SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Health Matrix: The Journal of Law-Medicine

Volume 30 | Issue 1 Article 3

2020

Competency to Decide for Another

Elyn R. Saks

Competency to Decide for Another

Elyn R. Saks†

Contents

Scope of Topic

Our topic is competency of a Substitute Decisionmaker (SubDM) to make a decision about medical treatment for another who is incompetent himself (the "ward"). While there is

† Orrin B. Evans Distinguished Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law; Adjunct Professor of Psychiatry, University of California, San Diego, School of Medicine; and Faculty at the New Center for Psychoanalysis.

I wish to thank Professor Scott Altman, Reference Librarian Cindy Guyer, Director, Saks Institute, Christopher Schnieders, Program Specialist Sonja Castaneda Cudney, and law students Shelby Cummings and Sultan Alaskar for their expert assistance on this article.

considerable literature on competency to decide for oneself,[1] there is very little on competency to decide for another.[2] Some studies look at a range of things that a SubDM needs to do[3]—for example, seek information on what the ward has said—but there is none on how well a person must understand the relevant issues to be a competent SubDM.

Why would this question arise? Clearly we would not select someone to be a guardian if we knew him to be decisionally

1. *See, e.g.*, Stephen H. Behnke & Elyn R. Saks, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103 (1999); Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996); William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937 (1998); Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283 (1992); Phillip Harris & Kirsten Stalker, *The Exercise of Choice by Adults with Intellectual Disabilities: A Literature Review*, 11 J. APPLIED RES. INTELL. DISABILITIES 60 (1998); Molly S. Jacobs et al., *Competence-Related Abilities and Psychiatric Symptoms: An Analysis of the Underlying Structure and Correlates of the MacCAT-CA and the BPRS*, 32 LAW HUM. BEHAV. 64 (2008); Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decision and* Parens Patriae *of Civil Commitments*, 45 U. MICH. J.L. REFORM 561 (2012); Daniel C. Marson et al., *Consistency of Physicians' Legal Standard and Personal Judgments of Competency in Patients with Alzheimer's Disease*, 48 J. AM. GERIATRICS & SOC'Y 911 (2000); Grant H. Morris, *Judging Judgement: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343 (1995).

2. In fact, we have found no literature on competency of SubDMs *per se* to make these decisions, though there is literature on some tasks that SubDMs must do. The following databases were searched: Westlaw (Journals and Law Reviews); AgeLine; ProQuest (Social Sciences/PsycINFO); Web of Science; PubMed; and, Google Scholar.

3. *E.g.*, Emily H. Bower, *Evaluation of a Tube Feeding Decision Aid for Substitute Decision Makers*, W. VA. U. GRAD. THESES, DISSERTATIONS, AND PROBLEM REPORTS 2385 (2006); Nina A. Kohn, *Matched Preferences and Values: A New Approach to Selecting Legal Surrogates*, 52 SAN DIEGO L. REV. 399 (2015); Linda S. Whitton & Lawrence A. Frolik, *Surrogate Decision-Making Standards for Guardians: Theory and Reality*, 2012 UTAH L. REV. 1491 (2012).

impaired. But an appointed guardian could become impaired. Also, sometimes family surrogates who are not court-appointed but serve as proxy decisionmakers will have impairments. Or a Durable Power of Attorney (DPA) competent at the time that the document is drawn up, but impaired now, will be the SubDM.

Indeed, likely a fairly standard scenario is when spouses appoint each other as DPA. Suppose one of the spouses becomes severely demented. And suppose the other spouse is suffering impairments as well. This may be a case where we would want the nondemented spouse to be evaluated to make sure that she has sufficient capacity to be a SubDM.

In short, it is a useful theoretical exercise to see what the SubDM must be able to know. The point of the exercise is to suggest what level of capacity the SubDM must have and how much departure from the ideal would be allowed. That's to say, we are trying to establish how competent the SubDM must be.

If the SubDM has to have a relatively high level of decisionmaking capacity when the ward doesn't, then, as I will suggest, the question is how we arrive at and justify that conclusion, and what that level of capacity looks like. In the last section, we locate this question in the context of our standards requiring reasonable care when one acts on behalf of another.

I. THE LEGAL LANDSCAPE

The space we are occupying for this problem is that of a patient's literal incompetency that is enough to justify a SubDM, for example a court-appointed guardian or a DPA. Typically, guardianship is divided into guardian of the person and guardian of the estate.[4] These are called plenary guardianships.[5] Many jurisdictions also have limited guardianship: for example, the ward can make financial decisions, but not exceeding a certain

4. Phillip B. Tor & Bruce D. Sales, *A Social Science Perspective on the Law of Guardianship: Directions for Improving the Process and Practice*, 18 LAW & PSYCHOL. REV. 1, 4 (1994); Judith C. Barker & David King, *Taking Care of My Parents' Friends: Non-Kin Guardians and Their Older Female Wards*, 13 J. ELDER ABUSE & NEGLECT 45, 49 (2001).

5. Tor & Sales, *supra* note 4, at 3; Rachel M. Kane, 28 FLA. JUR. GUARDIAN & WARD 2D, *Definitions* § 1 Westlaw (database updated Nov. 2019); Mary J. Quinn & Howard S. Krooks, *The Relationship Between the Guardian and the Court*, 2012 UTAH L. REV. 1611, 1620 (2012).

amount; or, the ward can make most life decisions, but not many medical decisions.[6] Scholars have noted, however, that limited guardianships are actually rarely used in practice.[7]

In seventy-five percent of cases, the guardian will be a family member,[8] and there are lists of who may serve in order of priority.[9] For example, spouses come before adult children and adult children come before parents.

Guardians of the person can make all sorts of decisions for their ward—where to live, with whom to associate, whom to marry, to whom to bequeath an estate.[10] The focus of this paper will be on medical decisionmaking. The group of people subject to guardianship is getting smaller and smaller as there is a move toward helping people with decisional impairments make decisions in collaboration with others, such as family and friends and professionals.[11] This is called Supported Decisionmaking (SDM).

