questions of what it operationally means for “the medical examination [to] suggest that full restoration [of the ward’s legal right to make his or her own decisions] is not appropriate” and why or when the court should be “satisfied with the medical examination”.

The law consists not only of statutes and regulations, but also of judicial decisions that interpret those statutes and regulations as well as creating and applying principles of common law. One Florida decision admonishes that, “[i]n our present day paternalistic society we must take care that in our zeal for protecting those who cannot protect themselves we do not unnecessarily deprive them of some rather precious individual rights” [4]. Hence, one might hope that judicially enunciated case law will provide a clue to the decisional capacity evaluation puzzle for health care and human services professionals. Research into Florida case law reveals a common example of judicial guidance on this matter that is simultaneously both partially helpful and distressingly confusing.

In re Guardianship of J.D.S. [5] involved the following facts:

Jennifer Wixtrom filed a petition to be appointed guardian of J.D.S.’s fetus. Wixtrom alleged that the appointment was essential because J.D.S. lacked the mental capacity to provide proper prenatal care and to make necessary decisions for the protection and enhancement of the fetus during its formative months.

The appellate court approved of the trial court’s findings that:

The nature and scope of the Ward’s incapacities are: severe mental retardation, cerebral palsy with a history of autism. The following facts demonstrate that the Ward is totally without capacity to care for the Ward’s person or property: . . . She is unable to communicate and unable to make her needs known. She requires assistance with ambulation and requires total assistance with all activities of daily living. She cannot hold a pen, cannot write, doesn’t know her name or very basic information. She is unable to follow simple commands [sic] and is unable to express basic needs. Her intellectual deficit and inability to make her needs known significantly impairs her ability to make informed decisions in all areas of her life.

The value of the court’s opinion for evaluators of decisional capacity is mixed. On the positive side, the opinion accurately notes for evaluators that observations of the proposed ward’s inability to communicate, to know her own name or very basic information, and to follow simple commands and express basic needs certainly are vital considerations in evaluating that individual’s ability to make informed decisions in all areas of her life. What is exceedingly unhelpful, though, is the court’s serious failure to distinguish between decisional capacity (which is a primary ethical and legal concern for the

exercise of personal autonomy), on the one hand, and executional capacity, on the other [6]. The impairment in J.D.S.'s ability to ambulate or physically perform certain activities of daily living and hold a pen tells us a great deal about whether she can independently execute her wishes; she cannot, and needs the help of others to do so. By contrast, her need for helpers in order to physically carry out her choices tells us nothing at all about the sufficiency of her cognitive and emotional ability to formulate her own choices in the first place, that is, about her decisional capacity. Many decisionally capable people need the physical assistance of others to execute their wishes. That need should not disqualify those persons from the right to exercise autonomy in decision making. This distinction between decisional and executional autonomy is crucial, and the courts and legislatures do a serious disservice to decisional capacity evaluators and the persons they serve when that distinction is ignored or mangled.

3. Assessing Diminished Capacity in the Context of Legal Services

This article has concentrated primarily on the role of health care professionals in engaging in determinations about a patient's functional capacity to make decisions regarding medical intervention. However, the decisional capacity issue also often arises in the context of practicing attorneys needing to determine whether their clients currently have sufficient functional ability to make valid decisions that carry significant legal consequences. Unfortunately, the approach that has evolved within the legal services context provides very limited useful guidance for arriving at fair and reliable decisional capacity determinations.

The clinical practice of attorneys is governed by the American Bar Association Model Rules of Professional Conduct [7], as adopted by the practitioner's individual state [8]. Rule 1.14, "Client with Diminished Capacity", section (a), talks about the client-lawyer relationship "[w]hen a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason". The "for some other reason" verbiage logically translates as "for any reason", and thus eviscerates any meaningful categorical or diagnostic requirement as a component of capacity assessment. Moreover, the language "adequately considered decisions" gives neither the attorney nor anyone else helpful guidance with which to work. Rule 1.14(b) goes on to declare, as the trigger for initiating permissive (not mandatory) "reasonably necessary protective action" for the client's well-being, the lawyer's "reasonabl[e] belie[f] that the client has diminished capacity". Problematically, though, any clue about what factors ought to inform or inspire the lawyer's "reasonable belief" that the client has diminished capacity is missing from the Model Rules.

4. What Are the Remedies?

Even assuming *arguendo* that one agrees that the examples provided above are typical of legislation, court rules, and judicial opinions that provide few useful, practical clues to guide health care and human services professionals in conducting evaluations of decisional capacity in older adults, so what? The policy ramifications must be identified. Stated bluntly, the dichotomous choice is to either do nothing or do something.