---

6. *See* Tor & Sales, *supra* note 4, at 18 n. 90; Kane, *supra* note 5; Quinn & Krooks, *supra* note 5, at 1620.

7. *E.g.*, Tor & Sales, *supra* note 4, at 20; Michael E. Bloom, *Asperger's Disorder, High-Functioning Autism, and Guardianship in Ohio*, 42 AKRON L. REV. 955 (2009); Jamie L. Leary, *A Review of Two Recently Reformed Guardianship Statutes: Balancing the Need to Protect Individuals Who Cannot Protect Themselves Against the Need to Guard Individual Autonomy*, 5 VA. J. SOC. POL'Y & L. 245 (1997); Jan Ellen Rein, *Preserving Dignity and Self-Determination of the Elderly in the Face of Competing Interests and Grim Alternatives: A Proposal for Statutory Refocus and Reform*, 60 GEO. WASH. L. REV. 1818 (1992); Barbara A. Venesy, *1990 Guardianship Law Safeguards Personal Rights Yet Protects Vulnerable Elderly*, 24 AKRON L. REV. 161, 176 (1990).

8. Tor & Sales, supra note 4, at 20, 35.

9. Peter G. Guthrie, Annotation, *Priority and Preference in Appointment of Conservator or Guardian for an Incompetent*, 65 A.L.R.3d 991, *2 (2016); Amy Brown, *Broadening Anachronistic Notions of "Family" in Proxy Decisionmaking for Unmarried Adults*, 41 HASTINGS L.J. 1029, 1045–47 (1990).

10. Kim Dayton, *Standards for Health Care Decision-Making: Legal and Practical Considerations*, 2012 UTAH L. REV. 1329, 1329 (2012); Mark D. Andrews, *The Elderly in Guardianship: A Crisis of Constitutional Proportions*, 5 ELDER L. J. 75, 76 (1997); Bloom, *supra* note 7, at 962–63; Leary, *supra* note 7, at 245; Rein, *supra* note 7, at 1824–26; Venesy, *supra* note 7, at 164.

11. *See, e.g.*, Michelle Browning et al., *Supported Decision Making: Understanding How Its Conceptual Link to Legal Capacity Is*

SDM is in use with developmentally disabled and demented patients. Together with colleagues, I am conducting two studies of SDM in the case of people with mental health disorders, in particular schizophrenia and bipolar illness—the first of their kind in this population. One funded study will look at whom patients choose to be their supporters and why, their satisfaction with the decision-making process, and downstream effects on quality of life, such as living and working more independently. We have four sites with this study—USC, UCLA, UCSD, and SUNY Downstate—and at this point France and Israel are possibilities, so we will have an international perspective.

The second is a contract with California's Mental Health Services Oversight and Accountability Commission (MHSOAC) for an Innovation Plan around PADS and SDM. This project will look at SDM and Psychiatric Advance Directives (PADs), both in the civil sphere and in criminal justice. This multi-county Innovation Project is intended to support counties in the implementation and evaluation of using PADs and SDM to improve access to care, the appropriateness and quality of care to improve outcomes for consumers at risk of involuntary care and criminal justice involvement. Psychiatric Directives are used in times of crisis that can be episodic with the likelihood of individuals stabilizing and retaining their immediate decision making authority. We will approach a number of County Departments of Mental Health in California to consider SDM and PADs in their jurisdictions, and we will choose two to four to study intensively. Both of these projects have received significant funding.

In any event, SDM is not that different from how most people make important decisions. That is, they consult family and friends to try to make the best decision they can. It appears anecdotally that this kind of collaboration is possible and does

Influencing the Development of Practice, 1 RES. & PRAC. IN INTEL. & DEVELOPMENTAL DISABILITIES 34, 35, 37 (2014); Robert D. Dinerstein, *Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making*, 19 HUM. RTS. BRIEF 8, 9 (2012); Nina A. Kohn et al., *Supported Decision-Making: A Viable Alternative to Guardianship?*, 117 PENN STATE L. REV. 1111, 1111 (2013); Rachel Chabany & Shirli Werner, *Guardianship Law Versus Supported Decision-Making Policies: Perceptions of Persons with Intellectual or Psychiatric Disabilities and Parents*, 86 AM. J. ORTHOPSYCHIATRY 486, 487 (2016).

increase the decisional authority of people with impairments—e.g. developmentally disabled and demented people.[12] This, in turn, increases their quality of life,[13] essentially permitting more people to be the architects of their own lives.

But it cannot be a complete substitute for the incompetent ward-guardianship scenario.[14] Consider a person with severe developmental disability who has the mental age of a one-year-old. No amount of effort can help him to understand the choices that he faces. We can't even ask him what he wants or prefers: he doesn't understand our questions. Or, take an individual who has severe Alzheimer's. He or she can't put two sentences together or understand two sentences put together.

What about floridly psychotic people who can't make decisions, for example, a person in the midst of a psychotic episode with delusions and hallucinations around the choice? We can't convince him that his beliefs are untrue, and he is deciding based on his beliefs. (Of course, the beliefs of some psychotic people may be irrelevant to their choice and then they may have capacity to choose.) Or, suppose that a psychotic person is so disorganized and confused that he can't track the informed consent conversation. This could conceivably be remedied with simplified explanations, but sometimes not.[15]

12. *See* Johanne Eliacin et al., *Factors Influencing Patients' Preferences and Perceived Involvement in Shared Decision-making in Mental Health Care*, 24 J. Mental Health 24 (2014); Julie Beadle-Brown et al., *Person-Centered Active Support—Increasing Choice, Promoting Independence and Reducing Challenging Behavior*, 25 J. Applied Res. in Intell. Disabilities 291, 303 (2012).

13. *See* Annika Tagizadeh Larsson & Ann-Charlotte Nedlund, *To Protect and to Support: How Citizenship and Self-Determination Are Legally Constructed and Managed in Practice for People Living with Dementia in Sweden*, 15 Dementia 343 (2016); Sharon Lawn et al., *Mental Health Recovery and Voting: Why Being Treated as a Citizen Matters and How We Can Do It*, 21 J. Psychiatric & Mental Health Nursing 289, 290 (2014).

14. Kohn et al., *supra* note 11, at 1154–55; Dinerstein, *supra* note 11, at 10; Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 Univ. Colo. L. Rev. 157, 181–182 (2010).

15. Laura B. Dunn et al., *Enhancing Comprehension of Consent for Research in Older Patients with Psychosis: A Randomized Study*

Of course, one could say that one should at least ask the ward what he or she wants. So, perhaps the most compelling case where a guardian is needed—and would have the fullest authority—is when the patient is in a coma.

In the bulk of these cases, we will of course try to help the person understand and decide, but will not always succeed. There are studies, for example, those by Dr. Laura Dunn and colleagues, that show that with "enhanced consent" protocols, a significantly greater proportion of patients with schizophrenia and other psychotic disorders score 100% on first and second trials of the posttest compared to those receiving the routine procedure.[16] We can accommodate the SDM's decisionmaking deficiency in each of these examples.

Still, not everyone can be restored to competency. Enter SubDMs. These will be the cases where the SubDM makes the choice for the ward. Below we discuss the standards that are used.

Note also that while we are discussing the capacity of SubDMs to decide for their ward, it will be well at some point to consider the capacity of the supports in SDM. Perhaps they need less capacity because the ward has some decisional authority. Or perhaps they will need more capacity because they must more finely judge when and where the ward can decide. They will also clearly need other skills than a SubDM, e.g., to be able more thoroughly to engage the person whose decision is at issue. But for now I focus on SubDMs.[17]

I turn to the context of competency to decide for oneself to see what abilities are required. I turn then to the abilities required in the SubDM context—are they the same as or different from the ones in the case of the person deciding for herself?

II. COMPETENCY TO DECIDE FOR ONESELF: THE COMPARISON

There are three criteria that any adequate competency standard must meet. First, it must meet the "abilities" criterion,

of a Novel Consent Procedure, 158 AM. J. PSYCHIATRY 1911–13 (2001).

16. *Id.* at 1913.

17. This begs the question whether to put supports in place for an impaired SubDM or simply remove her or him from the case. But that is an inquiry for another time.

i.e., it faithfully identifies the abilities that are necessary to making decisions that deserve deference. Second, it must meet the "unconventionality" criterion, which mandates that a competency standard protect a person's expression of her values and beliefs, however unconventional. This is so because one important purpose of the competency doctrine is to allow people to pursue their interests according to their own lights. Freedom to decide includes, within limits, freedom to decide what is true no less than what is good. Finally, the "irrationality" criterion requires that a competency standard designate a reasonably small class of individuals as incompetent in the face of the pervasive influence of the irrational and the unconscious.[18]

Both the "unconventiality" criterion and the "irrationality" criterion have an effect on the "abilities" criterion. The "unconventionality" criterion means that a wide range of abilities will be allowed, because to do otherwise would trench too much on choice; and the "irrationality" criterion means that a wide range of abilities will be allowed because if we ruled out choices with any degree of irrationality, there would be few choices remaining to be honored.[19] This is the backdrop against which a competency standard must be measured. Numerous tests and standards exist in the literature. Along with colleagues, I reviewed some of them in an article in the *American Journal of Psychiatry* in 2006.[20]

The "gold standard" is probably the MacArthur instruments. They look at four different components of competency: (1) does one "understand" the relevant information, for example, the nature of the procedure and the risks and benefits; (2) does one "appreciate" how this information applies to oneself; (3) can one "reason" with the information, for example, is one able to think comparatively or, where warranted, in probabilistic terms about different options; and, (4) can one "evidence a choice"? [21]

18. Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 949 (1991); Saks & Behnke, *supra* note 1, at 130.

19. Saks, *supra* note 18, at 950.

20. *See* Elyn R. Saks et al., *Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments*, 163 AM. J. PSYCHIATRY 1323 (2006).

21. *See* Elyn R. Saks & Dilip V. Jeste, *Capacity to Constent to or Refuse Treatment and/or Research: Theoretical Considerations*, 24 BEHAV. SCI. & L. 411 (2006).

(Obviously, if one can't, then that choice can't be honored.) The MacArthur researchers have sketched out the meaning of these four component abilities and have studied them in application to patients with, for example,depression and schizophrenia.[22]

To me, there are three problems with the Macarthur instruments. First, the distinction between their concepts of understanding and appreciating is not well taken.[23] Essentially, appreciating is a subset of understanding: forming adequate beliefs about the illness and procedure ("understanding") and forming adequate beliefs about these things with reference to oneself ("appreciating"). In other words, the two skills are the same skill applied to different things. To me this is not ideal. Second, the MacArthur instruments at least veer in the direction of requiring the patient to have mostly true beliefs.[24] I believe a better standard would require having no patently false beliefs (PFBs), rather than having no false beliefs at all. Below we discuss why the PFB standard is the most appropriate standard. Third, the MacArthur instruments are agnostic on the question of how incapable a person should be to take away his choice. That

22. *See, e.g.*, Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW. & HUM. BEHAV. 149, 149 (1995); Duncan Milne et al., *Community Treatment Orders and Competence to Consent*, 17 AUSTRL. PSYCHIATRY 273 (2009); Bruce J. Winick, *The Macarthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL'Y, & L. 137, 137–138 (1996); Michael Koelch et al., *Report of an Initial Pilot Study on the Feasibility of Using the MacArthur Competence Assessment Tool for Clinical Research in Children and Adolescents with Attention-Deficit/Hyperactivity Disorder* 20 J. OF CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY 63 (2010); Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 PSYCH. PUB. POL. AND L. 45, 62 (1996); JAMES G. SHARRATT, THE EFFICACY OF THE MACARTHUR COMPETENCE ASSESSMENT TOOL FOR TREATMENT DECISIONS (MACCAT-T) TO ASSESS SOUTH AFRICAN PATIENTS' ABILITIES TO GIVE CONSENT TO TREATMENT, at 5 (Sept. 1997) (on file with Univ. of Stellenbosch).