In response to the foregoing discussion of deficiencies in the present law when it comes to guiding health care and human services clinicians who conduct decisional capacity evaluations of older adults,

it is tempting to conclude that it would be best to leave well enough (or bad enough) alone. According to this view, attempts to rewrite the relevant statutes, court rules, and judicial opinions may open up an enormous “can of worms”, and that potential makes the present silence and/or ambiguity of the law very palatable by comparison. After all, while surely not perfect, the prevailing practice of “bumbling through” capacity evaluations using working clinical criteria that have evolved incrementally and mainly *ad hoc*, has worked reasonably well thus far in balancing the fundamental social values at stake.

However, I would submit that yet another concerted effort to try to clarify and harmonize legal standards for evaluating decisional capacity should be substituted for the present predominance of statutory, regulatory, and judicial silence and/or ambiguity. Otherwise, capacity evaluations will continue to be conducted largely subjectively, unreliably, and at worst even arbitrarily, and adverse legal consequences—in the form of either too little respect for autonomy or too little protection of vulnerability—may be imposed unfairly on individuals when various kinds of life decisions must be made. Admittedly, a number of questions relating to the implementation of a proposed “There ought to be better law” strategy will need to be addressed.

First, who should be afforded the official or unofficial role of substantive consultants in the writing of any revised statutes, regulations, or court rules? The answer is that this challenge calls for a true interprofessional collaboration both in writing more clear laws and in implementing them [9,10]. Attorneys, ethicists, and health care providers from the clinical spheres of medicine, psychology, and social work each bring to the drafting table special insights and attributes. Organizational representatives who advocate for the perspective of older persons and families also should be included in a state’s law revision process. Moving from process to substance, what about the content of revised laws? What would new and improved statutes, court rules, and judicial opinions say about decisional capacity and its evaluation? How would we correct current deficiencies? How should lawmakers codify more objective measures into legal definitions of capacity that could be credibly validated by studies testing inter-rater reliability or concordance in utilizing those measures?

To begin, state statutes should more emphatically command that the process of assessing decisional capacity entail a functional inquiry, rather than a purely categorical or outcome-based one. Among the basic questions to be posed are the following: (1) Can the person make and communicate in an understandable form any decisions at all? (2) Is the person able to offer reasons for the choices made, indicating some degree of reflection and consideration? (3) Are the reasons given based on logical reasoning proceeding from factually accurate suppositions? (4) Can the patient appreciate the ramifications (that is, the likely risks and benefits) of the options outlined and the choices expressed, and the reality that these ramifications apply to that patient? (5) Does the individual, in fact, comprehend the practical implications of his or her choices?

Additionally, statutory language should emphasize that a patient’s present cognitive and emotional capacity should be evaluated on a decision-specific, rather than a global or all-or-nothing, basis. A patient may be capable of making some kinds of decisions, but not others; partial or limited capacity is quite possible even when total capacity is not. Moreover, capacity may fluctuate within a specific patient according to variables such as time of day, day of the week, physical location, acute and transient physical problems, other persons available to support or coerce the patient’s choice, and medication reactions. Older individuals may be especially vulnerable to fluctuations in capacity induced by these factors. Some of these factors may be susceptible to manipulation by caregivers (for example,

through changes in the timing of drug administration) so that discussions with the patient (rather than or in addition to the surrogate) about the care plan can take place under the most lucid circumstances possible. The same point may apply regarding the timing of court appearances for persons whose decisional capacity is being questioned, a procedural detail that legislation or regulation should clarify.

Assuming that legal changes were to occur in an attempt to better guide the process and outcomes of decisional capacity evaluations conducted by health care and human services clinicians, ideally some sort of process for evaluating the effectiveness of those changes should be built directly into the revised laws. Social scientists with qualitative research skills should do and report such evaluations demonstrating and documenting the extent to which purported improvements in autonomy, beneficence, and nonmaleficence promotion actually work. Moreover, any legal revisions should contain automatic sunset provisions to assure periodic external review of concordance between the revised laws' intent and impact.

5. Conclusions

Asking whether an adult person has, at any particular point in time, sufficient cognitive and emotional capacity to be allowed to autonomously make important life choices is a question with complex and compelling legal and social significance. Answering that question for any individual should involve the application of a concept that has content derived from many sources; however, this article has argued, using Florida jurisprudence as illustrative, that the current law ordinarily cannot be looked upon as a very helpful source of wisdom in this regard. The implicated policy response urged in this essay places optimism in the possibility that trying to revise existing laws to more clearly and unambiguously define decisional capacity can result in better ethical outcomes—both for individuals and collectively—for health care and human services consumers (particularly but not exclusively older persons), their families, and the professionals who care for and about them.

Conflicts of Interest

The author declares no conflict of interest.

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