23. Saks & Jeste, *supra* note 21, at 414.

24. *See* Berg et al., *supra* note 1, at 355–57; Christopher Slobogin, *Appreciation as a Measure of Competency: Some Thoughts About the MacArthur Group's Approach*, 2 PSYCHOL., PUB. POL'Y, & L. 18, 20–21 (1996).

is, they don't address the normative issues around establishing a cut point.[25] On the other hand, they do suggest a level they call "impaired."

Thus, I have suggested that competency to make treatment decisions requires[26]: (1) "understanding," in the sense of comprehending what is being told to one; (2) "appreciating," in the sense of forming acceptable beliefs about what one is told; (3) "reasoning" with the information; and (4) "evidencing a choice." With this standard, "understanding" and "appreciating" require different skills—comprehension and belief-formation.

And under "appreciating," again, we need to specify how distorted one's beliefs must be to vitiate capacity. So, I and my colleagues have suggested that the concept of a PFB should govern.[27] This gives people maximal decisional authority, including the authority to say what is true. It also takes into account the fact that many "truths" are unknown and considers the fact that many people are at least somewhat irrational. In other words, the "unconventionality" criterion allows all beliefs except the PFBs. And the "irrationality" criterion allows irrational beliefs so long as they are not patently false.

As for the definition of PFBs, they are beliefs that are grossly improbable for any of three reasons. First, PFBs may be "impossible" or violate the laws of nature.[28] An example would be that one's thoughts can kill. Second, a PFB may be *practically* impossible; that is, a belief so improbable that we feel confident

25. Saks & Behnke, *supra* note 1, at 125; Saks & Jeste, *supra* note 21, at 414; *See* Vijay A. Mittal et al., *Ethical, Legal, and Clinical Considerations when Disclosing a High-Risk Syndrome for Psychosis*, 29 BIOETHICS 543, 555 (2015).

26. Saks & Behnke, *supra* note 1, at 112–13; Saks, *supra* note 18, at 960; Mittal et al., *supra* note 25, at 553.

27. *E.g.*, ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 185 (2010) [hereinafter SAKS—REFUSING CARE]; Dilip V. Jeste et al., *A Collaborative Model for Research on Decisional Capacity and Informed Consent in Older Patients with Schizophrenia: Bioethics Unit of a Geriatric Psychiatry Intervention Research Center*, 171 PSYCHOPHARMACOLOGY 68, 71 (2003); Elyn R. Saks, *Competency to Refuse Medication: Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, 22 S. CAL. REV. L. & SOC. JUST. 167, 170 (2013).

28. SAKS—REFUSING CARE, *supra* note 27, at 183.

in saying it is false without additional evidence.[29] An example would be that one is able to calculate as fast as a supercomputer. Finally, a PFB may be a belief that represents a gross distortion of obvious facts; that is, a belief that flies in the face of empirical happenings obvious to everyone.[30] An example would be that there is a large spaceship in the middle of New York's Times Square.

I have studied this concept of competency, in particular of appreciation. Together with some colleagues at UCSD Medical School, I have developed an instrument called the "California Scale of Appreciation" (CSA), which has 18 items rated in accordance with a PFB standard.[31] For example, one statement is "[t]he researcher has special abilities or powers that will protect me from all harm."[32] If the subject says yes, then there is an effort to see if he really means this literally or is exaggerating or speaking metaphorically, and the item is scored accordingly.[33]

We have studied the CSA in thirty-nine patients (twenty-seven outpatients and twelve inpatients) with schizophrenia or a related psychotic disorder; and in fifteen normal comparison subjects.[34] The mean total CSA score was significantly lower in patients than in the normal comparison subjects; however, a majority of the patients were found to be fully capable on the CSA.[35] As expected, it calls fewer people with schizophrenia incompetent than the MacArthur Appreciation instrument calls impaired. The latter is around twenty-five percent,[36] while the former is around twelve percent.[37]

In conclusion, my standard adequately deals with the three problems raised about MacArthur: it identifies different skills

29. *Id.* at 183–84.

30. *Id.* at 184.

31. *See* Elyn R. Saks, et al., *The California Scale of Appreciation: A New Instrument to Measure the Appreciation Component of Capacity to Consent to Research*, 10 Am. J. Geriatric Psych. 166, 167 (2002) [hereinafter *Saks et al.—California Scale*].

32. *Id.* at 169.

33. *Id.*

34. *Id.* at 167.

35. *Id.* at 171.

36. Grisso & Appelbaum, *supra* note 22, at 171.

37. *Saks et al.—California Scale*, *supra* note 31, at 170.

under understanding and appreciating; it better identifies the kinds of distortions that should vitiate capacity; and it draws a normative line at the point that relevant beliefs become patently false.

In what follows, I use my own notion of what competency requires—for example, no PFBs under the Appreciation part.

III. THE THRESHOLD QUESTION ON COMPETENCY TO DECIDE FOR ANOTHER

When determining one's competency to decide for another, the threshold question is what standard to use: "substituted judgment"; or, "best interests." For substituted judgment one wants to select the choice the ward would have wanted if competent.[38] For best interests, one wants to select the option that serves the best interests of the ward.[39]

Often the rule is to use substituted judgment; but, if it's difficult to tell, then use best interests.[40] The reason for this is that the substituted-judgment standard most respects the person's autonomy; we are deciding what the autonomous self would have wanted. Sometimes, though, we just don't know, and in that event, we turn to the best-interests standard.

IV. COMPLICATIONS WITH THE SUBSTITUTED-JUDGMENT STANDARD

In asking "what choice the ward would have wanted if competent," "competent" can mean barely competent, very

38. *E.g.*, *In re* Truselo, 846 A.2d 256, 271 (Del. Fam. Ct. 2000); *In re* Fiori, 673 A.2d 905, 911 (Pa. 1996); Matter of Tavel, 661 A.2d 1061, 1068 (Del. 1995); MONT. CODE ANN. § 72-5-101 (2019); D.C. CODE § 7-1301.03 (2018); MD. CODE ANN., EST. & TRUSTS § 13-711 (West 2018).

39. *E.g.*, Matter of Guardianship of L.W., 482 N.W.2d 60, 75 (Wis. 1992); *In re* AMB, 640 N.W.2d 262, 293 (Mich. Ct. App. 2001); D.C. CODE § 7-1301.03 (2018); MD. CODE ANN., EST. & TRUSTS § 13-711 (West 2018).

40. *See, e.g.*, Barber v. Superior Court, 195 Cal.Rptr. 484, 493 (Cal. Ct. App. 1983); Foody v. Manchester Memorial Hosp., 482 A.2d 713, 721 (Conn. Super. Ct. 1984); D.C. CODE § 21-2047.02 (2008); *In re* Conroy, 486 A.2d 1209, 1231 (N.J. 1985); MD. CODE ANN., EST. & TRUSTS § 13-713 (West 2010); Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987).

competent, or something in the middle. A "barely competent" individual has no PFBs but may have many false beliefs, whereas a "fully competent" individual has no identifiable false beliefs. A person in the middle may have some number of false beliefs.

Whose decision governs when the SubDM wants to decide what the person—if competent—would want? Which competent person? If there are a number of competent or acceptable choices, then perhaps should we select the choice based on who, so to speak, is deciding? In considering this, does it matter which "person" the person is most of the time? Do we want to support the "best" version of oneself that the person can be? Or, do we want to look at the most minimally competent person to give the greatest scope to his autonomy?

We must decide which self to look at, including how competent he or she must be.

V. TASKS OF THE SUBDM IN THE CASE OF SUBSTITUTED JUDGMENT AND BEST INTERESTS

The SubDM on a substituted-judgment standard has various tasks that he must do: (1) search for any past statements of preferences regarding the medical decision; (2) consider any behavioral indicators of preference outside of direct statements; (3) figure out the person's goals and values; (4) determine the range of choices consistent with these goals and values; (5) see how choices land on significant people in the person's life (if the ward is close to them); and, (6) ultimately choose the option that best serves all of these.[41]

For the best-interests standard, the substitute decisionmaker needs to ask: (1) what are the costs and benefits of the different options; (2) what are the choices a reasonable person in the ward's position would want to make; and (3) how the different choices

41. *See generally*, STANDARDS OF PRACTICE, NAT'L GUARDIANSHIP ASS'N (2013), available at https://www.guardianship.org/wp-content/uploads/2017/07/NGA-Standards-with-Summit-Revisions-2017.pdf [https://perma.cc/CC72-LMGT]; HANDBOOK FOR SUBSTITUTE DECISION MAKERS, OFF. ATT'Y GEN. OF MINN. (Sept. 1999), available at https://mn.gov/omhdd/assets/substitutedecisionmakers_tcm23-27586.pdf [https://perma.cc/NMG3-JAFQ].

affect the other important people in the person's life, that is, what the costs and benefits are to them.[42]

Note that the competency to make a surrogate treatment decision in the substituted-judgment context is like competency to stand trial in that more is involved than simply understanding and appreciating. Indeed, the criminal defendant has to be able to assist his lawyer, for example, by remembering what happened and conveying it, by pointing out exonerating evidence, by identifying witnesses, etc.[43]

The SubDM similarly has a variety of tasks, for example, searching out evidence of what the patient has expressed about this issue. Suppose that the SubDM doesn't have the wherewithal to locate a witness to corroborate what the person has said—or, to confirm that this evidence indeed exists. He needn't have the skills of a private detective, but he has to be able to look into this and be motivated to do so as well.

Clearly, the SubDM has various tasks to perform that he can fall down on. When we think about competency of the SubDM, perhaps it is equivalent to the competency of someone to do any job, for example, building a house. A contractor can do this well or poorly, but in any event, there are minimum standards that she must meet to do the job. In fact, she has to do this reasonably well. Similarly, when we choose a SubDM, we are likely to select

42. Michael McCubbin & David Weisstub, *Toward a Pure Best Interests Model of Proxy Decision Making for Incompetent Psychiatric Patients*, 21 INT'L J. L. & PSYCHIATRY 1, 6–7 (1998); Lawrence A. Frolik & Linda S. Whitton, *The UPC Substituted Judgement/Best Interest Standard for Guardian Decisions: A Proposal for Reform*, 45 U. MICH. J. L. REFORM 739, 746 (2012); ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 10 (1990); *see* Michael C. Dunn et al., *Constructing and Reconstructing 'Best Interests': An Interpretative Examination of Substitute Decision-making Under the Mental Capacity Act 2005*, 29 J. SOC. WELFARE & FAM. L. 117 (2007); *see also* Ellen H. Moskowitz, *Moral Consensus in Public Ethics: Patient Autonomy and Family Decision-Making in The Work of One State Bioethics Commission*, 21 J. Med. & Phil. 149 (1996).

43. The "test must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding . . . and whether he has a rational as well as factual understanding of the proceedings against him." Dusky v. United States, 362 U.S. 402, 402 (1960).

someone who we believe is well qualified for the job. This person should have some ability to understand basic medical information, know the person's values and norms, have good judgment, and show genuine concern for the ward's wellbeing.

But why shouldn't we look at qualities of a *good* SubDM, rather than the minimum criteria? In fact, both are important to do. The first is what we should aim for. But sometimes there are reasons to not aim for the best and indeed to aim for someone only minimally qualified. Perhaps the ward values the SubDM's concern for him more highly than he does other criteria. After all, the ward has an interest in selecting his SubDM and the SubDM, as we shall see below, has an interest in keeping and performing this job.

It is also of note that there may be a difference between hiring and firing a SubDM. We might want to hire, as best we can figure out, the person most qualified to do this job for the ward. But once hired, the SubDM should be kept on the job unless she fails to meet minimum standards. Again, this will further the ward's decisional authority in having hired the SubDM—and the SubDM's autonomy interest in doing the job.

Additionally, the minimal competency standards that we will require are, in fact, fairly robust. So even if we can't or should not fire the SubDM unless she becomes incompetent in our sense, then that will leave a large range of decisional authority in the proxy.

Also, our standard for judging the capacity of a SubDM may be different depending on how consequential the decision is, both in terms of whether there are important issues at stake and whether the particular decision matters much. If the interests implicated are important and the decision matters a lot, then we might well want a more competent SubDM.[44] One can face an important decision in the sense that it will affect an important interest but the choices aren't importantly different—it's a toss-up.

For example, consider a person who has only a few months to live and the question is which medication will make him most comfortable. If each medicine works around equally well, then the decision is not very consequential. Also, if there is a clearly right

44. Mark Novak & Sean M. Novak, *Clear Today, Uncertain Tomorrow: Competency and Legal Guardianship and the Role of the Lawyer in Serving the Needs of Cognitively Impaired Clients*, 74 N.D. L. Rev. 295, 302–03 (1998).

answer and everyone recognizes it, then the SubDM's identity doesn't matter much.

On the other hand, if a decision implicates an important interest and the decision matters a lot, then we may want a higher level of capacity in the SubDM. Suppose that a life-saving procedure, "X," risks turning the ward into a quadriplegic, while the only alternative, procedure "Y," will cause the ward to no longer talk, or to become seriously cognitively impaired. The decision is important and we would want the SubDM to have a high level of decisionmaking capacity.

Note finally that the SubDM's competence involves both knowing the ward well—her values, desires, and interests—and having a good grasp of her medical information. Families are obviously better at the former and medical personnel at the latter.[45] Good SubDMs should be capable of both.

The idea of varying the level of capacity depending on the consequentiality of the decision, as it turns out, is controversial.[46] If competency doctrine gives patients wide scope in what they may choose, it follows that they should be given wide scope in deciding how important a particular decision is to them.

VI. SubDM Competency: How Well Must the SubDM Understand and Appreciate?

I wish to focus on the SubDM's competency to make the substitute decision for someone else in the sense of how well she must understand and appreciate the options in order to make a competent choice. For our purposes going forward, we will assume that a reasonably important choice is at stake.

The issues in competency to decide for oneself don't track those in the case of deciding for another. Thus, fostering the SubDM's decisional authority is less important than supporting

45. Alison Barnes, *The Virtues of Corporate and Professional Guardians*, 31 Stetson L. Rev. 941, 954–56 (2002).

46. Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 Or. L. Rev. 353, 357 (2008); Samantha Weyrauch, *Decision Making for Incompetent Patients: Who Decides and by What Standards*, 35 Tulsa L.J. 765, 778–81 (2000); Saks & Behnke, *supra* note 1, at 124; Elyn R. Saks, Competency to Decide on Treatment and Research: The MacArthur Capacity Instruments 2:59–78 (1999), *commissioned by* Nat'l Bioethics Advisory Comm'n.

the ward's decisional authority. Deciding about oneself is a more personal, heartfelt thing, than making a decision about someone else. It hurts more to take away one's autonomy to decide for oneself. You could also be unable to decide for another, not because you lack skills, but because you don't know the ward well enough, you have values and interests that clash with his, or you may be better at caring for yourself than for another. So, it is less a statement about oneself and one's limitations.

Taking choice away from the person himself is to discredit him more. You, who are theoretically in the best position to decide for yourself, are nevertheless deprived of the opportunity to choose. The SubDM's autonomy interest is simply less than the ward's himself.

The ward's autonomy is important for at least two reasons. For one, it feels good to exercise choice and to have one's choice honored because one feels respected as an autonomous agent. And for another, we think that decisions by the person herself are likelier to serve her well-being. That is, we think that the person who knows herself best and cares about herself most is likelier to make the best choice for herself.

For the SubDM, however, the calculation is different. Her autonomy may be important because it feels good to exercise choice and have it recognized. But again, it is more gratifying, and it confers more dignity, to have your choice about yourself respected than having your choice about *another* recognized. Again, it is a greater assault on one's dignity and autonomy to take choice away over oneself.

Perhaps more important, we don't grant autonomy to the SubDM because we think that she will make the best choice for a ward in a way we think her best interests will be served when she decides for herself. Generally, people know themselves best and care about themselves most, so they are likelier to make good decisions for themselves, leading to the person's best interests being served. At least in principle. So, we might tolerate more scope to make the decision—for example, endorse certain beliefs—for the person deciding for herself versus for another. The scope of allowable decisions is simply larger because we are keenly focused on the person's own autonomy in the service of her own best interests.

In short, we allow a greater range of choices for oneself for two reasons. First, it enlarges one's autonomy to have greater scope to make choices. Second, we think that affording the ward

some autonomy to exercise choice over himself is likelier to help him. The SubDM's wellbeing from choosing, then, is incidental (again, she feels good helping another), and not the point of the choice: To serve the ward's wellbeing. If it would hurt the SubDM for the SubDM to make a particular decision for the ward, but that decision would be best for the ward, then she would have to make that decision.

It's also sometimes the case, of course, that more autonomy will lead to worse decisions. Still, when someone is making a choice for himself, we may think it is permissible to trade off some of his own wellbeing for the sake of his autonomy. But it makes little sense to trade off some of the ward's wellbeing for the sake of the SubDM's autonomy.

In short, since the SubDM's competency to make a choice for herself is not at issue, there's not a strong autonomy argument to respect her choice and we need not give wide scope for her to form her beliefs as best she thinks. We may want her, as far as possible, to have correct beliefs (as best we can tell) rather than beliefs that are not patently false.

For example, take identifying beliefs connected with the ward's goals and values. Suppose that she has a goal of using enough medication—but not too much. The SubDM might hold a PFB that the ward wants to limit the use of medication because he thinks that medication is mostly—and quite literally—poison. The SubDM's PFB would remove choice from the SubDM. She might require treatment that the ward would want to reasonably refuse because of her PFB about his beliefs and goals.

An example of a false belief (but not a PFB) would be the ward has the goal because he doesn't like a particular side-effect that occurs at a specific dose, when he actually doesn't mind this but disprefers a different side effect from a different dose. If the SubDM has this false belief, then she is arguably not in a position to decide for the patient because she is wrong about what the ward prefers and disprefers and therefore is wrong about what the particular choice should be on his behalf.

While some false beliefs are easy to identify—for example, if the ward talks a lot about hating a particular side effect—others may be less clear. We can't require the SubDM to get everything right or to have no false beliefs—just to make a reasonable effort at this.

Another (perhaps easier) example is in the best-interests context, where we look at the costs and benefits of a decision.

Again, the patient himself should have no PFBs; if he believes that there is a risk of nuclear explosion if he takes meds, then that is a PFB that would vitiate capacity. But the SubDM herself should arguably have no false beliefs, to the extent this is possible and knowable. For example, if all the evidence is that the risk of tardive dyskenisia (TD) from anti-psychotics is thirty percent, and the SDM believes that it is one percent, then that would arguably vitiate her capacity on the issue of the ward taking medications.

Of course, very mild distortions would be OK: for example, the SubDM believes the TD risk is twenty-eight percent, when it actually is thirty percent. And of course, it's often true that the absolute truth about things is not known. Getting one of these wrong (which we cannot know) would not undermine capacity.

On the other hand, the question arises about what to do if there is a majority view about the truth of something and a minority view. Does the SubDM have to adopt the majority view? What if she has reason to think the minority view is right, or right for the ward: Can she adopt that? Note also that even a number of unimportantly wrong beliefs would arguably not undermine capacity. The beliefs have to be at least somewhat significant. So, if the SubDM slightly underestimate how much a blood draw will hurt, even over several blood draws, then that is arguably not enough to vitiate capacity.[47]

One of the most problematic things a SubDM can do is get the person's values and desires wrong. This is critical with the substituted-judgment standard, but it is also arguably true with the best-interests standard. Part of being "best" is meeting the desires and expectations of the person, *i.e.*, taking into account what she wants.

Note finally that an understudied issue in both the SubDM and the SDM contexts is the proxy or support person's ability to empathize with the decisionmaker. The more that the proxy or support person can stand in the shoes of the impaired person to

47. *See* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L. J. 899, 916 (1994); Margaret A. Berger & Aaron D. Twerski, *Uncertainty and Informed Choice: Unmasking Daubert*, 104 MICH. L. REV. 257, 270 (2005); John Kindley, *The Fit Between the Elements for an Informed Consent Cause of Action and the Scientific Evidence Linking Induced Abortion with Increased Breast Cancer Risk*, 1988 WIS. L. REV. 1595, 1605 (1988); Smith v. Shannon, 666 P.2d 351, 354 (Wash. 1983).

understand where he or she is coming from and why, then the better the substitute or supported decision will be.

VII. Complexifying the Capacity of the SubDM

I want to now complexify the notion that the SubDM must have a high level of capacity. The ward may have selected the SubDM for a number of different reasons. Suppose that she selects the SubDM for the SubDM's welfare—grief about one's situation might thereby be diminished. Or, she selects the SubDM as a sign of her love for him. So, the surrogate can be less than fully or ideally competent because he was chosen for other reasons than his maximal capacity to get the surrogate decision right.[48]

Additionally, as I discussed above, the SubDM may care about being able to choose. The SubDM may have a desire to act for someone else's benefit—but for his own reasons as well. He may want some control over the exercise of meaningful tasks. He has a strong interest in not being displaced in this role by someone who is judged to be better informed or more rational or better at understanding what the patient will have wanted.[49]

One problem with the first idea is that it is hard, in real time, to distinguish cases where the person has a special reason to not care about suboptimal choices because of her particular reasons for choosing the SubDM. I suppose we could have a norm that the ward indicates in advance why she is selecting the SubDM. But absent some evidence, the question becomes where the presumption should be. I suggest we should presume that the ward wants the best and most competent decision possible.

An alternative is to presume that the ward has an autonomy interest in choosing his SubDM and, even if the SubDM becomes somewhat impaired, honoring the ward's choice is more important than making the objectively "best" decision. This of course would only be at play in those circumstances in which the ward has had a voice in the choice of his SubDM. A ward might be too incapacitated to even choose a SubDM. On the other hand, a ward is likely to presume that his SubDM has a certain amount of ability to make decent decisions for him. That is, he won't anticipate that the SubDM will be impaired herself.

48. I thank Scott Altman for this point.

49. I thank Scott Altman for this point, as well.

As for the SubDM's autonomy, I concede, as suggested, that the SubDM does not entirely lack autonomy interests. Take the analogy of a parent deciding for her child. She values her autonomy in doing this, even while the primary welfare being served is the child's.[50] I would suggest, though, that the SubDM's autonomy interest in having his choice respected is not as strong as a decisionmaker's interest in making her own decisions, as we have seen, or even of a parent making a decision for her minor child.

Is this true, though, of a SubDM making a choice for an adult family member? She may get great utility in exercising her powers to help the family member. And this will often be the scenario in the substitute decisionmaking process: A relative will have been appointed to be the SubDM. This makes some sense, but of course we cannot settle the question without empirical research—something that I would advocate be done. Still, in the context of deciding for another, I think, one wants to make the right decision more than simply being the one to decide.

VIII. SUBDM COMPETENCY VERSUS REASONABLENESS

One might balk at the idea that the SubDM must have a higher degree of capacity than the ward. Perhaps his capacity is measured in the same way as the ward's; it's just that, as a fiduciary of the ward, he must be not only rational but also reasonable. For example, if it is rational (but not reasonable) for the SubDM to believe something—that some action is below the standard of care for a doctor or fiduciary—then choice should arguably be taken away from him.

Consider that the SubDM is caring for his ward in the same way that a doctor cares for her patients. Arguably, the SubDM's beliefs should be measured by what a reasonable surrogate would believe, just as a clinician's acts should be measured by what a reasonable clinician would do.[51] By contrast, the person herself

50. *E.g.*, Emily Buss, *"Parental" Rights*, 88 VA. L. REV. 635, 647 (2002); Stephen G. Gilles, *On Educating Children: A Parentalist Manifesto*, 63 U. CHI. L. REV. 937, 937 (1996); Carol K. Dillon Margaret Betsy, *In Re Roger S.: The Impact of a Child's Due Process Victory on the California Mental Health System*, 70 CAL. L. REV. 373, 380 (1982).

51. *See, e.g.*, *Standard of Care Required of Skilled Person*, N.Y. L. OF TORTS § 7:3 (Lee S. Kreindler et al., eds. 2019); Paul M. Coltoff, *Professional Standard of Care or Conduct*, 65 C.J.S. NEGLIGENCE

should be forbidden only to have beliefs that seriously depart from a *rational* person's beliefs. She has the right to be *unreasonable*.

But should we hold surrogates to the standard of a reasonable surrogate in the same way we hold doctors? They need not be professionals. On the other hand, perhaps even friends' help is judged by a standard of reasonableness—if you intervene, then you must be reasonable. Indeed, the conventional wisdom is that even helpful bystanders intervening are, in some jurisdictions, judged by a standard of reasonableness. So the important distinction is between acting on behalf of oneself versus acting on behalf of another. In the latter case you need to be reasonable.

The analogy to a doctor providing treatment, or a person helping another, may suggest that the surrogate indeed must be reasonable. But given this, perhaps it could be argued that we needn't concern ourselves with the capacity of the SubDM at all because, unlike the patient himself, the SubDM has to make a reasonable decision. So, if she makes a reasonable decision but lacks capacity, then it does not matter.

But I would suggest that making a reasonable decision does not mean that one needn't have capacity. If, say, there are five reasonable choices, then the SubDM must have the capacity to choose among them as to which best meets the standard in question: substituted judgment or best interests.

Consider, too, that in the context of the capacity of a person to decide for herself, making a reasonable decision does not mean that one has capacity. For example, one could make a reasonable choice on the basis of a PFB, when one would have wanted a different reasonable choice. And this could lead to a finding of incapacity. Indeed, a person may try to communicate a choice by blinking his eyes. But if that is all that we have to go by, then honoring the blink, so to speak, does not make much sense. Does a blink indicate "yes" or "no?" And how do we know that it is not completely random?

If this is so, then the patient himself must not be grossly irrational (incompetent) but needn't be reasonable. By contrast, the SubDM must be both rational *and* reasonable. Being reasonable does not remove the need for rationality because one

§ 163 (2019); Aves v. Shah, 997 F.2d 762, 765 (10th Cir. 1993); Rehab. Care Sys. of Am. v. Davis, 43 S.W.3d 649, 657 (Tex. Ct. App. 2001); Susan L. Thomas, *Establishing Causation—Medical Malpractice*, 15 GA. JUR. PERSONAL INJURY AND TORTS § 36:31 (2020).

must have enough rationality to choose among reasonable choices. And the SubDM also has to meet a higher level of rationality or competency than the patient himself.

The bottom line, then, is that the SubDM must have more intact reasoning than the ward; the SubDM must behave with a higher level of ability than a person deciding for himself. The important distinction is between acting on behalf of oneself versus acting on behalf of another. In the latter case you need to be both rational *and* reasonable.

Conclusion

A SubDM plays an important function in the lives of their wards, people who have lost capacity to make their own decisions. The SubDM must do her best to choose the decision that would best approximate to what the ward would have wanted if competent.

We have seen that this is more complicated than it might at first seem: "who" is the competent self whose wishes should be respected? The "best self?" The "self in control most of the time?" The "self currently in control?"

And how do we determine what he or she would have wanted? What she says? What she says about related things? What decision is most consistent with her stated needs and values? How the decision affects her family (unless, of course, they are at odds)? And what do we do if there is serious conflict among these?

The main contribution of this Essay is to ponder what capacity means in the context of substitute decisionmaking. The context of deciding for oneself can be somewhat a model for capacity in the decisionmaking context, but some of the interests are different. Teasing out these differences will lead to a standard of capacity that is specifically designed for this context.

So, the degree to which the SubDM must be competent in the sense of understanding and appreciating the issues at stake is high. She is caring for someone else's welfare and her own autonomy to form beliefs with a wide range of correctness is a minor issue if an issue at all.

Finally, going forward, there is a great need to develop instruments to measure SubDM capacity. In addition, there is a great need to study SubDM capacity empirically.

In conclusion, pondering the competency of SubDMs to make decisions for their wards further describes the space of acceptable decisionmaking in the context of surrogate decisionmaking.